

**Study Abroad Medical/Physical Form**

This form serves to ensure the student has an opportunity to discuss medical needs, medications/prescriptions, questions/concerns related to participation in a study abroad program. Pages 1-3 (original) should be put into a sealed envelope with the student’s name and program on the outside of the envelope and then given to the Office of International Programs. The second portion of the form, page 4, the Physical Certification (original), is also to be submitted to IP, but not in a sealed envelope. The student should make a copy of the forms for their records and travel.

LAST Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Travel Itinerary:** List all countries of travel, including layovers and any countries you plan with visit.

Reason for travel abroad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return Date to the U.S.: \_\_\_\_\_\_\_\_\_\_\_\_

Arrival Date Country City, Region, or Area Departure Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**General Data:** DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_\_\_ Vision: R-20/\_\_\_\_\_\_\_ L-20/ \_\_\_\_\_\_ Corrected: \_\_ Y \_\_ N

Pupils: \_\_\_\_\_ Equal \_\_\_\_\_ Not Equal Hearing: Normal \_\_\_\_\_ Y \_\_\_\_\_ No Corrected: \_\_\_\_ Y \_\_\_\_ N

Known Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or existent medical conditions, including dietary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known accommodations related to a current or existent medical condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications/Prescriptions, including over-the-counter and vitamins:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consume alcohol? \_\_ Y \_\_ N If yes, how often? \_\_\_\_\_\_\_\_\_\_ Smoke? \_\_ Y \_\_ N If yes, how often?\_\_\_\_\_\_\_\_\_

E-Cig? \_\_ Y \_\_ N If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oral Tobacco? \_\_ Y \_\_ N If yes, how often?\_\_\_\_\_\_\_\_

Nicotine Patch? \_\_ Y \_\_ N If yes, how often? \_\_\_\_\_\_\_\_\_\_ Cigar? \_\_ Y \_\_ N If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_

Illegal Drug Use? \_\_\_\_ Y \_\_\_\_ N If yes, what drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations you have received and dates:**

|  |  |  |
| --- | --- | --- |
| Tetanus (last):  TDAP \_\_\_\_\_\_\_\_\_  Td \_\_\_\_\_\_\_\_ | MMR:  1 \_\_\_\_\_\_\_\_\_  2 \_\_\_\_\_\_\_\_\_ | Hepatitis B:  1 \_\_\_\_\_\_\_\_  2 \_\_\_\_\_\_\_\_ |
| Polio (last)  \_\_\_\_\_\_\_\_\_ | Japanese Encephalitis  \_\_\_\_\_\_\_\_\_\_ | Hepatitis A:  1 \_\_\_\_\_\_\_\_  2 \_\_\_\_\_\_\_\_ |
| Yellow Fever  \_\_\_\_\_\_\_\_\_\_ | Typhoid Oral caps  \_\_\_\_\_\_\_\_\_ | Hepatitis A&B:  1 \_\_\_\_\_\_\_\_  2 \_\_\_\_\_\_\_\_ |
| Varicella  1 \_\_\_\_\_\_\_\_\_  2 \_\_\_\_\_\_\_\_\_ | Typhoid injection  \_\_\_\_\_\_\_\_\_ | Meningococcal  \_\_\_\_\_\_\_\_\_\_ |
| Pneumococcal 23-vallent  \_\_\_\_\_\_\_\_\_ | Influenza  \_\_\_\_\_\_\_\_ | Rabies (>3 doses)  \_\_\_\_\_\_\_\_\_\_ |

**Risk Assessment: Please check all that apply:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Time w/animals  Farms, zoo | Excessive Walking | Rural Area ONLY | Urban Areas ONLY | Biking | Stay w/local family | High altitude (over 8,000 ft/2,500 m | Scuba Diving |
| Excessive Walking | Spelunking/caving | Excessive freshwater exposure | Mosquitoes | Share living space | Public transport | Excessive saltwater exposure | Historic Location, including uneven pavement |

**Medical Conditions:**

|  |  |  |
| --- | --- | --- |
| Positive TB Skin Test | Severe Headaches | Blood Clotting Disorder, a DVT or PE |
| Heart Problems | Pregnant/Breastfeeding | Any Thymus Disorders |
| Seizure Disorders | Sickle Cell Anemia or Sickle Cell Trait | Tested for G6^PD deficiency |
| Psoriasis | History of tendon rupture | Splenectomy |
| Asthma | Diabetes | Immune Deficiency |
| Psychiatric Disorder | Carry and Epinephrine-EpiPen | Latex Allergy |
| Penicillin Allergy | Other: | Other: |

**Heath History:**

* Anemia - Have you ever been diagnosed with or sought treatment for Anemia?
* Asthma/Hay Fever - Have you ever been diagnosed with or sought treatment for Asthma/Hay Fever?
* Blood Pressure Problems - Have you ever been diagnosed with or sought treatment for Blood Pressure Problems? High or Low Blood Pressure Problems.
* Cancer/Tumors - Have you ever been diagnosed with or sought treatment for Cancer/Tumors?
* Chemical Dependency - Have you ever been diagnosed with or sought treatment for Chemical Dependency?
* Have you ever been diagnosed with Chicken Pox?
* Have you ever been diagnosed with Convulsive Disorders?
* Depression/Anxiety – Have you ever been diagnosed with or sought treatment for Depression/Anxiety?
* Diabetes - Have you ever been diagnosed with or sought treatment for Diabetes?
* Eating Related Disorders - Have you ever been diagnosed with or sought treatment for Eating Related Disorders?
* Heart Disease/Rheumatic Fever - Have you ever been diagnosed with or sought treatment for Heart Disease/Rheumatic Fever?
* Kidney Disease – Have you ever been diagnosed with or sought treatment for Kidney Disease?
* Malaria - Have you ever been diagnosed with or sought treatment for Malaria?
* Panic Attacks - Have you ever been diagnosed with or sought treatment for Panic Attacks?
* Stomach/Intestinal Disorders - Have you ever been diagnosed with or sought treatment for Stomach/Intestinal Disorders?

Any other concerns:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician Certification Form**

This form serves to ensure the student has an opportunity to discuss medical needs, medications/prescriptions, questions/concerns related to participation in a study abroad program. This portion of the form needs to be submitted to the UNCP SA Coordinator with IP.

LAST Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Banner ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

To ensure the patient is aware of the recommended or required immunizations for travel to the country(ies) listed above, the Center for Disease Control (CDC), the World Health Organization (WHO), the U.S. Department of State, and HTH Worldwide (the required student insurance) are resources for advising.

* It is my professional/medical opinion, this patient meets the physical/medical requirements to participate in a study abroad program based on the information provided by the student.
* All listed medications have been discussed with regard to entering the country(ies) listed above, the ability to have a prescription filled in the host country(ies), and/or a generic medication/prescription (in case the primary medication/prescription is not permitted to be taken into said country(ies) or obtained in said country(ies)), etc.
* I have discussed with the patient all possible conditions, diseases or other factors the student may be exposed to while participating in this study abroad program, per the countries and activities listed above.
* I have discussed all recommended or required vaccines and/or immunizations for the country(ies) listed above. \*\*If any immunization are required the student will need to obtain proof of the vaccines and/or immunizations\*\*

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_