**Male New Patient Package**

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in Bioidentical hormone therapy. In order to determine if you are a candidate for bio- identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if hormone therapy can help you live a healthier life. **Please complete the following tasks before your appointment:**

**2 weeks or more before your scheduled consultation:** **IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, CALL OUR OFFICE FOR SELF-PAY BLOOD DRAWS.** We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to.  **Please note that it can take up to two weeks for your lab results to be received by our office. Please fast for 12 hours prior to your blood draw.**

**Your blood work panel MUST include the following tests:**

\_\_\_ Estradiol

\_\_\_ Testosterone Free & Total

\_\_\_ PSA Total

\_\_\_ TSH

\_\_\_ T4, Total

\_\_\_ T3, Free

\_\_\_ T.P.O. Thyroid Peroxidase

\_\_\_ CBC

\_\_\_ Complete Metabolic Panel

\_\_\_ Vitamin D, 25-Hydroxy

\_\_\_ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

**Male Post Insertion Labs Needed at 5 Weeks:**

\_\_\_ Estradiol

\_\_\_ Testosterone Free & Total

\_\_\_ PSA Total (If PSA was borderline on first insertion)

\_\_\_ CBC  
\_\_\_ Lipid Panel (Optional) **(Must be a fasting blood draw to be accurate)**

\_\_\_ TSH, T4 Total, T3 Free, TPO (**Only needed if you’ve been prescribed thyroid medication**)

Name: Today’s Date:   
 *(Last) (First) (Middle)*

Date of Birth: Age: Occupation:

Home Address:

City: State: Zip:

Home Phone: Cell Phone: Work:

Email Address:

How did you hear about us? ☐ Patient (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Event (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Practitioner (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Pharmacy (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Social Media (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ TV (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Radio (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Web (Keyword Searched:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Signage (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Print (Ad seen in:\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

In Case of Emergency Contact: Relationship:

Home Phone: Cell Phone: Work:

Pharmacy Name: Phone:

Address:

Primary Care Physician’s Name: Phone:

Address:

May we share your clinical information with your PCP? ☐ Yes ☐ No

**MEDICAL HISTORY**

Weight: Have you ever had any issues with anesthesia? ( ) Yes ( ) No   
Any known drug allergies: ( ) Yes ( ) No If yes please explain:

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Current Medications and dosage:

Nutritional/Vitamin Supplements:

Current Hormone Replacement Therapy: Past HRT:

Surgeries, list all and when:

Current medical conditions:

Do you/family member history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other

( ) Hemochromatosis  
( ) Depression / anxiety  
( ) Psychiatric disorder  
( ) Diabetes  
( ) Thyroid disease  
( ) Arthritis

( ) Trouble passing urine or take Flomax or Avodart  
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)

( ) Prostate enlargement  
( ) Elevated PSA  
( ) Cancer:

( ) Testicular or prostate Year:

( ) Other: Year:

( ) High blood pressure  
( ) High cholesterol  
( ) Heart disease  
( ) Stroke  
( ) Heart attack  
( ) Blood clot or pulmonary emboli

*I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, I will produce less testosterone from my testicles. And if I stop testosterone replacement I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.*

**PRINT NAME SIGNATURE DATE**

**MRS Checklist - BEFORE HRT**

**Which of the following symptoms apply at this time?**

**Place an “X” for EACH symptom. For symptoms that do not apply, please mark NONE.**

Extremely

None Mild Moderate Severe Severe

1. **Hot flashes, sweating** (episodes of sweating) ☐ ☐ ☐ ☐ ☐
2. **Heart discomfort** (unusual awareness of heart beat, ☐ ☐ ☐ ☐ ☐

heart skipping, heart racing, tightness)

1. **Sleep problems** (difficulty in falling asleep, difficulty in ☐ ☐ ☐ ☐ ☐

sleeping through the night, waking up early)

1. **Depressive mood** (feeling down, sad, on the verge of tears, ☐ ☐ ☐ ☐ ☐

lack of drive, mood swings)

1. **Irritability** (feeling nervous, inner tension, feeling aggressive) ☐ ☐ ☐ ☐ ☐
2. **Anxiety** (inner restlessness, feeling panicky) ☐ ☐ ☐ ☐ ☐
3. **Physical and mental exhaustion** (general decrease in performance, ☐ ☐ ☐ ☐ ☐

impaired memory, decrease in concentration, forgetfulness)

1. **Sexual problems** (change in sexual desire, ☐ ☐ ☐ ☐ ☐

in sexual activity and satisfaction)

1. **Bladder problems** (difficulty in urinating, increased need to urinate, ☐ ☐ ☐ ☐ ☐

bladder incontinence)

1. **Dryness of vagina** (sensation of dryness or burning in the vagina,☐ ☐ ☐ ☐ ☐

difficulty with sexual intercourse)

1. **Joint and muscular discomfort** (pain in the joints,☐ ☐ ☐ ☐ ☐

rheumatoid complaints)

**Please share any additional comments about your symptoms you would like to address.**

Bio-identical testosterone pellets are concentrated, compounded hormone, biologically identical to the testosterone that is made in your own body. Testosterone was made in your testicles prior to “andropause.” Bio-identical hormones have the same effects on your body as your own testosterone did when you were younger. Bioidentical hormone pellets are made from yams and bio-identical hormone replacement using pellets has been used in Europe, the U.S. and Canada since the 1930’s. Your risks are similar to those of any testosterone replacement but may be lower risk than alternative forms. During andropause, the risk of not receiving adequate hormone therapy can outweigh the risks of replacing testosterone.

**Risks of not receiving testosterone therapy after andropause include but are not limited to:**

Arteriosclerosis, elevation of cholesterol, obesity, loss of strength and stamina, generalized aging, osteoporosis, mood disorders, depression, arthritis, loss of libido, erectile dysfunction, loss of skin tone, diabetes, increased overall inflammatory processes, dementia and Alzheimer’s disease, and many other symptoms of aging.

**CONSENT FOR TREATMENT:** I consent to the insertion of testosterone pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. **Surgical risks are the same as for any minor medical procedure.**

**Side effects may include:**

Bleeding, bruising, swelling, infection and pain. Lack of effect (typically from lack of absorption). Thinning hair, male pattern baldness. Increased growth of prostate and prostate tumors. Extrusion of pellets. Hyper sexuality (overactive libido). Ten to fifteen percent shrinkage in testicle size. There can also be a significant reduction in sperm production.

There is some risk, even with natural testosterone therapy, of enhancing an existing current prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test is to be done before starting testosterone pellet therapy and will be conducted each year thereafter. If there is any question about possible prostate cancer, a follow-up with an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. While urinary symptoms typically improve with testosterone, rarely they may worsen, or worsen before improving. Testosterone therapy may increase one’s hemoglobin and hematocrit, or thicken one’s blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin and Hematocrit.) should be done at least annually. This condition can be reversed simply by donating blood periodically.

**BENEFITS OF TESTOSTERONE PELLETS INCLUDE:**

Increased libido, energy, and sense of well-being. Increased muscle mass and strength and stamina. Decreased frequency and severity of migraine headaches. Decrease in mood swings, anxiety and irritability (secondary to hormonal decline). Decreased weight (Increase in lean body mass). Decrease in risk or severity of diabetes. Decreased risk of Alzheimer’s and Dementia. Decreased risk of heart disease in men less than 75 years old with no pre-existing history of heart disease.

On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65 years old with pre-existing heart disease and men over the age of 75 years old with or without pre-existing heart disease. These studies were performed with testosterone patches, testosterone creams and synthetic testosterone injections and did not include subcutaneous hormone pellet therapy.

I agree to immediately report to my practitioner’s office any adverse reactions or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefits from the administration of bio-identical therapy. I certify this form has been fully explained to me, and I have read it or have had it read to me and I understand its contents. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

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**Print Name Signature Today’s Date**

**Hormone Replacement Fee Acknowledgment**

Although more insurance companies are reimbursing patients for the Bioidentical Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

**New Patient Consult Fee $150.00**

**Female Hormone Pellet Insertion Fee $400.00**

**Male Hormone Pellet Insertion Fee $650.00**

**Male Hormone Pellet Insertion Fee (>2000mg) $700.00**

**We accept the following forms of payment:**

**Master Card, Visa, Discover, American Express, Care Credit, Personal Checks and Cash.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Print Name Signature Today’s Date**

**HIPAA Patient Consent Form**

**\*\*\*A copy of the Patient Privacy Practices is posted.**

**If you would like a full copy of Patient Privacy Practices we will happily provide you with one**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portablility and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
* The Practice reserves the right to change the Notice of Privacy Practices.
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition receipt of the treatment upon execution of this Consent.
* The patient acknowledges that he/she has received a copy of our HIPAA practices handout.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Post-Insertion Instructions for Men**

* Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip and the outer layer is a waterproof dressing.
* We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue for swelling if needed. *Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.*
* No tub baths, hot tubs, or swimming pools for **7 days**. You may shower, but do not scrub the site until the incision is well healed (about 7 days).
* **No major exercises for the incision area for 7 days.** This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and walking.
* The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
* The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
* You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
* You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
* If you experience bleeding from the incision, apply firm pressure for 5 minutes.
* Please call if you have any bleeding (not oozing) not relieved with pressure, as this is NOT normal.
* Please call if you have any pus coming out of the insertion site, as this is NOT normal.

**Reminders:**

* Remember to go for your post-insertion blood work **4 weeks** after the insertion.
* Most men will need re-insertions of their pellets **5-6 months** after their initial insertion.
* Please call to make an appointment for re-insertion as soon as symptoms that were relieved from the pellets start to return. The charge for the second visit will be only for the insertion, not a consultation.

**Additional Instructions:**

**I acknowledge that I have received a copy and understand the instructions on this form.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name Signature Today’s Date**

**WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE)**

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

* + **FLUID RETENTION**: Testosterone stimulates the muscle to grow and retain water which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.
  + **SWELLING of the HANDS & FEET**: This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.
  + **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system.
  + **FACIAL BREAKOUT**: Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.
  + **HAIR LOSS**: Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

**OFFICE USE ONLY – INITIAL PELLET INSERTION FORM MALE**

**NAME: DATE**:

**Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature:\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT MEDICATIONS**:

**SURGERY/PAST MEDICAL HISTORY**:

**SYMPTOMS**:

**LABS:**

**Estradiol: \_\_\_\_\_\_\_\_\_\_ Testosterone:\_\_\_\_\_\_\_\_\_\_ Free Test:\_\_\_\_\_\_\_\_\_ PSA:\_\_\_\_\_\_\_\_\_\_ Vitamin D: \_\_\_\_\_\_\_\_\_**

**TSH: \_\_\_\_\_\_\_\_\_ Free T3: \_\_\_\_\_\_ Total T4: \_\_\_\_\_\_ TPO: \_\_\_\_\_\_\_ Hgb: \_\_\_\_\_\_\_\_ GFR: \_\_\_\_\_\_\_**

**LDL: \_\_\_\_\_\_\_\_\_HDL: \_\_\_\_\_\_\_\_ Triglycerides: \_\_\_\_\_\_\_**

**PLAN**:

This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of testosterone pellet implants was signed. An area in the hip was prepped with Chloraprep swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy was given to the patient. Placement was : L hip ☐, R hip☐, L flank ☐, R flank☐, Other \_\_\_\_\_\_\_\_\_\_\_. Pellets used are as follows;

**TREAT WITH:**

**Testosterone: \_\_\_\_\_\_\_\_\_\_\_ MG’s Testosterone Lot Numbers:**

**Femara**: **Arimidex**: **DIM**:

**Vitamin D**: **Thyroid Iodine**

**Probiotic:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Omega 3:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS:**

**Treatment Plan**

° The following medications or supplements are recommended in addition to your pellet therapy.

° Please refer to the supplement brochure to help you understand why these are beneficial.

° Unless specified, these can be taken any time of day without regards to meals.

**Supplements**: These may be purchased in our office. When you run out they can be mailed to you for your convenience.

**\_\_\_\_\_\_\_ ADK 5,000 (vitamins A, D3 and K2)**

\_\_\_\_\_\_ 1 a day\_\_\_\_\_ 2 a day for \_\_\_\_\_ weeks, then one a day

**\_\_\_\_\_\_\_ ADK 10,000 (vitamins A, D3 and K2)**

\_\_\_\_\_\_ 1 a day\_\_\_\_\_ 2 a day for \_\_\_\_\_ weeks, then one a day

**\_\_\_\_\_\_\_Probiotic** Take 1 a day for one week, then take 2 a day starting week 2

**\_\_\_\_\_\_\_Omega 3** Take 1 -4 softgels a daily with meal

**\_\_\_\_\_\_\_Iodine** 12.5 mg daily with food or as directed by physician

\_\_\_\_\_\_\_**DIM** Take 1 a day

\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescriptions**: **These have been called into your preferred pharmacy**

Please do not skip doses of this medication as it can result in vaginal bleeding or an increased risk for endometrial cancer.

**\_\_\_\_\_ Nature-throid**  \_\_\_\_\_\_\_ mg every morning. This should be taken on an empty stomach. Please wait 30 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements. \_\_\_\_\_ Sample given

\_\_\_\_\_Wean off Synthroid/levothyroxine: alternate your desiccated thyroid (Nature-throid) every other day with Synthroid/levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

**\_\_\_\_\_ Spironolactone** 100 mg daily \_\_\_\_ (other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Wean off your antidepressant (see wean protocol) \_\_\_\_ (other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please call or email for any questions about these recommendations.

**I acknowledge that I have received a copy and understand the instructions on this form**

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Print Name Signature Date