Molina Healthcare of Florida, Inc.
Practitioner Application

1. INSTRUCTIONS

This form should be:

- **Typed or legibly printed in black or blue ink.**
- Keep a copy of the application on file for future requests.
- If more space is needed than provided on original, attach additional sheets and reference the question being answered.
- *Please do not use abbreviations*.
- If a section does not apply to you, please check the provided box at the top of the section.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.

Please attach c**urrent copies of the following documents with this application:**

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- **Please sign and date page 13** and **answer the three additional questions.**
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

Incomplete applications will be returned for completion prior to processing. Please return application and attachments to:

Molina Healthcare of Florida, Inc., ATTN: Provider Services Department, 8300 NW 33rd St, #400, Doral, FL 33122

2. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ( )	Pager Number/Cell Phone Number: ( )	E-Mail Address:	
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number	☐ Male ☐ Female	Languages spoken by Practitioner	
Have you ever voluntarily opted-out of Medicare? ☐Yes ☐No			

NPI:	Medicare UPIN:	Medicare Number:	Florida Medicaid Number:	L & I Number(s):

Primary Practicing Specialty:	Other specialties:
Other Professional Interests in Practice, Research, etc.:	

3. PRIMARY PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) _____

Practice Type (Please check all that apply)
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other_____

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No
If you are a PCP, do you provide OB services? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____

Please list languages spoken by office staff:
_____
_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday:_____

Do you provide 24-hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____
_____

Modification to the wording or format of the Practitioner Application may invalidate the application.

4. ADDITIONAL PRACTICE INFORMATION

***Please make a copy of this page and complete for each additional location in which you practice

Effective Date at Primary Practice location (MM/YY) _____

Practice Type (Please check all that apply)
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other_____

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No
If you are a PCP, do you provide OB services? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____

Please list languages spoken by office staff:
_____
_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday:_____

Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____
_____

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5. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS **(Attach Additional Sheet if Necessary)**		
Florida State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

6. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS					
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

7. UNDERGRADUATE EDUCATION (*Do not abbreviate*)		**Does Not Apply** ☐
College or University Name:	Degree Received(be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)
Mailing Address:	City: State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)
Mailing Address:	City: State:	Zip Code:

8. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)			
Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

9. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION				**Does Not Apply** ☐
Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

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10. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

11. RESIDENCIES (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

12. FELLOWSHIPS (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

13. BOARD CERTIFICATION				Does Not Apply ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? ☐ Yes ☐ No If so, list certification and date:				
If you participate in a specialty which does not have board certification, please indicate specialty:				

14. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)		
Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply ☐
Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) previous hospital affiliations, (D) current military affiliations, (E) previous military affiliations. (F) In-patient coverage plan **(for those without admitting privileges).** List only affiliations here, list employment in section XVI, Work History.	

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)	
Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

B. HOSPITAL APPLICATIONS IN PROCESS (*Do not abbreviate*)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

C. PREVIOUS HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Admitting Hospital:		Department:	
Mailing Address	City, State, Zip	Phone Number:	Fax Number:
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:			

Name of Admitting Hospital:		Department:	
Mailing Address	City, State, Zip	Phone Number:	Fax Number:
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:			

D. CURRENT MILITARY AFFILIATIONS (Do not abbreviate)	
Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

E. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)	
Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

17. Inpatient Coverage Plan (for those without admitting privileges)	Does Not Apply ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

18. Covering Providers/Call Group			Does Not Apply ☐
Provider Name & Degree	Specialty	Address	Phone Number

19. WORK HISTORY (*Do not abbreviate*)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.

Name of Current Practice / Employer:	Contact Name: Email:			Telephone Number: ( ) Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)

Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

20. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

Modification to the wording or format of the Practitioner Application may invalidate the application.

21. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

22. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. CURRENT INSURANCE CARRIER:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)

Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

23. PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have a history of chemical dependency/substance abuse?		YES ☐	NO☐
3.	Do you have, or have you had in the last two years, any physical condition, or mental health condition that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO☐
4.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

24. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	**Does Not Apply** ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

25. ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

By submitting this authorization and release of information form, I understand and agree as follows:

I understand and acknowledge that, as an applicant for participating status with Molina Healthcare of Florida, Inc. for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

I further understand and acknowledge that Molina Healthcare of Florida, Inc. or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Molina Healthcare of Florida, Inc. as part of the verification and credentialing process.

I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Molina Healthcare of Florida, Inc., their staffs and agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Molina Healthcare of Florida, Inc. or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies of Molina Healthcare of Florida, Inc.

I agree to abide by the policies, procedures, and or contractual agreements of Molina Healthcare of Florida, Inc. from whom I am seeking initial or recredentialing.

I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Molina Healthcare of Florida, Inc. where I have membership and/or participation status before initiating judicial action.

I understand that completion and submission of this application/Attestation/Authorization and Release does not automatically grant me membership or participating status with Molina Healthcare of Florida, Inc.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

1.	**Do you have more than 3,000 patients (defined as seen a minimum of (3) times per year) in your practice, including all populations; Medicaid FFS, MSM Network, MHO, Health Plan, Medicare and commercial.**	**YES** ☐	**NO**☐
2.	**Are you eligible to become Medicaid provider?**	**YES** ☐	**NO**☐
3.	**Are you currently enrolled in the Florida Medicaid fee-for-service program?**	**YES** ☐	**NO**☐

ATTESTATION/RELEASE FORM

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____