New Hampshire Veterans Home

139 Winter St.
Tilton, NH 03276

Margaret D. LaBrecque
Commandant

Telephone: (603) 527-4400
Fax : (603) 527-4402

Dear Applicant:

Thank you for your interest in the New Hampshire Veterans Home.

For more than a century, the Veterans Home has been a home and health resource for Granite State armed forces veterans. Established initially in 1890 as the Soldier's Home for Civil War Veterans, it has provided care and comfort for thousands who have served their country and fellow-citizens.

Located in the foothills of the magnificent White Mountains, the scenic beauty, along with the warm fellowship shared by residents, staff, and volunteers make for a most appropriate environment for those who have made personal sacrifices in the military and are now unable to care for themselves.

You will find the eligibility requirements within the Application packet for admission to the Home. Our own requirements, along with Federal and State regulations, necessitate that all applicants for admission provide full and complete information on the forms provided in this packet. Please note that any incomplete forms and/or information will result in a delay of the application process.

The Admissions Coordinators are available at 527-4846 or 527-4843 for questions regarding the application process and for scheduling a tour.
We look forward to hearing from you.

Sincerely,

Margaret D LaBrecque

Margaret D. LaBrecque
Commandant

TDD Access: Relay NH 1-800-735-2964

New Hampshire Veterans Home
Application for admission instructions.

If you meet the following Admissions Criteria, you are eligible for consideration for admission to the NH Veterans Home:

- Honorably Discharged from active duty service from the armed forces or reserve or NH Army/Air National Guard (takes effect August 19, 2010.).
- The applicant has been a resident of the State of New Hampshire for one (1) year preceding the application or home of record at discharge was NH.
- The applicant's condition(s) are within the Home's resources and ability to treat, and that the applicant does not present potential harm to self or other Residents.
- Financial Requirements (see Financial Cost Information sheet)

Applicant Completes the Following: (If a Physician has certified the Veteran lacks the capacity to understand his/her medical needs and has activated his Durable Power-of-Attorney for Health Care or there is a Guardian of the Person in place; then that designated person can complete the required paperwork)

- Application Form
- Final Requests Form
- Financial Affidavit
- Applicant Agreement Form
- Review and keep Notice of Privacy Practices
- Consent for Care & Treatment, Use of Health Care Information and Acknowledgement of Privacy Notice Form
- (3) Medical Release Forms
- Security Form
- Criminal Record Release Authorization Form (last page) - a signature in both
- places <u>must be</u> witnessed by a notary. There is <u>**no**</u> fee.

Give to your Physician or ARNP to Complete:

- Instructions to your MD/ARNP are on page 5 for them to complete both the VA Form 10-10SH and the NH Medical Information Form in its entirety.

Documentation to be included:

- **Original** DD-214 or other military papers showing entry and discharge dates with type of discharge. The original will be returned to you after VA verification.
- Copies of any Health Insurance Cards, including Medicare.(Please copy front and back of the insurance cards)
- Copies of Advanced Directives i.e. Living Will, Power of Attorneys for Healthcare and Finances or Guardianship over the Person and/or Estate.
- Certified Marriage Certificate/Civil Union Contract or Divorce Decree.
- Copy of proof of financial assets i.e. checking and saving statements and monthly income <u>**for One Full Year**</u>.
- Copies of Trusts, Long Term Care Insurance Policies and Deeds are required if applicable.

NH VETERANS HOME ADMISSION APPLICATION

Full Name: ________________________________ SS #: ________________________

Address: _________________________________ Phone #: _____________________

____

Where have you lived in the past two years? ____

DOB: ___________Place of Birth: ___________________________ Male: _____ Female: _____

Mother's Maiden Name: ___________________________

Religion: _______________Education Level: _____________

Previous Occupations: ____

Married/Civil Union: _____ Divorced: _____ Widowed: _____ Single: _____ Separated: ____

MILITARY INFORMATION:

Branch of Service: ____

Service Connected Disability? ___No ___ Yes, What %______

Type of Service Disability: ____

Date of Enlistment: __________________Place of Enlistment: __________________________

Date of Discharge: __________________ Place of Discharge: __________________________

Rank: _________________________ Type of Discharge: _______________

Veterans Service Groups: ____Post#:_______

____Post#:_______

MEDICAL INSURANCE INFORMATION:

Medicare: Part A ____ Part B ____Number:______________________

Other Insurances: _______________________________________Policy #:__________________

MEDICAL INFORMATION:

Primary Care Physician/ARNP: __________________________________

Address: ____

____

Phone: _________________

Fax: _________________

Name the hospitals you have been in the past 2 years:

____

____

____

LEGAL/CONTACT INFORMATION

LEGAL INFORMATION: Do you have any of the following? If so, please include copies.

	Yes	No	Name
Power of Attorney for Healthcare	______	______	______________________________
Power of Attorney for Finances	______	______	______________________________
Living Will	______	______	______________________________
Court Appointed Guardian	______	______	______________________________

SPOUSE/ PARTNER TO A CIVIL UNION:

Name:____

Phone Numbers: Home__________________Work____________________Cell__________________

Address: ____

City, State, Zip:____

Date of Birth:_________________________Social Security #:________________________

Date of Marriage or Civil Union:_______________City and State:_______________________

Date of Death (if applicable):____

FIRST CONTACT PERSON:

Name:____

Phone Numbers: Home__________________Work____________________Cell__________________

Address:____

City, State, Zip:____

Relationship:___________________ ☐Durable Power of Attorney for Healthcare? ☐Guardian?

SECOND CONTACT PERSON:

Name:____

Phone Numbers: Home__________________Work____________________Cell__________________

Address:____

City, State, Zip:____

Relationship:___________________ ☐Durable Power of Attorney for Healthcare?

___________________________ ___________________________

Witness Signature (Required) Veteran's Signature or Legally Authorized Person (DPOAHC, Guardian)

____

Date

NHVH MR# 0011
Revised 3/17/2008

Name:___________________________ SS #: ___________________________

FINAL REQUESTS

The following instructions direct the New Hampshire Veterans Home of my wishes in regards to final services in the event of my demise while a resident of the home.

Name of Funeral Home: ____
Address: ____
____
____
Phone Number: ________________________________

Location of cemetery plot: _______________________________________
Purchaser's name of plot: ____
Have these arrangements been prepaid? ______ Yes ______ No
Special instructions, i.e.: military funeral, private services, cremation, etc.:

____
____

Do you have Life Insurance? _____ Yes _____ No
Do you have a will? _____ Yes _____ No If yes, where is it located?

____

*I understand that if a funeral home has not been chosen; that one must chosen within 60 (sixty) days of admission to the Veterans Home.
*I understand that all personal possessions left at the Home 30 (thirty) days, after my departure, shall follow the procedure set forth by the NHVH's Deceased and Discharged Member Belongings Policy.
*I understand the Unit Social Worker, assigned to me, will inform me of the New Hampshire Veteran's Home "Final Salute" and will address the following:
Remembrance photo: Yes _____No_______
Final Salute participant: Yes_____ No_______

_______________________ ____
Witness Signature Veteran's signature or Legally Authorized Person (DPOAHC/Guardian)

____
Date

FINANCIAL COST INFORMATION

The financial cost to the veteran for residing at the Veterans Home is dependent on the veteran's assets up to $275,000.00 (This cap is set by The State of New Hampshire). The applicant's home is not an accountable asset if the spouse/civil union partner are residing in the Home or if legal documents demonstrate other ownership. There is a required one year look back of all assets. Therefore the cost of care is determined as follows:

- **With ASSETS BETWEEN $30,000 – $ 275,000.00 :** The veteran's room and board charges will be as a self-pay resident at a daily rate of $ 280.00 per day (subject to yearly change) until spend down to less than $ 30,000.00.

- **With ASSETS less than $30,000** the Veteran's room and board charges will be based on the veteran's **total** monthly income * based on the following formula:

Veteran's total monthly income = $_____
Deduct $l00.00 (for the veteran) - l00.00
New total of monthly income: = $
Multiply by X .90 **
This is the monthly cost to the veteran = $
*Monthly income represents all income received from federal, state or private companies, to include, but not limited to social security, retirement of any kind, interest income, annuities, VA disability/compensation check and other income sources received by the Veteran.
**The l0% difference is for personal needs, and expenses not covered.

- Additional spousal/civil partner assistance can be addressed by contacting the Business Administrator.

ROOM AND BOARD CHARGES include: all VA formulary prescription medications, 24 hour nursing care, physical therapy for maintenance/restorative care only, recreational activities, transportation to and from medical appointments ordered by the NHVH MD, all dietary services (three meals and snacks), daily housekeeping services, laundry services, incontinency products, basic cable TV, routine dental care, management of resident account and co-ordination of VA/Pension benefits, social services, library services.

EXPENSES NOT COVERED: Additional medical services may be required that are not covered by the room and board rate and of which may or may not be covered by the VA , Medicare, or other health care insurances you may have. Other items not covered are: non- covered VA formulary brand name prescription medications, 20 % Medicare co-pay, supplemental health care insurance premiums cost, hair cuts, personal clothing, personal toiletries, eyeglass prescriptions, dentures/partial plates (new or repaired), hearing aides (new or repaired), personal cell phones, personal computers, private travel to local banks, fees for legal documents, legal services, personal snacks, out of house meals, entertainment equipment as TV's, DVD's, CD's, Radios, etc and some durable medical equipment.

APPLICANT'S FINANCIAL AFFIDAVIT FOR NHVH

Name:____ **SS#:** _________________________

Assets:	**Veteran**	**Spouse or Civil Union Partner**	**Joint**	**Liabilities**
Checking Accounts	$____________	$______________	$____________	
Savings Accounts	$____________	$______________	$____________	
Certificates of Deposit	$____________	$______________	$____________	
Investments				
Annuities	$____________	$______________	$____________	
Mutual Funds	$____________	$______________	$____________	
Bonds	$____________	$______________	$____________	
IRAs	$____________	$______________	$____________	
Stocks	$____________	$______________	$____________	
Other Ret. Benefits	$____________	$______________	$____________	
Property				
Residence (value)	$____________	$______________	$____________	$__________Mortgage
Other Real Estate	$____________	$______________	$____________	$__________Mortgage
Rental Income	$____________	$______________	$____________	$__________
Time share	$____________	$______________	$____________	$__________
Business Ownership	$____________	$______________	$____________	$__________
Loans due you	$____________	$______________	$____________	

Alimony/Child Support: Yes_________ No_________ How much per month?_________________

Long Term Care Insurance: Yes_________ No_________ Rate per day___________________________

Length of coverage:____

Trusts: Yes_________ No_________ Revocable____________________ Irrevocable_______________

Monthly Incomes:	**Veteran**	**Spouse or Civil Union Partner**
Social Security	$______________	$______________
Military Retirement	$______________	$______________
Federal, State, City Retirement	$______________	$______________
Railroad Retirement	$______________	$______________
Other Retirement	$______________	$______________
Non-Service Connected Compensation	$______________	$______________
Service Connected Compensation	$______________	$______________
Interest on Investments	$______________	$______________
Income from other sources such as rental, loans due you, etc.	$______________	$______________
Total Monthly Income:	$______________	$______________

NEW HAMPSHIRE VETERANS HOME
AGREEMENT FORM

I understand the New Hampshire Veteran's Home is owned and operated by the State of New Hampshire and therefore subject to the rules of the State.

I give permission to the NH Veterans Home to provide requested information as needed to the Department of Veterans Affairs (VA). This includes spouse's income and Social Security number, which is required to determine VA benefits.

I agree to abide by the NH Veterans Home rules and regulations established by the Commandant, the Board of Managers, and the State of New Hampshire.

I verify that the assets listed in this application are accurately stated. I verify that I have not transferred any assets in the twelve-month period prior to applying to the New Hampshire Veterans Home, for the sole purpose of complying with the eligibility requirements.

I will provide proof of financial assets and monthly income during the admission process and anytime thereafter, upon request by the Business Office, in determining my monthly cost of care.

I agree to accept transfer/discharge to another facility capable of providing for my needs if the NHVH does not have the resources and is advised by the Medical Director.

I have read, or had read to me and understand the information provided in this application.

The information given in this admission application is true and correct to the best of my knowledge and belief. The New Hampshire Veterans Home reserves the right to request updated information regarding this application.

I certify there are no willful misrepresentations or answers to questions. If an investigation discloses such misrepresentations, my admission to the Home maybe denied. If I should already be a NHVH resident, I may be discharged from the Home.

______________________________ Witness Signature (Required)

______________________________ Veteran's Signature or Legally Authorized Person (DPOAHC, Guardian)

______________________________ Date

NHVH MR#0012
Revised: 3/17/2008

NEW HAMPSHIRE VETERANS HOME
139 Winter Street
Tilton, NH 03276

INSTRUCTIONS TO PHYSICIAN/ARNP

1 - Please complete VA form 10-10SH and the NHVH Medical Information Form on behalf of your patient, who is applying to the New Hampshire Veterans Home.

2 - Results of current (within last three (3) months): Chest X-Ray, TB Test, Urinalysis, and CBC **are required.** ***Note: If TB Test is positive, contact the Admissions Office for further instructions.***

3 - The Physician or ARNP's signature is required at the bottom of VA Form 10-10SH and where indicated on the NHVH Medical Information Form.

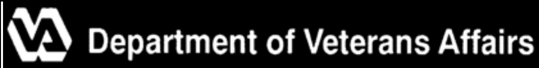
These papers may be faxed to: 603-527-4850 or mailed to:

Admission Coordinators
New Hampshire Veterans Home
139 Winter Street
Tilton, NH 03276

Please call the New Hampshire Veterans Home Admission Office at 603-527-4846 or 527-4843 if you have any questions.

Thank you.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 30 min.



STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

STATE HOME FACILITY	DATE ADMITTED	GENDER
New Hampshire Veterans Home		☐ M ☐ F
RESIDENT'S NAME *(Last, First, Middle) (This is a mandatory field)*	SOCIAL SECURITY NUMBER. *(Mandatory field)*	
RESIDENT'S STREET ADDRESS	AGE	DATE OF BIRTH *(mm/dd/yyyy)*
CITY, STATE AND ZIP CODE	ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES	

PART II - HISTORY AND PHYSICAL *(Use separate sheet if necessary)*

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT

NECK	CARDIOPULMONARY
ABDOMEN	GENITOURINARY
RECTAL	EXTREMITIES
NEUROLOGICAL	ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB						
	CHEST X-RAY	DATE *(mm/dd/yyyy)*	RESULTS	CBC	DATE *(mm/dd/yyyy)*	RESULTS
	SEROLOGY					
	URINALYSIS	DATE *(mm/dd/yyyy)*	ALBUMEN	SUGAR		ACETONE

CHECK ALL BOXES THAT APPLY OR CHECK NA ☐

IS DEMENTIA THE PRIMARY DIAGNOSIS	IS THERE A DIAGNOSIS OF MENTAL ILLNESS	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS	IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY

☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

OXYGEN				FOLEY CATHETER
		☐ TUBE FEEDING	☐ DECUBITUS ULCERS	
☐ MASK	☐ PRN	☐ OSTOMY	☐ DRAINING WOUND	☐ TEMPORARY
☐ NASAL CANULAR	☐ CONTINUOUS	☐ TRACHOSTOMY	☐ WOUND CULTURED	☐ PERMANENT

REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: ☐ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT HEALTH CARE ☐ HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

NEW HAMPSHIRE VETERANS HOME
MEDICAL INFORMATION FORM

Name:________________________________ DOB:________________Social Security#___________________

Immunizations:

Date of last Tetanus booster: ___________________________Date of last Pneumovax: _________________

Date of last Flu shot:____________________________

PPD (Required within 3 months of Application Date): Date__________Results____________________

Is Applicant free of communicable disease, including TB? ☐ Yes ☐ No

Past History of TB? ☐ Yes ☐ No Date:_______________Where Treated:__________________________

Past History:

Mental Illness* ☐ Yes ☐ No Date:_______________ Where Treated:_________________________

Type of Mental Illness ____

Alcohol Abuse* ☐ Yes ☐ No Date:_______________Where Treated:__________________________

Drug Abuse* ☐ Yes ☐ No Date:_______________Where Treated:__________________________

**Include copies of above Consults, if applicable*

Self Care Status: Can applicant do the following?

Dress self?	☐ Yes	☐ No
Feed self without assistance?	☐ Yes	☐ No
Use bathroom without assistance?	☐ Yes	☐ No
Incontinent? Bowel	☐ Yes	☐ No
Bladder	☐ Yes	☐ No
Does applicant exit seek?	☐ Yes	☐ No

Diet Order: ___________________________________**Activity Order:**______________________________

Mobility Status: ☐ Ambulatory ☐ Cane ☐ Wheelchair ☐ Walker

Does the Applicant have the capacity to understand Health Care Issues?

☐ Yes ☐ No

Has the Durable POA for Health Care been activated?

☐ Yes ☐ No Date:____________________________

Physician/ARNP Signature:_________________________________ **Date of Exam:**______________

Physician's Name & Address (Please print) ____

____

Phone:____Fax:____

FOR NH VETERANS HOME PHYSICIAN USE ONLY

☐ Recommend for Admission ☐ Not Recommended for Admission

Signature:_____________________________________ Date:_______________________________________

Comments:____

____

NHVH MR#0011
Revised: 3/17/2008

NEW HAMPSHIRE VETERANS HOME
139 WINTER STREET
TILTON, NH 03276

RELEASE OF INFORMATION

To: ____(Name of medical provider, i.e. Hospital, Physician, Rehab Center, VA Hospital, Nursing Home, VNA)

I, the undersigned, hereby authorize you to furnish a copy(ies) or allow a review of the medical record of:

______________________	______________	__________________
Name of Patient	Date of Birth	SS #

Address:____

City: State Zip Code: ____

Information requested is for the specific purpose of consideration for admission and for continued care if approved for admission to the New Hampshire Veterans Home:

- Discharge summaries for the past twelve months.
- Medical and psychiatric consults (including treatment of alcoholism/drug abuse) for the past twelve months.
- Chest x-rays and any laboratory results within the past 3 months.
- Immunization records.
- Primary care provider and consultant office notes for the past twelve months.
- Long term care facility medical records such as MDS, medication list, rehabilitation consults/summaries, medical/psychological consults, social work assessments, diet, MD orders, nursing notes, lab results, X-rays, immunizations.
- Most recent DPOAHC and/or POA and/or guardianship documents

Please mail to: **Admissions Coordinator**
New Hampshire Veterans Home
139 Winter Street
Tilton, N.H. 03276

The information obtained herein is confidential, must be used solely for the purpose as stated, and may not be re-released. I also request that my consent become invalid one year from the date of signature. This authorization is subject to revocation at any time, unless action on it has already begun in good faith.

Signature ____________________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

NHVH MRF#0015
Revised:7/6/12

NEW HAMPSHIRE VETERANS HOME
CONSENT TO TREATMENT, USE OF HEALTH CARE INFORMATION, AND RECEIPT OF PRIVACY NOTICE

Name of Resident:___________________________________ MR Number: __________________________

_____________ **(Please initial)** **1. Consent for Care and Treatment**

I hereby authorize New Hampshire Veterans Home, its staff, practitioners, and others involved in the provision of services on its behalf, to examine me, secure appropriate information, and perform any routine treatment that may be appropriate for my condition. I understand that the practitioner or other responsible person will explain to me any particular treatment, including both its benefits and its risks, and that I have the right to refuse any proposed treatment.

_____________ **(Please initial)** **2. Consent to Use of Health Care Information**

I understand that New Hampshire Veterans Home will make use of my health care information for purposes of treatment and other lawful functions including securing payment and other usual health care operations. I understand that this information may be available to persons working on behalf of New Hampshire Veterans Home, who will be subject to the same duty of confidentiality as New Hampshire Veterans Home with respect to my information. I understand that if New Hampshire Veterans Homes holds certain sensitive information related to my health care such as (i)records covered by federal law governing confidentiality of alcohol or drug abuse treatment programs; (ii) records covered by state rules governing the rights of recipients of mental health services;, or (iii) records concerning my diagnosis or treatment for HIV infection, then my specific authorization will be required to disclose such information to others. However, I consent to the use of such information by New Hampshire Veterans Home for purposes of my evaluation and treatment. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

_____________ **(Please initial)** **3. Acknowledgement of Receipt of Privacy Notice**

I acknowledge receipt of the Notice of Privacy Practice for Protected Health Information from New Hampshire Veterans Home. I understand this notice contains important information about how my medical information may be used and disclosed and how I can get access to this information.

______________________________________ ______________________________________

☐ Patient or ☐ Authorized Representative Date

Relationship to Resident: ☐ Self ☐ Guardian ☐ DPOAHC ☐ Other (Please specify)___________

______________________________________ ______________________________________

Witness Signature Date

NHVH MR#0073
Revised: 3/17/2008

NEW HAMPSHIRE VETERANS HOME
SECURITY FORM

Please read this form carefully and sign/date as instructed.
Your witness does not have to be a Notary.

If you have ever been convicted of a crime (Felony or Misdemeanor) that has not been officially annulled by a Court, you **MUST** complete the following section, giving the date, location and nature of the Felony or Misdemeanor conviction. *If you leave this space blank; you are certifying that you have no current record of conviction.*

____
____
____
____
____

Please note: Conviction is not an automatic disqualification for admission to the New Hampshire Veterans Home. Each case is considered individually. Willful omission or misrepresentation of required information will be a basis for rejection of your application to the NHVH.

______________________________	______________________________
Witness Signature (required)	Veteran's Signature or Legally Authorized Person (DPOAHC/Guardian)
	______________________________
	Date

New Hampshire Department of Safety

DIVISION OF STATE POLICE

Central Repository for Criminal Records
33 Hazen Drive, Concord, NH 03305

CRIMINAL RECORD RELEASE AUTHORIZATION FORM

SECTION I

PLEASE TYPE OR PRINT CLEARLY, ALL INFORMATION IN THIS SECTION **MUST BE COMPLETED**

NAME____
LAST (MAIDEN / ALIAS) FIRST MI

ADDRESS____
STREET CITY STATE ZIP CODE

DATE OF BIRTH____________HAIR COLOR_____EYE COLOR_____ SEX____________

DRIVER LICENSE NUMBER______________________STATE___________________

PURPOSE FOR RECORD: ☐ Housing ☐ Employment ☐ Annulment/Expungement ☒ Other: Admissions
Specify

My below signature certifies that I am the individual listed above and that the information provided is true.

YOUR SIGNATURE:__________________________________ DATE______________
Signed under penalty of unsworn falsification pursuant to RSA 641:3.

SECTION II

IF RECORD IS TO BE MAILED **TO YOU, OR** RECEIVED BY SOMEONE OTHER THAN YOURSELF,

ALL OF SECTION II MUST BE COMPLETED

I hereby authorize the release of my criminal record conviction(s), if any, to the following individual:

NAME OF PERSON / FIRM TO RECEIVE RECORD: New Hampshire Veterans Home

ADDRESS 139 Winter Street Tilton NH 03276
STREET CITY STATE ZIP CODE

YOUR SIGNATURE__________________________________DATE______________

NOTARY'S SIGNATURE______________________________DATE______________
(Affix Seal) **(Comm. Exp.)**

____DATE______________
SIGNATURE OF PERSON / FIRM TO RECEIVE RECORD