SALVUS CENTER, INC

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Allergies/Hay Fever	☐ Chest/Heart	☐ Recent changes in:
☐ Anemia	☐ Back	☐ Weight
☐ Arthritis	☐ Intestinal	☐ Energy level
☐ Asthma	☐ Bladder	☐ Ability to sleep
☐ Bowel Irregularity	☐ Bowel	☐ Other pain/discomfort:
☐ Bronchitis	☐ Circulation	

SALVUS CENTER, INC
APPLICATION FOR PATIENT CARE

Please complete this form to the best of your ability and as fully and completely as possible. All of the requested information is needed to be able to provide you and your family with medical care at our clinic.

Date_____

APPLICANT INFORMATION					
FIRST NAME	**MI**	**LAST NAME**	**DATE OF BIRTH**	**SEX**	**MARITAL STATUS**
				M F	

HOME ADDRESS: STREET	**CITY**	**STATE**	**ZIP**	**HOME PHONE**

SOCIAL SECURITY NUMBER	**EMPLOYER**	**EMPLOYER ADDRESS**

EMPLOYER PHONE	**HOURS WORKED WEEKLY**	**AVERAGE MONTHLY EARNINGS**	**I WORK (CIRCLE ONE)**	
			FULL TIME	**PART TIME**

SPOUSE INFORMATION				
FIRST NAME	**MI**	**LAST NAME**	**DATE OF BIRTH**	**SEX**
				M F

EMPLOYER	**EMPLOYER ADDRESS**	**EMPLOYER PHONE**

HOURS WORKED WEEKLY	**AVERAGE MONTHLY EARNINGS**	**I WORK (CIRCLE ONE)**	
		FULL TIME	**PART TIME**

DEPENDENTS			
NAME	**AGE**	**DATE OF BIRTH**	**DO THEY LIVE WITH YOU?**

Do you or your spouse have health insurance provided by an employer? YES NO

Are you or your spouse eligible for TennCare or Medicare health insurance? YES NO

Are any of your dependents/children covered by TennCare insurance? YES NO

If you answered yes to any of the above, please give details about your health insurance:

_____

_____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?	
NAME	**PHONE**
ADDRESS	**RELATIONSHIP TO PATIENT**

INCOME SOURCES FOR YOUR FAMILY			
YOUR EARNINGS AVERAGE	**$**	**PER MONTH**	**SOURCE?**
YOUR SPOUSE EARNINGS AVERAGE	**$**	**PER MONTH**	**SOURCE?**
OTHER INCOME	**$**	**PER MONTH**	**SOURCE?**
OTHER INCOME	**$**	**PER MONTH**	**SOURCE?**
OTHER INCOME	**$**	**PER MONTH**	**SOURCE?**
TOTAL FAMILY INCOME	**$**	**PER MONTH**	
DO YOU OWN YOUR HOME?		**DO YOU RENT AN APARTMENT?**	

The information I have provided on this form is true and accurate to the best of my knowledge. I understand that Salvus Center, Inc. furnishes care only to those individuals that qualify for services under the Clinic's guidelines regarding health insurance status and employment. I understand that if I am accepted for care at the clinic I will be responsible for an affordable payment for each visit made to the Clinic by myself and/or a member of my immediate family. If I am accepted by the clinic I agree to follow all the Clinic regulations and guidelines.

By signing below I:

1. Authorize Salvus Center, Inc. to release records to me or my guardian.
2. Authorize Salvus Center, Inc. to release immunization records to any Tennessee school nurse or his/her designee for the above listed patient.

Your Signature

How did you hear about Salvus Center, Inc.? _____

Comments/Suggestions:
_____

May we use your name and/or comments in our monthly newsletter? _____YES _____No

SALVUS CENTER, INC.
PATIENT DATA FORM

Salvus Center, Inc. welcomes patients of all backgrounds. The information on this form will be kept confidential and is used for statistical purposes only. Please circle the answers that apply to you.

Patient Name: _____ Date: _____

1. City where you live: _____
2. Marital Status: Single Married Divorced
3. Race: African-American Caucasian Hispanic Other_____
4. Age: _____
5. Family Size _____
6. Living Situation:

   Own Home Live with a friend

   Rent Home/Apartment Live in a homeless shelter

   Live with a family member
7. Yearly family income range:

   $5,000 - $10,000 $30,000 - $40,000

   $10,000 - $20,000 $40,000 - $50,000

   $20,000 - $30,000
8. Primary Income Source

   Part-time employment self-employment

   Full-time employment spouse or parent employment
9. Place of employment of patient (spouse or parent if the patient is not working)

   _____
10. Education Level – Last grade completed

    High school (G.E.D.) _____ Vocational/Technical _____ College _____
11. Usual Source of Health Care:

    Physician's office _____ Name of physician

    Sumner Regional Medical Center Emergency Room

    Hendersonville Medical Center Emergency Room

    Portland Emergency Room

    Sumner County Health Department

    Usually do not go to the doctor

    Other
12. Number of visits to the Emergency room in the last year _____
13. How did you hear about Salvus Center? Newspaper Referral Brochure Internet Other: _____

SALVUS CENTER, INC.
556 HARTSVILLE PIKE SUITE 200
GALLATIN, TN 37066
PHONE: 615-451-0038 FAX: 615-451-0121

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Our office is permitted by privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health Information:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office – we are not required to grant the request, but we will comply with any request granted.
2. Obtain a paper copy of the Notice Of Privacy Practices for Protected Health Information by making a request at our office.
3. Right to inspect and copy your health record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances.
4. Right to request that your health care record be amended to correct incomplete information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendment); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment any denial be attached in all future disclosures of your protected health information.
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you at your request, or disclosures made to family members or friend in the course of providing care.
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request.

*If you want to exercise any of the above rights, please contact, Shelley Ames, Executive Director, Salvus Center, Inc., 556 Hartsville Pike Suite 200 Gallatin, TN 37066, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

This office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable request regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

* We reserve the right to amend, change or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of this Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information Or File A Complaint

If you have questions, would like to additional information, or want to report a problem regarding the handling of your information, you may contact Shelley Ames, Executive Director, at 615-451-0038.
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Shelley Ames. You may also file a complaint by mailing it to the Secretary of Health and Human Services whose street address is

The U.S. Department of Health and Human Services
200 Independence Avenue, S. W. Washington, DC 20201
1-202-619-0257 or Toll Free 1-877-696-6775

Other Uses and Disclosures Allowed by the Privacy Rule

- Patient contact:
  We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of fund-raising effort.
- Notification – Opportunity to Agree or Object
  Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
- Communication with family
  Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify health Information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency
- We may use and disclose our protected health information to assist in disaster relief efforts.

Public Health Activities

- Controlling Disease – As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Child Abuse & Neglect – We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.
- Food & Drug Administration (FDA) – We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.
- Victims of Abuse, Neglect, or Domestic Violence – We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statue or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to Prevent serious harm to the individual or other potential victim.
- Oversight Agencies – Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversite activities to include audits, civil, administrative or criminal investigations; inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.
- Judicial/Administrative Proceedings – We may disclose your protected health information in the course of judicial or administrative proceedings as allowed or required by law, or as directed by a proper court order or administrative tribunal, provide that only the protected health Information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
- Law Enforcement – We may disclose your protected health information for law enforcement purposes as required by law; such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.
- Coroners, Medical Examiners and Funeral Directors – We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
- Organ Procurement Organizations – Consistent with applicable law, we may disclose your protected health information to organ procurement organizations procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.
- Research – We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- threat to Health and Safety – To avert a serious, imminent threat to the health or safety of a person or the public.
- for Specialized Governmental Function – We may disclose your protected health information for specialized government functions as authorized by law such as Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- Correctional Institutions – If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected information to the extent necessary for your health and the health and safety of other individuals.
- Workers Compensation – If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
- Others Uses and Disclosures – Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization, which you may revoke except to the extent information or action has already been taken.
- Website – If we maintain a website that provides information about our entity, this Notice will be on the website.

EFFECTIVE DATE: MARCH 20, 2006

Please sign that you have read and agreed with this Notice.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

SIGNATURE OF REPRESENTATIVE/GUARDIAN (IF PATIENT IS A MINOR AND NOT ABLE TO SIGN) **DATE**

_____

RELATIONSHIP TO PATIENT

**** CHECK THE "YES" BOX BELOW IF YOU WANT A COPY OF THIS NOTICE****

□ Yes, I **DO** want a copy of this notice

□ No, I do **NOT** want a copy of this notice

SALVUS CENTER, INC.
PATIENT AGREEMENT

Salvus Center is committed to providing compassionate and quality health care to our patients. To better serve you, it is important that you understand our services and agree to abide by our policies.

ELIGIBILITY
Patients will be screened prior to see if they qualify to be a patient at Salvus Center. Periodically patients will be "re-screened" for eligibility. Salvus Center has the right at any time to request information from you, including but not limited to proof of address, current employment, and income. If you no longer meet our eligibility requirements, Salvus Center will be unable to continue to provide services to you.

SERVICES
Patient must pay for services at the time of the appointment with the doctor. Fees are based on your income and the number of people in your family. You must provide proof of employment, residency and the number of people in your family when you come for your appointment.

MEDICATIONS
It is very important to bring the medications that you are currently taking to every appointment or a current list of those medications including the name of the medication, strength, and how often you take that drug. Samples of medications may be supplied to the patient if it is available. Patients may also be given assistance to enroll in various patient assistance programs which provide free medications to patients if they qualify. In order to determine eligibility for those programs, you will be asked to bring a tax return from the most recent year. Patients may also be given prescriptions for some medications. **Salvus Center is unable to supply all medications to patients – patients will be expected to purchase some of their medications. Narcotic drugs are not kept in the clinic. We are unable to provide medications for chronic pain management.**

Lab Test, X-Rays, and Other Test
Test are provided to our patients by hospitals in Sumner County. You may be responsible for some portion of these cost of these test. You will be given an estimate of the charges and will be asked to pay your portion when the services are provided. Please do not go to the Emergency Room for these test. Our staff will help you schedule these test and direct you to employees at the hospital who can help you with the cost of the test.

Specialty Physician Referrals
Referrals to specialty physicians are made when our doctor determines it is medically necessary. These referrals are made as available and it is not guaranteed that the referral physician will be able to see you. If a referral is made, you will be responsible for the cost or some portion of the cost of these visits. The referral physicians will talk with you about the cost. Also, if surgery or further testing is needed, you will be responsible for all or some of the cost. The Salvus Center staff will help you with this scheduling.

Emergency Room Visits
Patients who seek care in the Emergency Rooms of local hospitals will be responsible for the total cost of these visits. Our patients are not given a discount for these visits.

Cancellations
Please call Salvus Center at 615-451-0038 at least 24 hours in advance if you cannot keep your appointment. If you do not show up for your appointment and have not called to cancel in advance, you will be considered a "no show". After three "no shows" you will be notified that Salvus Center will no longer be able to provide services to you. If you cancel your appointment less than 24 hours in advance or "no show" for an appointment you will be charged $10 for that missed visit. Also, please let us know if you will be running late for your appointment so we can let you know if you can still be seen or if you will need to reschedule.

I understand and agree to the following:

1. I will inform Salvus Center if my address, telephone number(s), employment income, or insurance status changes within 30 days of the change.
2. I will give Salvus Center 24 hours notice if I am unable to keep my appointment. If I miss three appointments without notifying Salvus Center, I understand that I may no longer be able to receive services at the clinic.
3. I understand that only appointments at Salvus Center are based on a sliding scale determined by my income and family size. I understand that I will be responsible for payment of services provided outside of Salvus Center by other providers. I understand that if I seek treatment in the Emergency Room, I will be responsible for those charges (bills).
4. I understand that I am solely responsible for following through on testing and treatment ordered by providers at Salvus Center. I understand that if I fail to follow the physician orders or fail to take my medications as prescribed, my treatment may be unsuccessful.
5. I understand that if I am uncooperative, verbally or physically abusive, intoxicated, or behave in an inappropriate manner, I may be unable to receive services at the Salvus Center.
6. I understand that my relationship with Salvus Center exists only so long as both of us desire the relationship. Either of us can terminate our relationship at any time, for any reason, without liability.

I have received a full explanation of Salvus Center's services and understand and agree to all of the above. I understand that I can be terminated from Salvus Center based on any of the above.

_____ _____

PATIENT'S SIGNITURE **DATE**

Salvus Center INC.
Partners in Health

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient's name:_____ Date of birth:_____

The Provider
Who has the information
That you would like to have
Released? (name and address)

O Hospital: _____
_____
_____

O Doctor/Clinic: _____
_____
_____

The Requester
To whom the
Information be sent?

O Salvus Center
556 Hartsville Pike Ste 200
Gallatin, TN 37066
Phone: 615-451-0038
Fax: 615-451-0121

The information to Be sent should Include...

O All record of treatment

O Other, _____
_____
_____

Special Authorization (Check the applicable box(es) and sign below.)
By signing below, I am authorizing the office to release any and all information regarding:

O Alcohol O Drugs O HIV/AIDS O Sexually – Transmitted Diseases

O Mental Health

Purpose for release Of information:

O Treatment and related uses O Other (Explain):_____
_____
_____

I give permission to the PROVIDER to release Medical Record Information to the above-named facility.
I understand that this release will take effect on the date signed and will be in effect for one year.

Signature of patient or guardian: _____ Date: _____

Medical Information Release Form
HIPAA Release of Information

Name: _____ Date of Birth: ____/____/____

I authorize the release of information including the diagnosis; treatment rendered to me and claim information. This information may be release to:

- ○ Spouse _____
- ○ Child(ren) _____
- ○ Other _____

○ **Information is not to be released to anyone.**

This Release of Information will remain in effect until terminated by me in writing.

Messages

The best number to reach me is: _____
If unable to reach me:

- ○ You may leave a detailed message
- ○ Please leave a message asking me to return your call
- ○ _____

The best time to reach me is (day)_____ between (time) _____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____