APPLICATION FOR EMPLOYMENT

All prospective employees will receive consideration without discrimination because of race, color, creed, age, natural oaring or handicap. All information provided herein will be kept Confidential.

Personal

_____ _____

Last Name First Name Middle date

_____ _____

Street Address Home Phone

_____ _____

City, State, Zip Code Business Phone

Emergency contact (person not living with you) _____

Have you ever applied for employment with this Agency? _____Yes _____No

How many hours a week are available for work? _____

Are you legally eligible for employment in the United States? _____Yes _____No

How did you learn of our Organization? ___Newspaper ad _____agency employee _____Other

Are you willing to work: _____evening _____weekends?

Position applying for: _____

Education:

School Name	**Location of School**	**Course of Study Degree/ Study**	**Years**	**Diploma**
College:				
_____	_____	_____	____	_____
_____	_____	_____	____	_____
Vo-Tech or Trade:				
_____	_____	_____	____	_____
_____	_____	_____	____	_____
High School:				
_____	_____	_____	____	_____

_____ _____ _____ ____ _____

Other:

_____ _____ _____ ____ _____

_____ _____ _____ ____ _____

Employment history:

List the last five (5) years employment history, starting the most recent employer.

1.Company Name: _____ Telephone: _____

Address: _____ Date of Employment: _____

_____ Starting pay: _____

City State Zip Code

Job Title and Describe your Work: _____ Reason for leaving: _____

2.Company Name: _____ Telephone: _____

Address: _____ Date of Employment: _____

_____ Starting pay: _____

City State Zip Code

Job Title and Describe your Work: _____ Reason for leaving: _____

3.Company Name: _____ Telephone: _____

Address: _____ Date of Employment: _____

_____ Starting pay: _____

City State Zip Code

Job Title and Describe your Work: _____ Reason for leaving: _____

4.Company Name: _____ Telephone: _____

Address: _____ Date of Employment: _____

_____ Starting pay: _____

City State Zip Code

Job Title and Describe your Work: _____ Reason for leaving: _____

5.Company Name: _____ Telephone: _____

Address: _____ Date of Employment: _____

_____ Starting pay: _____

City State Zip Code

Job Title and Describe your Work: _____ Reason for leaving: _____

Was your Name different from your present name during the above listed jobs? _____Yes _____No

If Yes, what was your Name_____

Are you currently employee? _____Yes _____No

Do you have reliable transportation? _____Yes _____No

Professional References

Person who can furnish information about job performance

1.Name_____Telephone_____

Fax: _____

Address: _____

2.. Name: _____Telephone_____

Fax: _____

Address: _____

3.. Name: _____Telephone_____

Fax: _____

Address: _____

4.. Name_____Telephone_____

Fax: _____

Address: _____

GENERAL: Have you ever been convicted of a crime in the past 5 years, Barring employment in a Home Care and community support Agency? _____Yes _____No

Conviction will not necessarily disqualify an applicant from employment. If yes describe in full:_____

_____

_____

_____

Are you capable of performing the job set forth in the job description? ____Yes _____No

If you answer No, which job requirement can you not meet?

_____

_____

_____

_____

CREDENTIALS/SPECIALIZED SKILLS & QUALIFICATIONS/EQUIPMENT OPERATED

List all states in which licensed giving registration and expiration date. Summarize special job-related skills and qualification acquired from employment or other experience.

_____

_____

_____

_____

I Certify that the facts contained in this application are true and complete to the best of my knowledge and understand, that, if employed, falsified statements on this application SHALL BE GROUNDS FOR DISMISSAL

I Authorize complete investigation of all statements contained herein and herby give my full permission for the Agency to contact and fully discuss my background and history with all persons and entities listed above to give the Agency all information concerning my previous employment and any information they may have, and release all former employees and others listed above from all liability for any damage that my result from furnishing the same to the Agency.

I understand and agree that, if hired, my employment is for no definite period arid may, regardless of the date of payment of my wages and salary, be terminated at any time for any fault reason, without prior notice and with or without cause.

Date: _____ Signature_____

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ - ☐☐ - ☐☐☐☐

or

Employer identification number

☐☐ - ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number _____

Employee/Worker Name _____ **Employee/Worker Number** _____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer/company.

EMPLOYER/COMPANY: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name:

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name

I wish to change my deposit amount to (check one): ☐ From _____% to____% of Net ☐ From $_____.00 To $_____.00
☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: _____

Employer/Company Representative Signature: _____ **Date:** _____

* All fields are required except Employee/Worker Number.

** Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.

Caregiver Expectations
The Basic 12

1. Arrive at the Care Recipient's home on time and remain for the full scheduled time.

2. All time off requests must be made 24 hour in advance. Provide 2 weeks advance notice for extended time off.

3. You are expected to be in professional attire at a Care Recipient's home. This includes clean, neat scrub uniform or Joytogether Homecare shirt, no dangling jewelry, name badge worn in a visible manner and clean, closed toed shoes or athletic shoes.

4. You represent Joytogether Homecare . Therefore any/all client and caregiver schedule changes must be arranged with the office staff and receive approval.

5. Time sheets must be accurate and submitted on time **Monday by 3 p.m.**. This is necessary so that the office can complete payroll and billing processes. Neglecting to do so will result in your payment being delayed.

6. Complete the tasks on the customized care plan and according to schedule.

7. Any requests for tasks not on the care plan must be called into the office. The office must speak with the Care Recipient, and notify you of any changes.

8. You are required to maintain confidentiality of the Care Recipient. Not only is confidentiality good practice, it is the law.

9. You may not discuss your pay rate or client billing rates with the Care Recipient or other Caregivers.

10. You may only use the Care Recipient's phone for authorized reasons. You may not use your personal cell phone while you are working in the Care Recipient's home.

11. You are required to report incidents or complaints when they occur.

12. You are required to comply with certification requirements on a timely basis (TB, CPR mandatory in-services, updated CNA certification).

Independent Contractor Signature Date

Joytogether Homecare Representative Date

F.1.2 Caregiver Agreement (format 2)

If you are found to be working for any of our clients that we have introduced you to on a basis not sanctioned by Joytogether Homecare , you will be immediately liable to reimburse Joytogether Homecare the amount of revenue lost in one month of service. Joytogether Homecare will pursue every legal means possible to protect their rights under this agreement, and the cost of any legal fees incurred in the protection of our rights will also be incurred by you. Initial here that you understand the above restriction: _____

You agree to release *Joytogether Homecare* from any/all responsibility for any incidents that may occur that are personally harmful to you while you are performing services to clients (or in traveling to and from the client's residence) including all injuries, or potential loss of revenue.

You hereby authorize *Joytogether Homecare* to run state, county, federal criminal checks, social security # trace checks, driving record checks, previous employment reference checks and credit checks to determine your qualifications for referrals to our clients.

Caregiver/Signature	Date
Caregiver Date of Birth	Social Security Number

Joytogether Homecare Respresentative/Witness Date

Exhibit A

Independent Contractor Services

Joytogether Homecare & Contractor agree that payment will be set at the following rate:

Rate: _____ (designate if rate is per hour or per visit)

Contractor will not be reimbursed / compensated for travel time, recordkeeping or other time spent performing responsibilities required in connection with client care.

_____ _____

Independent Contractor Signature Date

_____ _____

Joytogether Homecare Representative Signature Date

CAREGIVER DISASTER FORM

NAME:_____
First M.I. Last

HOME PHONE:_____ ALT. PHONE:_____

HOME ADDRESS:

_____

_____APT._____

CITY:_____ STATE:_____ ZIP:_____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE:_____

PLEASE CHECK YOUR PREFERENCE OF AVAILABILITY:

1) BEFORE DISASTER _____
2) DURING DISASTER _____
3) AFTER DISASTER _____

WHAT EVACUATION ZONE ARE YOU IN?_____

Will you (and your family) STAY AT HOME?_____

Will you (and your family) go to a SHELTER?_____
If yes which shelter? _____

Do you have arrangements for your pet(s) in case of a disaster?_____

Caregiver signature: _____
Date:_____