Take this form to
Licensed Medical Provider
MD / DO / PA / NP

ME

MEDICAL EXAMINATION

If FAXING documents to AFRH, please make a black & white copy before sending the fax so that it will be legible when it is received. Please call and let us know to look for the documents to come through as well – thank you for all your help! We want to prevent any delays in processing applications!

Dear Applicant:

The Armed Forces Retirement Home requires the completion of a comprehensive Medical Examination and current Tuberculosis Screening for all applicants in order to determine eligibility for residence.

Please provide this form to a licensed medical provider **[must be a Physician (M.D. or D.O.), Nurse Practitioner (NP) or Physician's Assistant (PA)]** to complete. In order to be considered for residency, this form will need to be submitted along with the completed Application Form and Functional Assessment.

Please review the form before submitting and ensure all items have been completed and that your provider has initialed and signed in all of the appropriate fields. Incomplete forms will delay processing of the application.

Thank you
AFRH

RETURN EVALUATION TO:

ARMED FORCES RETIREMENT HOME
PUBLIC AFFAIRS OFFICE #584
3700 NORTH CAPITOL ST, NW
Washington, DC 20011-8400
Fax Number: (202) 541-7519
Telephone: (800) 422-9988 opt. 1

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

PURPOSE: To determine and verify eligibility for admission to the AFRH.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the records contained herein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: To the Federal Reserve for processing the debt on the resident account; To authorized contractors or vendors for the purpose of providing medical services to the residents of the Armed Forces Retirement Home; To any Federal agency which provides medical services to residents of the Armed Forces Retirement home; To the Inspector General of the Department of Defense or his/her designee, for conducting inspections of AFRH records; To a Federal agency, or an organization or person contracting with the AFRH for information needed in the performance of official duties related to reconciling or reconstructing data files, compiling descriptive statistics, and/or making analytical or financial studies to support the function for which the records were collected and maintained; Law Enforcement Routine Use; Congressional Inquiries Disclosure Routine Use; Disclosure of Information to the National Archives and Records Administration Routine Use; Disclosure to the Merit Systems Protection Board Routine Use; and Data Breach Remediation Purposes Routine Use.

The applicable system of records notice is DPR 38 DoD, Armed Forces Retirement Home electronic Resident Information System (eRIS) and is available at: (ADD LINK WHEN PUBLISHED).

DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

ARMED FORCES RETIREMENT HOME

Medical Examination

Form Completed by a Licensed Medical Provider

ME

Last Name _____ First Name _____ MI _____ Birthdate _____

Patient: _____ Age: _____

Street: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone*: _____ Email: _____

THIS FORM IS TO BE COMPLETED BY THE APPLICANT'S LICENCED MEDICAL PROVIDER

Must be a Physician (M.D. or D.O.), Nurse Practitioner (NP), or Physician's Assistant (PA) ONLY

This examination form was completed on _____ by _____
Date — Printed Name of physician/nurse performing exam and credentials

Gender	Tobacco-Use / Vaping	Select Current Living Situation
(M) Male	(S) Smoker	Lives alone → ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
(F) Female	(N) Non-Smoker	Lives with → ☐ Spouse ☐ Child/Family ☐ Other:

Medical History - Please indicate if the person has ANY history of the following conditions [DO NOT LEAVE BLANKS]

Y	N	Condition (MARK ALL Y/N)	Y	N	Condition (MARK ALL Y/N)	Y	N	Condition (MARK ALL Y/N)
☐	☐	Coronavirus (COVID-19)	☐	☐	Medical Hospitalizations (5yrs)	☐	☐	Vision Loss / Legally Blind / Glaucoma
☐	☐	Anticoagulation Therapy	☐	☐	Psychiatric Hospitalizations	☐	☐	Dementia / Alzheimer's Disease
☐	☐	Cardiovascular Disease	☐	☐	Facility Treatment for Addiction	☐	☐	Cognitive Impairment / Disorientation
☐	☐	Hypertension / Hypotension	☐	☐	Hospice Care (at home/in facility)	☐	☐	Alcohol Use Disorder / Dependency
☐	☐	Stroke / TIA	☐	☐	Traumatic Brain or Head Injuries	☐	☐	Any Illegal Substance / Drug Use
☐	☐	Heart Attack / MI	☐	☐	Cirrhosis / Liver Failure	☐	☐	Medication Misuse / Dependency
☐	☐	Hemophilia / Blood Disorders	☐	☐	Sleep Apnea / Sleep Disorders	☐	☐	Self-Harm (plans/attempts)
☐	☐	Congestive Heart Failure	☐	☐	Dialysis / Renal Failure	☐	☐	Threatening or Violent Behavior
☐	☐	Edema / Swelling	☐	☐	Allergies / Anaphylaxis	☐	☐	Bipolar or Mood Disorders
☐	☐	COPD / Asthma / Emphysema	☐	☐	Seizures / Epilepsy	☐	☐	Psychosis: _____
☐	☐	High Cholesterol / Taking Statins	☐	☐	Neurological Disorders	☐	☐	Other mental health issue: _____
☐	☐	Oxygen Therapy	☐	☐	Parkinson's Disease	☐	☐	Anxiety or Panic Disorders
☐	☐	Colostomy / PEG Tube	☐	☐	Immune Disorders	☐	☐	Memory Loss* 1 2 3 4
☐	☐	Diabetes Mellitus	☐	☐	Rheumatoid Arthritis	☐	☐	Chronic Pain* 1 2 3 4
☐	☐	Amputation: _____	☐	☐	Gastrointestinal Disorders	☐	☐	Depression* 1 2 3 4
☐	☐	Cancer: _____	☐	☐	Balance Issues / Falls (2yrs)	☐	☐	PTSD* 1 2 3 4

1=Mild > 4=Severe*

(Yes/No responses are required for **every condition** above – **ANY** unmarked items in the history will result in the exam being sent back **for corrections):**

Describe all **POSITIVE** responses above and include any history of other conditions not listed above:

When was the patient's most recent... (approximate dates/timeframes are acceptable, i.e. Fall 2020)

Flu Vaccine:	Pneumonia Vaccine:	Dental Exam:	Vision Exam:

Last Name | First Name | MI | Birthdate

Medications and Allergies – Please indicate all allergies and current medications for the patient.

List all allergies, including medications, foods, latex, etc.: ☐ **Patient has no known allergies**

1.	4.
2.	5.
3.	6.

List all current medications – attach list as needed

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Physician initial here: x _____ *(I confirm that the medications annotated above are accurate and current)*

Physical Examination: (completed by provider ONLY (MD, DO, NP, or PA)

Date Vitals Were Taken

Current Vital Signs: All vital signs must be recorded on the date of the physical examination

ANY blank areas under the physical examination will delay processing. *Include an explanation, description, or notes for any indication of abnormalities or health concerns – you may attach copies of patient clinical notes.*

Blood Pressure:		**Temperature:**		**Height:**	
Respiratory Rate:		**Pulse:**		**Weight:**	

ABN	NOR	Indicate whether or not the following systems are normal - If abnormal, explain:	
☐	☐	HEENT: Head, eyes, ears, nose, throat	
☐	☐	Cardiovascular:	
☐	☐	Lungs:	
☐	☐	Thyroid:	
☐	☐	Abdomen:	
☐	☐	Lymphatic:	
☐	☐	Neurological:	
☐	☐	Extremities:	
☐	☐	Skin:	
☐	☐	Neck:	

Last Name _____ First Name _____ MI _____ Birthdate _____

Tuberculosis Screening Test: Applicant is required to submit a Tuberculosis Screening Test for admission to AFRH

TST test: ☐ Negative ☐ Positive	X-Ray: ☐ Negative ☐ Positive	IGRA: ☐ Negative ☐ Positive
mm Induration: _____mm	If TST is pos.; Chest X-ray results	If TST is pos.; Interferon Gold Test
Date: _____	Date: _____	Date: _____
If positive, list conversion date:	Findings:	Findings:

Signature/Credentials: _____ Date: _____

Stamps and/or copies of test results are accepted but the provider MUST mark result & have handwritten signature, credentials, & date in this field.

Covid-19 Screening and Vaccination Information

Has the patient been tested for COVID-19, if so indicate the type of test given (Molecular[PCR], Antigen [AG], Antibody [AB]), results, and date. Has the patient received a vaccine for COVID-19? If so; identify the vaccine manufacturer and what date/s the doses were administered? **Submit a copy of the CDC vaccination card.** If patient has a health concern or other reason for deciding not to be inoculated, indicate reason (allergies, EUA Emergency Use Authorization, religious objection, not available yet, etc.).

TEST	☐YES ☐NO	**VACCINE**	☐YES ☐NO	**REFUSAL REASON** ☐N/A
TYPE:	☐PCR ☐AG ☐AB	*MFGR:*	☐PFZ ☐MOD ☐OTH	
RESULTS:	☐NEG ☐POS ☐INC/INV	*1ST Dose Date:*		
DATE:		*2ND Dose Date:*		

YES	NO	Indicate whether or not following have occurred within the past 12 months: [IF TRUE, PROVIDE AN EXPLANATION]
☐	☐	a. Does the patient have any chronic or acute health issues, disease, physical limitations, or other ongoing concerns?
☐	☐	b. Has the patient had any recent hospitalizations, if so why/when? (If available, please attach discharge notes/info)
☐	☐	c. Does the patient have any conditions that would place them at an increased risk of falling or recently had any **falls**? If so, how many times?
☐	☐	d. Has the patient recently had a significant change in sleep patterns, appetite, weight, general physical fitness?
☐	☐	e. Is the patient currently on hospice, if so please describe medical condition, mental/physical limitations, etc.?
☐	☐	f. Ongoing therapy, treatments, or medications for chronic pain management, insomnia, or mental health conditions.
☐	☐	g. Does the patient currently smoke or vape? If so, is the patient currently on a cessation program and progressing towards quitting their habit? Smoking is not permitted indoors at AFRH facilities. *Note: those required to be in quarantine will NOT have any access to outdoor smoking areas.*

Last Name _____ First Name _____ MI _____ Birthdate _____

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Is the person able to complete the following tasks **INDEPENDENTLY** without assistance from another person (patient may use a device such as a wheelchair, PMD, grab bars, etc. as long as they are able to do so unassisted)?

I	A	INDEPENDENT or needs ASSISTANCE w/ ADL's
☐	☐	Independent Mobility / Ambulation
☐	☐	Transferring Positions to/from bed, bath, chair, car, etc.
☐	☐	Self-Managed Bathing / Showering
☐	☐	Self-Managed Toileting / Continence
☐	☐	Personal Grooming / Dressing / Undressing
☐	☐	Manages Community Navigation / Transportation

I	A	INDEPENDENT or needs ASSISTANCE w/ ADL's
☐	☐	Self-Directed Medication Management
☐	☐	Self-Directed Feeding / Nutrition Management
☐	☐	Independent Emergency Response / Safety Procedures
☐	☐	Appointment Keeping / Time Management Skills
☐	☐	Self-Managed Light Housekeeping and Laundry
☐	☐	Independent Financial Management, Shopping, etc.

Describe any type of assistance/accommodation needed (including devices, aid from staff, etc.):

Does the patient have a medically necessary service dog for a disability? The patient will be issued a copy of AFRH Service Animal policy.

☐ Yes ☐ No If so, Physician initial here: _____

Does the patient have any support requirements or any limitations which may effect their level of independence?

Y	N	LIMITATION / SUPPORT
☐	☐	Moderate / High Fall-Risk
☐	☐	Altered gait / Instability
☐	☐	Limited hand-use/poor grip
☐	☐	Non-ambulatory
☐	☐	Full / partial paralysis
☐	☐	Vertigo / seizures / fainting

Y	N	LIMITATION / SUPPORT
☐	☐	(Legally) Blind/low vision
☐	☐	Wears corrective lenses
☐	☐	Bladder incontinence
☐	☐	Urinary catheters
☐	☐	PEG tube/CVAD port
☐	☐	CPAP/sleep apnea

Y	N	LIMITATION / SUPPORT
☐	☐	Deaf / low hearing
☐	☐	Wears hearing aid
☐	☐	Bowel incontinence
☐	☐	Colostomy
☐	☐	Amputation
☐	☐	Oxygen therapy

Y	N	LIMITATION / SUPPORT
☐	☐	Wheelchair / PMD
☐	☐	Rollator, Walker, Cane
☐	☐	Braille or Sign Language
☐	☐	Dentures / Oral Health
☐	☐	Speech unclear/nonverbal
☐	☐	ESL / Limited English Skills

Describe any type of assistance/accommodation needed (including devices, aid from staff, etc.):

*Individuals requiring language/communication accommodations (i.e.: braille, visual alarms, etc.), service dogs, mobility devices, or other medical equipment **may still be considered** for an independent living level of care **except** when staff members must provide regular support to the individual for use/safety.*

COGNITIVE AND BEHAVIORAL HEALTH STATUS

Does the patient exhibit any of the following mental health concerns? *Must mark all conditions as TRUE or FALSE*

T	F	CONDITION
☐	☐	Memory Loss / Dementia
☐	☐	Confusion / Disorientation
☐	☐	Wandering / Gets Lost

T	F	CONDITION
☐	☐	Mood / Emotional Instability
☐	☐	Dysthymia / Anhedonia
☐	☐	Anxiety / Panic Disorders

T	F	CONDITION
☐	☐	Post Traumatic Stress
☐	☐	Irrational Thoughts
☐	☐	Threatening Behaviors

T	F	CONDITION
☐	☐	Suicide Risk / Ideation
☐	☐	Addictive Behaviors
☐	☐	Self-Harm/Risky Behavior

Last Name _____ First Name _____ MI _____ Birthdate _____

True	False	A. COGNITIVE FUNCTIONS: Indicate if any of the following are TRUE or FALSE and explain responses.
☐	☐	1. Demonstrates signs of cognitive decline such as requiring cues/support to perform daily tasks like basic shopping, managing medications, healthcare decisions, nutrition, or ability to navigate independently -- gets lost, wanders… (N) None (1) Slight Change (2) Mild Issue (3) Moderate Concern (4) Significant Problem (5) Severe
☐	☐	2. Demonstrates decline in the ability to remember accurately, make reasonable decisions, or communicate thoughts clearly; and/or shows poor judgement/risk assessment, poor listening/reading comprehension, or has difficulty in expressing ideas -- forgetting terms, losing train of thought, repetition of statements … (N) None (1) Slight Change (2) Mild Issue (3) Moderate Concern (4) Significant Problem (5) Severe
☐	☐	3. Demonstrates signs of confusion or lack of orientation (person, place, date/time, or situation); if so, describe…
☐	☐	4. If any decline in cognition is noted in #1, #2, or #3 above, have you completed a cognitive assessment *(i.e.: MoCA, MMSE…)*? *Assessment:* *Score:* *Date:* (attach copy if available)

True	False	B. SUBSTANCE USAGE: Indicate whether these statements are true or false (within the past 12 months) *Any incidents/behaviors taking place over 12 months ago that have not been resolved or **pose any risk** should also be disclosed.*
☐	☐	5. **Does the patient drink any alcohol?** How many **servings** of alcohol does the patient drink on an average week? ☐ #_____ beer (12oz/can) ☐ #_____ wine (5oz glass) ☐ #_____ cocktails/hard-liquor (1.5oz/shot)
☐	☐	6. **Do any of the following statements apply to his/her consumption habits?** Describe **any** true response. a. Normally drinks alcohol on a daily basis (25+ servings/month).
☐	☐	b. Occasionally has 4 or more drinks in one sitting.
☐	☐	c. Occasionally uses recreational or illegal drugs.
☐	☐	7. **Do any of the following statements apply to the patient's use of drugs, alcohol, substances, or other behaviors? If any are true please indicate the substance/behavior and mark any specific items (underline/circle) that apply to their behavior.** a. Hazardous use — driving intoxicated, falls/injuries, black-outs/overdosing, reckless/illegal activities, risky/erratic behaviors, violence…
☐	☐	b. Use aggravates or causes physical/mental health problems — cirrhosis, COPD, hypertension, cognitive loss, depression, anxiety…
☐	☐	c. Neglects major social/work roles, has developed cravings, or expends a lot of effort/time planning, obtaining, using, recovering …
☐	☐	d. Has social/interpersonal conflicts due to the behavior/use or has withdrawn from activities that exclude the behavior or substance
☐	☐	e. Has failed at attempts to control behavior, has been increasing quantity/time using, has developed tolerance/withdrawal symptoms *Substances/behaviors:* _____ *Specific issues:* _____
☐	☐	8. Has the patient continued to use **ANY** alcohol, drugs, or tobacco against medical/professional advice **or** even when the patient is aware of adverse drug interactions, specific use-related illnesses, medical complications, cognitive issues, falls/injuries, psychological/social problems, or any other detrimental consequences of such use (***i.e.: Continues Smoking with COPD***).
☐	☐	9. Has the patient **EVER** been counseled, sought help, or been diagnosed with AUD, SUD, or other addictive behaviors? If true, has the condition been **active** within the past 12 months? Select one of the following statements & describe: (A) Early Remission or Currently Active (R) In Remission longer than 12 months (N) No history of addictive behaviors

True	False	C. PSYCHIATRIC CONDITIONS: Indicate whether these statements are true or false (occurring within the past 12-24 months) *Any incidents/behaviors taking place over 2 years ago that have not been resolved or **pose any risk** should be disclosed.*
☐	☐	10. Reports decreased participation in usual activities, loss of interest, feeling bored or listless, lacking enjoyment or motivation; or has had a significant change in the level of self-isolation, sleep disturbances, personal grooming/hygiene, or disorganization. (N) None (1) Slight Change (2) Mild Issue (3) Moderate Concern (4) Significant Problem (5) Severe

Last Name _____ First Name _____ MI _____ Birthdate _____

☐	☐	11.	Reports or exhibits feelings of anxiety, sadness, grief, apathy, depression, moodiness, loneliness, helplessness, hopelessness, or worthlessness; or shows signs of distress – *crying, irritability, frustration, concentration loss, confusion, anhedonia…*	(N) None	(1) Rare/Occasional	(2) Mild Issue	(3) Moderate Concern	(4) Significant Problem	(5) Severe
☐	☐	12.	Demonstrates signs of behaviors that are antagonistic, threatening, menacing, aggressive, combative, hostile, agitated, angry, erratic, dangerous, volatile, or otherwise intimidating – *yelling, fighting, threats, fuming, bullying, violent/destructive behaviors…*	(N) None	(1) Rare/Occasional	(2) Mild Issue	(3) Moderate Concern	(4) Significant Problem	(5) Severe
☐	☐	13.	Reports or shows signs of anxiety or posttraumatic stress – persistently nervous, withdrawn, detached; has preoccupied/persistent thoughts or behaviors; avoids certain social interactions/activities; or has overwhelming feelings of fear, dread, or panic.	(N) None	(1) Rare/Occasional	(2) Mild Issue	(3) Moderate Concern	(4) Significant Problem	(5) Severe
☐	☐	14.	Exhibits signs of delirium, stupor, idiosyncratic/false perceptions, irrational thoughts, paranoia, hallucinations, or psychosis.	(N) None	(1) Rare/Occasional	(2) Mild Issue	(3) Moderate Concern	(4) Significant Problem	(5) Severe

True	False	**GENERAL HEALTH & SAFETY ASSESSMENT: Indicate whether these statements are true or false (occurring within the past 5 years)** *Any incidents/behaviors taking place over 5 years ago that present an ongoing issue or may still pose a risk should be disclosed.*
☐	☐	Some monitoring, evaluation, treatment, or support is necessary for decision-making, hazard protection, or psychological stability.
☐	☐	Has been medically advised to seek in-patient or outpatient treatment for a psychiatric condition or addiction.
☐	☐	Has intimidated, threatened, or attempted to harm others and/or may represent a safety risk to the community.
☐	☐	Has attempted or planned self-harm and may represent a danger to themselves or pose a potential risk of suicide.
☐	☐	Requires intervention from staff members on a regular basis to perform basic activities of daily living.
☐	☐	Requires full-time skilled nursing, hospice care, rehabilitative treatment, or long-term care for current healthcare support.

(Y) (N) Patient is mentally and physically capable of **LIVING INDEPENDENTLY** in a community environment with **ELDERLY** residents.

Level of Care: Provider select the recommended level of care for this individual - write **INITIALS** inside the box:

☐ **Independent Living**	Individual is physically and mentally self-sufficient, stable, and capable of safely managing activities of daily living without supportive services or aid from others
☐ **Home Health Care**	Individual is able to manage daily activities independently; however, may require some support from caregivers, monitoring, supervision, and/or minimal assistance on an intermittent basis
☐ **Assisted Care**	Includes some assistance from staff with activities of daily living, diversionary activities, protection from hazards, and/or other supportive services on a regular basis
☐ **Skilled Care**	Includes professional nursing care and assessment on a daily basis due to a serious condition, which is unstable, or a rehabilitative, therapeutic regime requiring professional staff

** Stamps are accepted but the provider MUST sign with handwritten signature, license number, and date or the form will be returned.*

Please Print (Stamp is acceptable)

Physician's Name: _____

Credentials*: _____

Street Address: _____

City, ST Zip _____

Phone Number*: _____

Fax Number*: _____

*Credentials, phone number and fax number are required to confirm

Signature, Date and License Number Required

x

Signature*

Date* License Number*

Patient Last Name _____ First Name _____ MI _____ Birthdate _____

MEDICAL RECORD RELEASE FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C 136, Under Secretary of Personnel and Readiness; 24 U.S.C. 401, Armed Forces Retirement Home; DoD Directive 5124.09 Assistant Secretary of Defense for Personnel and Readiness Force Management; DoD Instruction 1000.28, Armed Forces Retirement Home (AFRH); and E.O. 9397 (SSN), as amended.

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DISCLOSURE: Voluntary; however, failure to provide the required information may result in the delay or denial of admission.

Medical Record Release Form

PMRF

Patient Last Name _____ First Name _____ MI _____ Birthdate _____

MEDICAL INFORMATION DISCLOSURE FORM:

*SIGNATURE OF RELEASE IS **REQUIRED** FOR PROCESSING OF ANY MEDICAL FORMS*

Patient's Name:				Birthdate:	
Street:		Apt.:			
City:		State:		Zip:	
Phone:		Cell:			
Email:					(if available)

Healthcare providers: Applicants must include the examiner's Name, Phone, and FAX numbers for all providers who complete evaluations for the applicant.

Primary Care Provider
(must be a licensed Physician (MD/DO), Nurse Practitioner, or Physician's Assistant

Examiner's Name :				Credentials*	
Street:		Clinic:			
City:		State:		Zip:	
Phone*:		Fax*:			
Email:					(If provided, email is only to be used for contact not submission of patient information)

I grant my permission to disclose information to:

☐ Armed Forces Retirement Home
3700 North Capitol Street, NW
Washington, DC 20011

Attn: Admissions Board
Public Affairs Office #584
Tel: 202-541-7922 Fax: 202-541-7519

Specific information to be disclosed:

- ☐ Medical Records covering the last 12 months
- ☐ Patient history and office notes
- ☐ Insurance records
- ☐ Billing records
- ☐ Records of drug, alcohol, & substance use disorders
- ☐ Mental Health records
- ☐ HIV/AIDS-Related Information and test results
- ☐ COVID-19 Related Information and test results

I understand that release of this information is provided on a voluntary basis in accordance with the Privacy Act Statement Authority: 10 U.S.C 136; 24 U.S.C. 401 (full version is provided on the cover page of the application) to determine and verify eligibility for admission to the Armed Forces Retirement Home. I understand that I may revoke this authorization at any time by giving written notice to AFRH at the aforementioned address. I also understand the revocation of this authorization will not affect any action taken by AFRH in reliance on this authorization prior to receipt of a written revocation.
I fully acknowledge that failure to provide any required information may result in the delay or denial of admission to the Armed Forces Retirement Home.

Patient's Signature*	***Date****

* Signature of this release is REQUIRED for processing of any medical forms submitted with the application for residency.