**FUNCTION REPORT**

**SECTION A: GENERAL INFORMATION**

1. **NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **DAYTIME PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **WHERE DO YOU LIVE? (PLEASE CHECK ONE.)**
	* **HOUSE ( )**
	* **APARTMENT ( )**
	* **BOARDING HOUSE ( )**
	* **NURSING HOME ( )**
	* **SHELTER ( )**
	* **GROUP HOME ( )**
	* **OTHER (WHAT?) ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **WITH WHOM DO YOU LIVE? (PLEASE CHECK ONE.)**
	* **ALONE ( )**
	* **WITH FAMILY ( )**
	* **WITH FRIENDS ( )**
	* **OTHER (DESCRIBE RELATIONSHIP.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SECTION B: INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS**

1. **HOW DO YOUR ILLNESSES, INJURIES OR CONDITIONS LIMIT YOUR ABILITY WORK?**

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**SECTION C: INFORMATION ABOUT DAILY ACTIVITIES**

1. **DESCRIBE WHAT YOU DO FROM THE TIME YOU WAKE UP UNTIL GOING TO BED.**

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**2. DO YOU TAKE CARE OF ANYONE ELSE SUCH AS A WIFE/HUSBAND, CHILDREN, GRANDCHILDREN, PARENTS, FREIND, OTHER? YES ( ); NO ( )**

**IF YES, FOR WHOM DO YOU CARE, AND WHAT DO YOU DO FOR THEM?**

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**3. DO YOU TAKE CARE OF PETS OR OTHER ANIMALS? YES ( ); NO ( )**

**IF YES, WHAT DO YOU DO FOR THEM?**

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**4. DOES ANYONE HELP YOU CARE FOR OTHER PEOPLE OR ANIMALS?**

 **YES ( ); NO ( )**

**IF YES, WHO HELPS, AND WHAT DO THEY DO TO HELP?**

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**5. WHAT WERE YOU ABLE TO DO BEFORE YOUR ILLNESSES, INJURIES, OR CONDITIONS THAT YOU CAN’T DO NOW?**

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**6. DO THE ILLNESSES, INJURIES OR CONDITIONS AFFECT YOUR SLEEP?**

 **YES ( ); NO ( )**

**IF YES, HOW?**

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**7. PERSONAL CARE (CHECK HERE \_\_\_\_\_ IF NO PROBLEM WITH PERSONAL CARE.)**

1. **EXPLAIN HOW YOUR ILLNESSES, INJURIES OR CONDITIONS AFFECT YOUR ABILITY TO:**
* **DRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **BATHE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **CARE FOR HAIR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **SHAVE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **FEED SELF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **USE THE TOILET\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**b. DO YOU NEED ANY SPECIAL REMINDERS TO TAKE CARE OF PERSONAL NEEDS AND GROOMER? YES ( ); NO ( )**

**IF YES, WHAT TYPE OF HELP OR REMINDERS ARE NEEDED?**

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**c. DO YOU NEED HELP OR REMINDERS TAKING MEDICINE? YES ( ); NO ( )**

**IF YES, WHAT KIND OF HELP DO YOU NEED?**

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**8. MEALS**

1. **DO YOU PREPARE YOUR OWN MEALS? YES ( ); NO ( )**

**IF YES, WHAT KIND OF FOOD DO YOU PREPARE? (FOR EXAMPLE, SANDWICHES, FROZEN DINNERS, OR COMPLETE MEALS WITH SEVERAL COURSES.)**

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**HOW OFTEN DO YOU PREPARE FOOD OR MEALS? (FOR EXAMPLE, DAILY, WEEKLY, MONTHLY.)**

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**HOW LONG DOES IT TAKE YOU?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY CHANGES IN COOKING HABITS SINCE YOUR ILLNESSES, INJURIES, CONDITIONS BEGAN?**

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**b. IF NO, EXPLAIN WHY YOU CANNOT OR DO NOT PREPARE MEALS.**

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**9. HOUSE AND YARD WORK:**

1. **LIST HOUSEHOLD CHORES, BOTH INDOORS AND OUTDOORS, THAT YOU ARE ABLE TO DO. (FOR EXAMPLE, CLEANING, LAUNDRY, HOUSEHOLD REPAIRS, IRONING, MOWING, ETC.)**

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**b. HOW MUCH TIME DOES IT TAKE YOU, AND HOW OFTEN DO YOU DO EACH**

 **OF THESE THINGS?**

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**c. DO YOU NEED HELP OR ENCOURAGEMENT DOING THESE THINGS?**

 **YES ( ); NO ( )**

**IF YES, WHAT HELP IS NEEDED?**

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**d. IF YOU DON'T DO HOUSE OR YARD WORK, EXPLAIN WHY NOT.**

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**10. GETTING AROUND**

1. **HOW OFTEN DO YOU GO OUTSIDE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF YOU DON’T GO OUT AT ALL, EXPLAIN WHY NOT.**

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**b. WHEN GOING OUT, HOW DO YOU TRAVEL? (CHECK ALL THAT APPLY.)**

* **WALK ( )**
* **DRIVE A CAR ( )**
* **RIDE IN A CARE ( )**
* **RIDE A BICYCLE ( )**
* **USE PUBLIC TRANSPORTATION ( )**
* **OTHER (EXPLAIN) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**c. WHEN GOING OUT, CAN YOU GO OUT ALONE? YES ( ); NO ( )**

**IF NO, EXPLAIN WHY YOU CAN’T GO OUT ALONE.**

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**d. DO YOU DRIVE? YES ( ); NO ( )**

**IF YOU DON’T DRIVE, EXPLAIN WHY NOT.**

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**11. SHOPPING**

1. **IF YOU DO ANY SHOPPING, DO YOU SHOP: (CHECK ALL THAT APPLY.)**
* **IN STORES ( )**
* **BY PHONE ( )**
* **BY MAIL ( )**
* **BY COMPUTER ( )**

**b. DESCRIBE WHAT YOU SHOP FOR:**

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**c. HOW OFTEN DO YOU SHOP AND HOW LONG DOES IT TAKE?**

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**12. MONEY:**

1. **ARE YOU ABLE TO:**
* **PAY BILLS: YES ( ); NO ( )**
* **COUNT CHANGE: YES ( ); NO ( )**
* **HANDLE A SAVINGS ACCOUNT: YES ( ); NO ( )**
* **USE A CHECKBOOK/MONEY ORDERS: YES ( ); NO ( )**

**EXPLAIN ALL “NO” ANSWERS:**

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**b. HAS YOUR ABILITY TO HANDLE MONEY CHANGED SINCE THE ILLNESSES, INJURIES, OR CONDITIONS? YES ( ); NO ( )**

**IF YES, EXPLAIN HOW THE ABILITY TO HANDLE MONEY HAS CHANGED.**

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**13. HOBBIES AND INTERESTS:**

1. **WHAT ARE YOUR HOBBIES AND INTERESTS? (FOR EXAMPLE, READING, WATCHING TV, SEWING, PLAYING SPORTS, ETC.)**

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1. **HOW OFTEN AND HOW WELL DO YOU DO THESE THINGS.**

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1. **DESCRIBE ANY CHANGES IN THESE ACTIVITIES SINCE THE ILLNESSES, INJURIES OR CONDITIONS BEGAN.**

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**14. SOCIAL ACTIVITIES:**

1. **HOW DO YOU SPEND TIME WITH OTHERS? (CHECK ALL THAT APPLY.)**
* **IN PERSON ( )**
* **ON THE PHONE ( )**
* **EMAIL ( )**
* **TEXTING ( )**
* **MAIL ( )**
* **VIDEO CHAT (FOR EXAMPLE, SKYPE OR FACEBOOK)**
* **OTHER (EXPLAIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
1. **DESCRIBE THE KINDS OF THINGS YOU DO WITH OTHERS.**

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**HOW OFTEN DO YOU DO THESE THINGS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **LIST THE PLACES YOU GO ON A REGULAR BASIS. (FOR EXAMPLE, CHURCH, COMMUNITY CENTER, SPORTS EVENTS, SOCIAL GROUPS, ETC.)**

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**DO YOU NEED TO BE REMINDED TO GO PLACES? YES ( ); NO ( )**

**HOW OFTEN DO YOU GO AND HOW MUCH DO YOU TAKE PART?**

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**DO YOU NEED SOMEONE TO ACCOMPANY YOU? YES ( ); NO ( )**

**IF YES, EXPLAIN.**

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1. **DO YOU HAVE ANY PROBLEMS GETTING ALONG WITH FAMILY, FRIENDS, NEIGHBORS, OR OTHERS? YES ( ); NO ( )**

**IF YES, EXPLAIN:**

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1. **DESCRIBE ANY CHANGES IN SOCIAL ACTIVITIES SINCE THE ILLNESSES, INJURIES, OR CONDITIONS BEGAN.**

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**SECTION D: INFORMATION ABOUT ABILITIES:**

**15. a. CHECK ANY OF THE FOLLOWING ITEMS THAT YOUR ILLNESSES, INJURIES, OR ABILITIES AFFECT:**

* **LIFTING ( )**
* **SQUATTING ( )**
* **BENDING ( )**
* **STANDING ( )**
* **REACHING ( )**
* **WALKING ( )**
* **SITTING ( )**
* **KNEELING ( )**
* **TALKING ( )**
* **HEARING ( )**
* **STAIR CLIMBING ( )**
* **SEEING ( )**
* **MEMORY ( )**
* **COMPLETING TASKS ( )**
* **CONCENTRATION ( )**
* **UNDERSTANDING ( )**
* **FOLLOWING INSTRUCTIONS ( )**
* **USING HANDS ( )**
* **GETTING ALONG WITH OTHERS ( )**

**PLEASE EXPLAIN HOW YOUR ILLNESSES, INJURIES, OR CONDITIONS AFFECT EACH OF THE ITEMS YOU CHECKED (FOR EXAMPLE, YOU CAN ONLY LIFT [HOW MANY POUNDS], OR YOU CAN ONLY WALK [HOW FAR]).**

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**b. ARE YOU: RIGHT HANDED? ( ); LEFT HANDED ( )?**

**c. HOW FAR CAN YOU WALK BEFORE NEEDING TO STOP AND REST?\_\_\_\_\_\_\_\_\_**

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**IF YOU HAVE TO REST, HOW LONG BEFORE YOU CAN RESUME WALKING?\_\_\_\_\_**

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**d. FOR HOW LONG CAN YOU PAY ATTENTION?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**e. DO YOU FINISH WHAT YOU START? (FOR EAMPLE, A CONVERSATION, CHORES, READING, WATCHING A MOVIE.) YES ( ); NO ( )**

**f. HOW WELL DO YOU FOLLOW WRITTEN INSTRUCTIONS? (FOR EXAMPLE, A**

**RECIPE.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**g. HOW WELL DO YOU FOLLOW SPOKEN INSTRUCTIONS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**h. HOW WELL DO YOU GET ALONG WITH AUTHORITY FIGURES? (FOR EXAMPLE, POLICE, BOSSES, LANDLORDS, OR TEACHERS.)**

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1. **HAVE YOU EVER BEEN FIRED OR LAID OFF FROM A JOB BECAUSE OF PROBLEMS GETTING ALONG WITH OTHER PEOPLE? YES ( ); NO ( )**

**IF YES, PLEASE EXPLAIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**IF YES, PLEASE GIVEN NAME OF EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**j. HOW WELL DO YOU HANDLE STRESS?**

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**k. HOW WELL DO YOU HANDLE CHANGES IN ROUTINE?**

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**l. HAVE YOU NOTICED ANY UNUSUAL BEHAVIOR OR FEARS?**

**YES ( ); NO ( )**

**IS YES, PLEASE EXPLAIN:**

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**16. DO YOU USE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY.)**

* **CRUTCHES ( )**
* **WALKER ( )**
* **WHEELCHAIR ( )**
* **CANE ( )**
* **BRACE/SPLINT ( )**
* **ARTIFICIAL LIMB ( )**
* **HEARING AID ( )**
* **GLASSES/CONTACT LENSES ( )**
* **ARTIFICIAL VOICE BOX ( )**
* **OTHER (EXPLAIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHICH OF THESE WERE PRESCRIBED BY A DOCTOR? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**WHEN WAS IT PRESCRIBED?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHEN DO YOU NEED TO USE THESE AIDS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**17. DO YOU CURRENTLY TAKE MEDICINES FOR YOUR ILLNESSES, INJURIES,**

**OR CONDITION? YES ( ); NO ( )**

**IF YES, DO ANY OF YOUR MEDICINES CAUSE SIDE EFFECTS? YES ( ); NO ( )**

**IF YES, PLEASE EXPLAIN. (DO NOT LIST ALL OF THE MEDICINES THAT YOU TAKE. LIST ONLY THE MEDICINES THAT CAUSE SIDED EFFECTS.**

|  |  |
| --- | --- |
| NAME OF MEDICINE | SIDE EFFECTS YOU HAVE |
|  |  |
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**SECTION E: REMARKS**

**USE THIS SECTION FOR ANY ADDED INFORMATION YOU DID NOT SHOW IN EARIER PARTS OF THIS FORM. WHEN YOU ARE DONE WITH THIS SECTION (OR IF YOU DIDN’T HAVE ANYTHING TO ADD), BE SURE TO COMPLETE THIS FIELDS AT THE BOTTOM OF THIS SECTION.**

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**NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DATE (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**