BATTLE BORN YOUTH CHALLE*NG*E ACADEMY

Lead the Way

MEDICAL APPLICATION

(Part Two)

Complete History Survey and see your Medical Care Provider with these forms.

The Youth & Medical applications must be submitted in their entirety before consideration can be given for acceptance.

Battle Born Youth Challe*NG*e Academy
PO Box 700
Carlin, NV. 89822

http://www.bbyca.org

Battle Born Youth Challe*NG*e Academy Medical Application

Dear Health Care Provider:

Please complete this Physical Form for admission to the Battle Born Youth Challe*NG*e Program (BBYCA). BBYCA is a volunteer program for youth 16-18 years of age, who are at-risk for dropping out of school or have already dropped out, located in Carlin, Nevada. The goal of our Program is to give youth a second chance to become responsible and productive citizens.

This Program consists of a 5-1/2 month residential stay in Carlin, Nevada. The Program training can by physically demanding and potentially hazardous. Physical training could include such physically strenuous activities as:

1. A daily run of two (2) or more miles over various terrains.
2. Daily vigorous physical exercises.

The Program is structured with a quasi-military model, promoting personal time management, accountability, and promoting positive and negative consequences for behavior. Cadets will be expected to comply with rules and regulations.

Mental and emotional demands of the Program include separation from family and loved ones, military-style discipline, military ceremonial drill for prolonged periods of time, marching and physical training. Cadets will live in close communal barracks with up to 50 other Cadets and must be able to cope with the inherent stress levels of barracks life.

We are staffed medically by two nurses (LPN or RN) who will see Cadets for minor injuries and illnesses. **We do not have a medical provider on staff, therefore, all medications will need to be maintained by the original prescriber throughout the youth's stay at BBYCA. Please provide or arrange for refills for the entire 6-months of his/her stay.** If this is not possible, please ensure the prescription is current, valid, and may be filled at our pharmacy.

This examination is for determining fitness to engage in strenuous activities and the *highly structured, stressful environment, as outlined above*. In most cases, the exam must be performed within twelve (12) months of the first day of the class start date. A shorter time interval may be required in some cases.

Any questions you have concerning this examination or your patient's ability to participate can be answered by contacting our medical department at **775-431-7062**. **All participants must have a physical, up-to-date immunizations, dental exam, and vision exam completed prior to acceptance.**

Medical Department:
775-431-7062

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form A – MEDICAL EXAMINATION

PURPOSE: **The following information must be filled-in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic.** Examination forms signed by any other health care practitioner will not be accepted.

APPLICANT'S NAME: _____ (Last) _____ (First) _____ (Middle)

Gender: ☐ Male ☐ Female **Age:** _____ **Date of Birth:** ____/____/____

Height: _____ **Weight:** _____ **P:** _____ **R:** _____ **B/P:** _____

Immunization Current: ☐ Yes or ☐ No **If not current, why?** _____

Vision: R 20/____ **L** 20/____ **Corrected?** ☐ Yes or ☐ No ***DATE OF LAST EYE EXAM: ____/____/____***

NORMAL	ABNORMAL		NORMAL	ABNORMAL	
		HEAD, FACE, NECK, SCALP			VASCULAR SYSTEM
		EARS – GENERAL			ABDOMEN & VISCERA (include hernia)
		DRUMS (PERFORATION)			ENDOCRINE SYSTEM
		NOSE			G-U SYSTEM
		SINUSES			UPPER EXTREMITIES
		MOUTH & THROAT			FEET
		EYES – GENERAL			LOWER EXTREMITIES
		OPTHALMASCOPIC			SPINE, OTHER MUSCULOSKELETAL
		PUPILS			IDENTIFYING BODY MARKS, SCARS, TATTOOS
		OCULAR MOTILITY			SKIN, LYMPHATIC
		LUNGS & CHEST			NEUROLOGICAL
		HEART			PSYCHIATRIC

HCG: Negative: _____ Positive: _____ **(Not used as selective screening criteria)** If Pos - EDC: _____

☐ Cleared for Full Participation – No Restrictions

☐ Cleared for Participation with the following accommodations for: _____

- Diagnosis: _____
- Treatment Plan / Accommodations: _____

☐ Not cleared for: _____ Reason: _____

PHYSICIAN SIGNATURE:

_____ **Physician Printed Name & Signature** _____ **Physician Phone #** _____/_____/_____ **Date of Evaluation**

_____ **Physician Address** _____ **Physician Fax #** _____ **Physician Email**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form B – MEDICATION AUTHORIZATION

APPLICANT'S NAME: _____ _____ _____
Last First Middle

MEDICATION AUTHORIZATION:

I give permission to the Academy Nurse and to those persons whom he/she has in-serviced to administer the medication(s) listed below. I give permission to the Academy Nurse as warranted, with the undersigned physician, regarding my youth's medications. I hereby agree to indemnify and hold forever harmless the Battle Born Youth Challe*NG*e Academy and their respective officials, agents, servants, and employees, against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor, for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state, as against such claim for reimbursement or indemnity.

MEDICATIONS SHOULD BE MAINTAINED BY THE ORIGINAL PRESCRIBER THROUGHOUT THE YOUTH'S STAY AT BBYCA. PLEASE PROVIDE REFILLS FOR THE ENTIRE SIX (6) MONTHS OF THEIR STAY.

SIGNATURES:

_____ _____/_____/_____
Youth Applicant Signature **Date**

_____ _____/_____/_____
Parent / Legal Guardian Printed Name & Signature **Date**

PHYSICIAN'S ORDER (to be completed by a LHP)**:**

Please list all prescription medication. All medications to be given by nebulizer must be provided in individual doses.

Medical Condition	Medication Name	Strength	Dosage	Route	Physician Signature

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form C – VISION HEALTH STATEMENT

PURPOSE: This patient is an Applicant for the Nevada Youth Challe*NG*e Academy (BBYCA) and may require an eye exam from an eye doctor specifying the information below. **This is a mandatory requirement for all Applicants.** Our desire is to ensure that Cadets in our Program will be able to see clearly when reading or viewing presentations from any seat in a classroom, without discomfort caused by poor vision or eye health. **Examinations can be no older than one (1) year from Program start date.**

APPLICANT'S NAME: _____ (Last) _____ (First) _____ (Middle) **DATE OF EXAM:** ____/____/_____

☐ This individual **HAS NORMAL** eye health.

☐ This individual **HAS ABNORMAL** eye health.

When answering the following statement, please consider the acuity required for reading or viewing presentations from any seat in the classroom.

☐ This individual **REQUIRES** corrective eyewear.

☐ This individual **DOES NOT REQUIRE** corrective eyewear.

SIGNATURES:

_____
Eye Care Provider Printed Name

_____ _____/_____/_____
Eye Care Provider Signature **Date**

_____ _____
Mailing Address **City** **State** **Zip Code** **Phone**

Battle Born Youth Challe*NG*e Academy Medical Application

ELKO COUNTY SCHOOL DISTRICT

IMMUNIZATIONS REQUIRED FOR SCHOOL ENROLLMENT

VACCINE	MINIMUM NUMBER OF DOSES
Diphtheria, Tetanus, Pertussis (DTaP, Td)	4-5 Doses □ Dose 5 is not necessary if Dose 4 was received after the fourth birthday □ Students aged 7-18 may require 3-4 doses; refer to Catch-up schedule for number of doses and intervals.
Diptheria, Tetanus, Pertussis (Tdap)	1 Dose □ One dose of Tdap is required prior to 7th grade entry. □ All new students entering 7-12 grades must have one dose of Tdap
Hepatitis A (Hep A)	2 Doses □ Must be given after the 1st birthday with at least 6 months between doses
Hepatitis B (Hep B)	3 Doses □ Must be at least 24 weeks (6 months) of age at time of dose 3
Measles, Mumps, Rubella (MMR)	2 Doses □ Must be given after the 1st birthday with 4 weeks between doses
Meningitis (MCV4)	1 Dose □ One dose of MCV4 is required prior to 7th grade entry. □ All new students entering 7-12 grades must have one dose of MCV4
Polio (IPV)	3 - 4 Doses □ The final dose of IPV series must be administered after the 4th birthday.
Varicella (VZV)	2 Doses, or Health Care Provider/Laboratory Verification

**Children who are 3 years old and are enrolling in school must be up-to-date with their immunizations. Please note that the final dose in the series (ie: Dtap, Polio, MMR, Varicella) will be due at age 4. Additionally, applicant must have been tested for tuberculosis in the last 4-years and present a negative test result when applying for the BBYCA. If the test results were positive, applicant must also present a current chest x-ray.*

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form D – SELF REPORT MEDICAL HISTORY

PURPOSE: The following information must be filled-in and signed, in order for the youth to participate in BBYCA. Understandably, youth will need to be able to withstand the physical and emotional stressors. These questions are designed to determine if the youth has developed any condition which would make it hazardous to participate in BBYCA academic / athletic program. "Yes" answers are not necessarily disqualifiers. Dishonesty or non-disclosure of medical history are disqualifiers.

APPLICANT'S NAME: _____ (Last) _____ (First) _____ (Middle) **Age:** _____

Parent / Legal Guardian: _____ **Date of Birth:** ____/____/____

Primary Care Physician: _____ **Physician Phone #:** _____

DO YOU HAVE OR HAVE YOU EVER HAD?	No	Yes	IF YES, EXPLAIN:
1 Asthma	☐	☐	
2 Sinusitis or hay fever	☐	☐	
3 Epilepsy or seizures	☐	☐	
4 Wear corrective lenses	☐	☐	
5 Lack of vision in either eye	☐	☐	
6 Hearing loss	☐	☐	
7 Food allergies	☐	☐	
8 Medication allergies	☐	☐	
9 Nose bleeds	☐	☐	
10 Shortness of breath	☐	☐	
11 Palpation or pounding heart	☐	☐	
12 High or low blood pressure	☐	☐	
13 Eating disorder	☐	☐	
14 Frequent sore throats	☐	☐	
15 Recurrent ear infections	☐	☐	
16 Frequent or severe headaches	☐	☐	
17 Dizziness or fainting spells	☐	☐	
18 Head injury	☐	☐	
19 Nerve injury	☐	☐	
20 Tonsils removed	☐	☐	
21 Jaundice or hepatitis	☐	☐	
22 Broken bones	☐	☐	
23 Skin disease	☐	☐	
24 Organ loss	☐	☐	
25 Hernia	☐	☐	
26 Periods of unconsciousness	☐	☐	
27 Recent gain / loss in weight	☐	☐	
28 Wear a brace or back support	☐	☐	
29 Swollen or painful joints	☐	☐	
30 Arthritis, rheumatism, or bursitis	☐	☐	
31 Frequent or painful urination	☐	☐	

(Continued on next page)

Battle Born Youth Challe*NG*e Academy Medical Application

DO YOU HAVE OR HAVE YOU EVER HAD?	No	Yes	IF YES, EXPLAIN:
32 Recurrent back pain or any back injury	☐	☐	
33 Trick or locked knee	☐	☐	
34 Foot trouble	☐	☐	
35 Bed wetting since age 12	☐	☐	
36 Household contact with anyone who has tuberculosis	☐	☐	
37 Tuberculosis or positive TB test	☐	☐	
38 Have you ever been sexually active	☐	☐	
39 STC / Syphilis / Gonorrhea, etc.	☐	☐	
40 Have you ever been diagnosed with a learning disability?	☐	☐	
41 Used illegal substance / Use tobacco	☐	☐	
42 Sleep walking	☐	☐	
43 Have you been a patient in any type of hospital?	☐	☐	
44 Have you had, or have you been advised to have any operations?	☐	☐	
45 Have you ever had any illness or injury other than those already noted?	☐	☐	
46 Diabetes or hypoglycemia*	☐	☐	
47 Heart trouble*	☐	☐	
48 Pain or pressure in chest*	☐	☐	
49 Bone, joint, or other deformity*	☐	☐	
50 Suicide attempt or plans*	☐	☐	
51 Ever been treated for mental health condition?*	☐	☐	
52 Chronic depression*	☐	☐	

*Questions with an * **require** clearance from a health care provider.*

FEMALES ONLY:

53 Treated For a female disorder	☐	☐	
54 Change in menstrual pattern	☐	☐	
55 Do you take any birth control?	☐	☐	
56 Date of last menstrual period: ___/___/___			

Please ensure you have not left any question unanswered. (Circle those questions you don't know the answers to, in order to indicate that you have read them). Include explanations on the following page for all those questions marked, "Yes." Explanations should include any of the following format that is applicable: "Date from – Date to, explanation or cause of illness or injury, treatment, or medication received/completed, outcome/result, etc."

_____ _____/_____/_____

Youth Applicant Signature **Date**

_____ _____/_____/_____

Parent / Legal Guardian Printed Name & Signature **Date**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form E – MEDICATION HISTORY

APPLICANT'S NAME: _____ _____ _____
Last First Middle

Are you currently using any over-the-counter medications? ☐ Yes or ☐ No

Are you currently using any prescribed medications? ☐ Yes or ☐ No

If yes, list all medications – dose and time taken: _____

_____

Medicine	Dose	Time	How long have you been taking it?

Have you stopped taking prescription medications within the last 3 months? ☐ Yes or ☐ No

If yes, list medications, and reasons for originally taking and reasons for discontinuing: _____

_____

Medicine	Reason for Medication	Why did you stop?

Are you allergic to any medications, foods, or other agents such as bee stings, ragweed, etc.? ☐ Yes or ☐ No

If yes, explain: _____

Do you have a current prescription for an Epi-pen? ☐ Yes or ☐ No

Do you have a current prescription for an inhaler? ☐ Yes or ☐ No

SIGNATURES:

I certify that I have reviewed the foregoing information, supplied by me, and that it is true and complete.

_____ _____/_____/_____

Youth Applicant Signature **Date**

_____ _____/_____/_____

Parent / Legal Guardian Printed Name & Signature **Date**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form F – DENTAL HEALTH STATEMENT

PURPOSE: This patient is an Applicant for the Battle Born Youth Challe*NG*e Academy (BBYCA). A dental examination is required by BBYCA to identify any required or anticipated dental work. **This is a mandatory requirement for all Applicants.** Our desire is that Cadets are able to participate in our Program, free from pain and discomfort caused by needed dental work. **Examinations can be no older than one (1) year from Program class start date.** Please complete the information below. This will facilitate this requirement.

APPLICANT'S NAME: _____ (Last) _____ (First) _____ (Middle) **DATE OF EXAM:** ____/____/_____

_____ By initialing, I certify that I have examined this youth and he/she has no apparent dental problems or concerns at this time.

Please indicate any dental or orthodontic treatments, if applicable:

_____

_____

_____

_____

Wisdom teeth <u>will not</u> be removed during the 5-1/2 month Residential phase of the program. If surgery is indicated, it needs to be completed at least two-weeks prior to the scheduled registration date. Sites must be completely healed and a release should be obtained from the dentist.

Cadets who wear braces should have adjustments made during scheduled break. Any appointments for orthodontia work will not be accommodated during the residential phase.

<u>SIGNATURES:</u>

_____
Dental Care Provider Printed Name

_____ _____/_____/_____
Dental Care Provider Signature **Date**

_____ _____
Mailing Address **City** **State** **Zip Code** **Phone**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form G – CONSENT FOR MEDICAL CARE

APPLICANT'S NAME: _____ _____ _____
Last First Middle

Social Security Number: _____-_____-_____ **Age:** _____ **Date of Birth:** ____/____/____

_____ _____
Mailing Address City State Zip Code Phone Number

This section is MANDATORY and must be filled out COMPLETELY

EMERGENCY CONTACT:

Contact Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: ____/____/____
Street City State Zip Code

Phone: _____

RESPONSIBLE PARTY (Person who is responsible for medical co-pays and outstanding balances):

Full Name: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____
Street City State Zip Code

Email address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

MEDICAL INSURANCE INFORMATION (Include a copy of your insurance card and/or Medicaid card – front & back)**:**

Medical Insurance Company: _____ Medicaid or Group #: _____

Policy Holder's Name: _____ SSN: _____ DOB: _____

Insurance Company Address: _____ Ins. Phone #: _____

SIGNATURES:

I hereby grant permission to BBYCA to provide medical care for my son/daughter. If my son/daughter needs emergency medical/dental attention due to an accident or injury, I hereby authorize the attending medical/dental personnel at the Emergency Facility to provide whatever treatment is necessary, to include but not limited to x-rays, anesthesia, diagnostic procedures, medical procedures, dental procedures, and/or interventions. In the event of an emergency illness or injury, I understand that reasonable effort will be made to contact me. Reasonable effort means that I may not be contacted first, but I will be contacted as soon as possible by the staff from BBYCA. I understand that BBYCA has full-time medical professionals. I grant permission for any of the Medical Staff and Cadre Team Leader in-charge to dispense medication to my son/daughter. This medication may be a prescription, which has been prescribed directly to my son/daughter by a physician, or it may be over-the-counter medication, as deemed necessary by BBYCA.

It is further understood that BBYCA carries medical insurance for accidental injuries only. Medical care outside the scope of BBYCA Staff will be the financial responsibility of the parent / legal guardian. The Medical Staff will determine the need for my son/daughter to be seen by a physician, if necessary.

_____ _____/_____/_____
Youth Applicant Signature **Date**

_____ _____/_____/_____
Parent / Legal Guardian Signature **Date**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form H – AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDS

PURPOSE: Both the parent/guardian and Applicant must read and sign this form, indicating their agreement and acceptance of the terms and conditions outlined below.

APPLICANT'S NAME: _____ _____ _____
Last First Middle

LIST OF OVER-THE-COUNTER MEDICATIONS THAT MAY BE USED:

Health Complaint	Examples of Medication Used
Allergies	Benadryl, Claritin, Allegra, Zyrtec
Athlete's Foot	Lotrimin, Anti-fungal creams
Bee Sting	Hydrocortisone cream, Benadryl
Cold, cough, sore throat	Mucinex, Coldonyl, Sudonyl, Delsem, chloraseptic spray
Constipation	Milk of Magnesia, Colace, MiraLAX
Cramps	Ibuprofen, Tylenol, Midol
Cuts, scrapes, lacerations	Hydrogen Peroxide, Bacitracin, Triple antibiotic ointment
Diarrhea	Imodium, Bismuth subsalicylate, Alkalak
Ear care	Debrox, Hydrogen Peroxide
Eye Irritation	Artificial tears, Visine
Ingrown toenail	Epsom salt soak
Insomnia	Melatonin
Irritated skin, bug bites, chapped lips	Aloe, Hydrocortisone cream, Carmex, Vaseline
Lice treatment	RID lice killing shampoo
Minor burns, sunburn	Aloe, sunscreen lotion
Mouth pain	Ambesol, orasol gel, dental wax
Pain, fever, headache	Tylenol, Ibuprofen, Naproxen
Upset stomach, heartburn	TUMS Antacid, Bismuth subsalicylate, Pepcid
Lactose Intolerant	Lactase Enzyme Chewable tablets

SIGNATURES:

I authorize the BBYCA Staff to give certain over-the-counter medications (per label instructions) for the treatment of minor injuries and illnesses (listed above). Before giving medications, the Nurse checks medical history, allergies, and any other medications your youth is taking, to make sure there is no conflict.

_____ _____/_____/_____
Youth Applicant Signature **Date**

_____ _____/_____/_____
Parent / Legal Guardian Printed Name & Signature **Date**

Battle Born Youth Challe*NG*e Academy Medical Application

BBYCA MED Form I – UNDERSTANDING OF LIMITED MEDICAL SERVICES

PURPOSE: This form outlines the medical conditions that might prevent entrance or continued enrollment into BBYCA. It explains the policies and procedures that govern how medications and medical services are provided to the Applicant.

APPLICANT'S NAME: _____ _____ _____
Last First Middle

OVERVIEW:

The Battle Born Youth Challe*NG*e Academy (BBYCA) has very limited medical services available to the Applicant. BBYCA has two full-time nurses that are available for minor illnesses and injuries. We are unable to provide and do not have the resources to transport youth to any "on-going" treatment or care. We are unable to accept Applicants who will require on-going psychiatric, medical or dental care. Parent(s)/legal guardian(s) are to take care of all medical, dental, and vision matters that will prevent Program participation prior to registration. All medical conditions must be disclosed at time of application. If it is learned after the Applicant arrives at BBYCA that serious medical conditions exist, the youth will be dismissed from the Program and sent home. BBYCA will not accept responsibility, financial for personal liability, or risk for previous medical, physical, or mental histories that limit participation in the Program. Applicants must have a physical examination completed by a licensed medial provider within twelve months from the start date of the class for which they are applying. All injuries and dental/medical/vision conditions must be resolved, and the Applicant free from additional required care, prior to entrance into the Program.

The following conditions may prevent entrance into BBYCA:

- Extensive use of multiple medications necessary to treat multiple conditions on a daily basis.
- Current or previous injuries/surgeries that prevent full participation in all BBYCA activities.
- Dental services: braces adjustments, broken teeth, cavities, abscess and mouth disorders that impact/prevent the ability of the Applicant to participate without on-site care or assistance.
- Conditions or medications that adversely react or have side effects impacted by the high intensity physical activity and seasonal weather conditions that that compromise the safety, health, and welfare of the youth. Medications/conditions that may react adversely to extreme summer heat and winter cold.
- Historic or current conditions requiring medical, psychological or psychotic intervention for suicide treatment, manic depression, anxiety, etc. Mental health services are not available from BBYCA.
- Extensive dietary restrictions medically required by a medical physician.

BBYCA medications/medical care policy:

- All required prescription medications must be disclosed in advance during the application process.
- All potential side effects and limitations of required medications must be disclosed at time of application.
- A medical release, approval and signature must be provided by the doctor in advance stating: Applicant can safely participate in extreme hot and cold conditions, while consuming required prescription/medication(s).
- Parents/guardians are entirely responsible for all prescription medications and re-fills during the Program.
- Parents/guardians are responsible for all required medical/dental/psychological care before, during, and after participation in BBYCA.
- Injuries/physical/medical changes or new medications, required by the Applicant after the initial physical examination, must be disclosed in writing prior to entry into BBYCA for purposes of review, safety, health, and welfare.
- Cadets with psychiatric, dental or medical needs that require ongoing "emergency" care off-site and time away from the Program for five (5) days, or that prevent participation will be dismissed and sent home.
- Medical/dental/vision care that does not hinder participation is to occur during BBYCA scheduled break.

SIGNATURES:

I understand and agree that I am responsible for all medical/dental/mental health care of my youth during, before and after participation in BBYCA. By my signature below, I acknowledge that I have read and understand the above medical information.

_____ _____/_____/_____
Youth Applicant Signature **Date**

_____ _____/_____/_____
Parent / Legal Guardian Printed Name & Signature **Date**

The Pill Box\
568 Spring Valley Ct
Spring Creek NV 89815
(775)778-3784
(775)778-3797

Request for Prescription Transfer

Name:_____
Address:_____
City:_____State:____ Zip Code: _____

Pharmacy Name: _____
Pharmacy Phone:_____
Pharmacy Address: _____
City:_____State: _____Zip Code: _____

Prescriptions to be transferred:
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____

Insurance Information
Insurance Provider:_____
Insurance RX BIN:_____
Insurance RX PCN: _____
Insurance Card Holder ID_____
Inusrance Group:_____

Credit Card Information

CC#_____ EXP Date: _____ CVC_____

Name: _____

Address: _____ST___ZIP_____

Signature:_____

PLEASE NOTE: Payment information will be encrypted in our system.