

Medical Review Team (MRT) Packet

The Family Support Division needs the following information and forms to establish the disability:

- **IM-61B - Disability Questionnaire** - Fill in the client's answers to all the questions, leave the pertinent information and observations of the Eligibility Specialist section blank.
- **IM-61C – Work History** - The form asks for the past 10 years work history. Complete the form based on information readily available from the individual, do not delay submitting the form trying to get exact information. If the individual doesn't remember specific information such as phone numbers, addresses, monthly income, etc. just put an approximation based on what is remembered.
- **IM-61D – Doctor/Medical Facility List** - The form asks the individual to list all hospitals, medical facilities, and physicians from whom he or she has received medical care in the past 12 months. Mental health professionals, such as psychologists and licensed clinical social workers should also be included.
- **MO 650-2616 – “Authorization for Disclosure of Consumer Medical/Health Information”** to the Department of Social Services FSD Medical Review Team
- **IM-60A – Medical Report form** signed by a psychiatrist or licensed clinical psychologist to certify that the client has a disability.
 - At the top of the first page put the client's name, date of birth and county.
 - Leave blank the individual DCN, eligibility specialist, FAMIS user ID, load, date of app., date submitted to MRT as the FSD worker will fill those in.
 - The most important parts of the form are **Diagnosis** section and the **Determination of incapacity** section.
 - The form is optional, but the opinion the treating psychiatrist or licensed clinical psychologist is often a key piece of information in the disability determination.
- **Record of Treatment** including an evaluation and a Global Assessment of Functioning (GAF)



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
DISABILITY QUESTIONNAIRE

NAME _____

DCN _____

DATE _____

Pertinent Information and Observations of the Eligibility Specialist:

1. Personal Information: Age __ Sex _ Height ____ Weight ____

2. Highest Grade Completed: __ GED Yes No

3a. What physical symptoms/problems do you have? _____

3b. What mental health symptoms/problems do you have? _____

Do you have crying spells or depression because of your disability? Yes No How Often? _____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? Yes No

4. When did these symptoms/problems begin? _____

5. When did these symptoms first prevent you from working? _____

6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform :

Able to perform? _____

Are you in need of caretaking? Yes No

If yes, who provides? (Check one) Nurse Relative Neighbor Friend Other

7. Did you see a doctor or seek medical treatment for your symptoms? Yes No

Physician _____ How often? _____

Treatment received: _____

When? _____

Physician _____ How often? _____

Treatment received: _____

When? _____

8. Have you been given a specific diagnosis for your problem? Yes No What is the diagnosis? _____

9. Have you gone to Vocational Rehabilitation? Yes No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral? _____

10. Have you applied for (Check if applicable) Social Security SSI VA ?
 Were you examined by a doctor for this application? Yes No (If yes, obtain medical reports from SSA)
 What is the status of your application? _____

11. Did your problem require physical therapy? Yes No (Obtain medical information or reports)
 If yes, where? When? _____
 Describe therapy _____

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports) _____

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken :

14. Who prescribed the medications? (Obtain medical information) _____

15. Have you been treated by or referred to a(n):	YES	NO	REFERRED	TREATED
Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist/Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Have you been hospitalized due to your disability or illness? Yes No
 If yes, where? _____
 How long? Dates? _____
 Admitting physician name _____

Medical information **must be current** (within the past 12 months). It must include information on each of the claimant's complaints. If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS

ITEM NO.	



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
Work History-Past 10 Years

INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	INDIVIDUAL DCN	DATE OF BIRTH
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Instructions: Please list all employers within the last ten (10) years, starting with the most recent. If you had more employers, please continue on a separate sheet and attach to this form.

Employer: _____ Telephone Number: (____)____ -
 Employer's Complete Address: _____
 Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income:
 TO (month/year): _____ \$ _____
 Job Description/Duties: _____
 Reason for Leaving: _____ Was this through a Sheltered Workshop: _____

Employer: _____ Telephone Number: (____)____ -
 Employer's Complete Address: _____
 Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income:
 TO (month/year): _____ \$ _____
 Job Description/Duties: _____
 Reason for Leaving: _____ Was this through a Sheltered Workshop: _____

Employer: _____ Telephone Number: (____)____ -
 Employer's Complete Address: _____
 Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income:
 TO (month/year): _____ \$ _____
 Job Description/Duties: _____
 Reason for Leaving: _____ Was this through a Sheltered Workshop: _____

Employer: _____ Telephone Number: (____)____ -
 Employer's Complete Address: _____
 Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income:
 TO (month/year): _____ \$ _____
 Job Description/Duties: _____
 Reason for Leaving: _____ Was this through a Sheltered Workshop: _____

Individual Name (First, Last) _____	Individual DCN _____	Date of Birth _____
<p>Employer: _____ Telephone Number: (____) _____ -</p> <p>Employer's Complete Address: _____</p> <p>Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income: _____ TO (month/year): _____ \$ _____</p> <p>Job Description/Duties: _____</p> <p>Reason for Leaving: _____ Was this through a Sheltered Workshop: _____</p>		
<p>Employer: _____ Telephone Number: (____) _____ -</p> <p>Employer's Complete Address: _____</p> <p>Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income: _____ TO (month/year): _____ \$ _____</p> <p>Job Description/Duties: _____</p> <p>Reason for Leaving: _____ Was this through a Sheltered Workshop: _____</p>		
<p>Employer: _____ Telephone Number: (____) _____ -</p> <p>Employer's Complete Address: _____</p> <p>Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income: _____ TO (month/year): _____ \$ _____</p> <p>Job Description/Duties: _____</p> <p>Reason for Leaving: _____ Was this through a Sheltered Workshop: _____</p>		
<p>Employer: _____ Telephone Number: (____) _____ -</p> <p>Employer's Complete Address: _____</p> <p>Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income: _____ TO (month/year): _____ \$ _____</p> <p>Job Description/Duties: _____</p> <p>Reason for Leaving: _____ Was this through a Sheltered Workshop: _____</p>		
<p>Employer: _____ Telephone Number: (____) _____ -</p> <p>Employer's Complete Address: _____</p> <p>Dates of Employment FROM (month/year): _____ Gross Earned Monthly Income: _____ TO (month/year): _____ \$ _____</p> <p>Job Description/Duties: _____</p> <p>Reason for Leaving: _____ Was this through a Sheltered Workshop: _____</p>		



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

Hospitals, Medical Facilities and Physicians Seen within the Past Year

INDIVIDUAL NAME (FIRST)	(MIDDLE)	(LAST)	INDIVIDUAL DCN	DATE OF BIRTH
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Instructions:List all hospitals, medical facilities, and physicians that have provided care or services to you within the last year (12 months).If needed use a separate sheet and attach to this form.

If you have not had any services in the last year, check here: NONE

Do you have a primary care physician? Yes ___ No ___ If yes, list your primary care physician here.

Facility & Doctor Name/s: _____

Complete Address: _____
City: _____ State/Zip Code: _____

Telephone Number: _____

Reason(s) Seen: _____ Diagnosis: _____

Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____

Upcoming Appointments/dates: _____

Facility & Doctor Name/s: _____

Complete Address: _____
City: _____ State/Zip Code: _____

Telephone Number: _____

Reason(s) Seen: _____ Diagnosis: _____

Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____

Upcoming Appointments/dates: _____

Facility & Doctor Name/s: _____

Complete Address: _____
City: _____ State/Zip Code: _____

Telephone Number: _____

Reason(s) Seen: _____ Diagnosis: _____

Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____

Upcoming Appointments/dates: _____

Individual Name (First, Last) _____	Individual DCN _____	Date of Birth _____
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Facility & Doctor Name/s: _____
 Complete Address: _____
 _____ City: _____ State/Zip Code : _____
 Telephone Number: _____
 Reason(s) Seen: _____ Diagnosis: _____
 Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____
 Upcoming Appointments/dates: _____

Facility & Doctor Name/s: _____
 Complete Address: _____
 _____ City: _____ State/Zip Code: _____
 Telephone Number: _____
 Reason(s) Seen: _____ Diagnosis: _____
 Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____
 Upcoming Appointments/dates: _____

Facility & Doctor Name/s: _____
 Complete Address: _____
 _____ City: _____ State/Zip Code: _____
 Telephone Number: _____
 Reason(s) Seen: _____ Diagnosis: _____
 Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____
 Upcoming Appointments/dates: _____

Facility & Doctor Name/s: _____
 Complete Address: _____
 _____ City: _____ State/Zip Code: _____
 Telephone Number: _____
 Reason(s) Seen: _____ Diagnosis: _____
 Last Date Seen: _____ Hospitalization (yes/no): _____ Duration: _____
 Upcoming Appointments/dates: _____



STATE OF MISSOURI
AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- Department of Mental Health (DMH) Department of Health and Senior Services (DHSS)
- Department of Social Services (DSS) Department of Elementary and Secondary Education (DESE)
- Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DCN	DATE OF BIRTH	SOCIAL SECURITY NUMBER
WHO RECEIVED SERVICES FROM (DATES)			

to **(check all that apply)**

- Department of Mental Health (DMH) Department of Health and Senior Services (DHSS)
- Department of Social Services (DSS) Department of Elementary and Secondary Education (DESE)
- Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- Eligibility Determination Assessment Aftercare
- Placement Transfer/Treatment Treatment Planning
- Continuity of Services/Care Conditional/Unconditional Release Hearing At Consumer's Request
- To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, etc.) to obtain services consistent with the _____ program (please complete the name of the program in which you want to participate)
- Other (specify) _____
- Do a general medical evaluation, psychological evaluation, orthopedic evaluation, or _____ Evaluation, and complete the enclosed IM-60A. The examination may include test (s) which are indicated by the patient's complaints and are necessary before you can reach a decision on his/her employability. The examination is scheduled for _____ at _____. The Family Support Division will honor a physician's usual and customary charges, up to but not exceeding our professional reimbursement schedule. If, in your opinion, the patient must be hospitalized in order for you to complete this medical report, Prior Written Authorization by the State Medical Review Team must be given before payment will be made by the Family Support Division.

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- Discharge Summary Progress Notes Treatment Plan and/or Review
- Social Service Assessment Educational testing, IEP, transcript, and/or grading reports
- Medical/Psychiatric Assessment(s), and complete the certification section of the enclosed IM-60a.
- Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
- Other _____
- Hospital's Pertinent data: History and Physical, Discharge Summary, Consultative exams, Lab reports, Radiology reports including MRI and CT scans, Cardiology Records, Operative Reports, Pathology Reports, and Emergency Room Records

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
4. This authorization becomes effective on _____ . This authorization automatically expires on the following date, event or special condition _____ .
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulation. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION
DATE

I, _____, (Consumer) hereby revoke my authorization of this disclosure of information to the Agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

INDIVIDUAL NAME (FIRST)		(MIDDLE)	(LAST)	INDIVIDUAL DCN	DATE OF BIRTH	COUNTY
ELIGIBILITY SPECIALIST		FAMIS USER ID	LOAD	DATE OF APP/REAPP/REVIEW	DATE SUBMITTED TO MRT	
TO THE EXAMINING PHYSICIAN			Physician's Name:		Specialty:	
<p>The above named person is applying for or is a member of a household which is applying for public assistance based on disability. Eligibility for assistance will be based, in part, on the medical information that you supply on this form. Therefore, please complete the entire form as thoroughly and accurately as possible. We need to know if this person has a mental or physical disability which makes him/her unable to function at his/her normal occupation or other suitable employment. After an examination has been completed and/or the medical information entered on the form, your opinion is needed about the person's mental and/or physical condition with regard to employability.</p> <p>NOTE: The Family Support Division will not assume responsibility for payment of inpatient costs unless prior written authorization is given by the County Manager of the Family Support Division office that initiated this form. If you feel that hospitalization is required before you can make a decision regarding employability, indicate this on the form and return it to the Family Support Division County Office.</p>						
TO BE COMPLETED BY THE EXAMINING PHYSICIAN						
ARE YOU NOW OR HAVE YOU TREATED THIS PATIENT IN THE PAST YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE						
BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)						
HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, ENTER NAME OF HOSPITAL ►				HOSPITAL		
COMPLETE FOR EACH PERSON		BLOOD PRESSURE		HGB OR HCT IF INDICATED		URINALYSIS
WEIGHT	HEIGHT	SYSTOLIC	DIASTOLIC	HGB	HCT	SUGAR ALBUMEN
EYES		VISION CORRECTED BY GLASSES TO			EARS HEARING (ORDINARY CONVERSATION)	
RIGHT	LEFT	RIGHT	LEFT	RIGHT (20 FT.)	LEFT (20 FT.)	
NOSE, THROAT, MOUTH, NECK (ABNORMALITIES)						
CARDIOVASCULAR SYSTEM						
CARDIAC ENLARGEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEGREE		MURMURS		RHYTHM
EVIDENCE OF CARDIAC DECOMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO BASILAR RALES <input type="checkbox"/> YES <input type="checkbox"/> NO LIVER ENLARGEMENT <input type="checkbox"/> YES <input type="checkbox"/> NO PERIPHERAL EDEMA <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN.						
ANGINA PECTORIS? <input type="checkbox"/> YES <input type="checkbox"/> NO DESCRIBE PAIN AND AMOUNT OF EXERTION REQUIRED TO PRODUCE IT.						
PULSE RATE	DYSPNEA	CYANOSIS	EDEMA	TYPE OF HEART DISEASE		FUNCTIONAL CLASSIFICATION
PERIPHERAL ARTERIAL DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN						
ABSENT PULSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN						
VARICOSITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN						
PULMONARY FUNCTION			RIGHT		LEFT	

NERVOUS SYSTEM			
PARALYSIS, SPEECH, GAIT, REFLEXES: PUPILLARY, KNEE, BABINSKI, ROMBERG			
EVIDENCE OF <input type="checkbox"/> PSYCHOSIS <input type="checkbox"/> NEUROSIS <input type="checkbox"/> MENTAL DEFICIENCY		DESCRIBE	
SEIZURES <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LIST ►		TYPE	FREQUENCY OF ATTACKS WITH MEDICATION
NEOPLASMS			
SITE	BENIGN	MALIGNANT	METASTASES
BONES, JOINTS, AND EXTREMITIES			
DESCRIBE DISEASE OR INJURY AND STATE LIMITATION OF MOTION, SUCH AS ABILITY TO WALK, STAND, BEND, STOOP, GRASP, ETC.			
ABDOMEN			
<input type="checkbox"/> SCARS	<input type="checkbox"/> TENDERNESS	<input type="checkbox"/> PALPABLY ENLARGED ORGANS	<input type="checkbox"/> HERNIA
DESCRIBE ITEMS CHECKED			
GENITO-URINARY			
<input type="checkbox"/> URETHRAL DISCHARGE	<input type="checkbox"/> HYDROCELE	<input type="checkbox"/> EPIDIDYMITIS	<input type="checkbox"/> PROSTATE <input type="checkbox"/> ABNORMAL TESTICAL
DESCRIBE ITEMS CHECKED			
GYNECOLOGICAL			
<input type="checkbox"/> PROLAPSE	<input type="checkbox"/> CYSTOCELE	<input type="checkbox"/> RECTOCELE	<input type="checkbox"/> CERVIX <input type="checkbox"/> ADNEXA <input type="checkbox"/> PREGNANT EXPECTED DUE DATE
DESCRIBE ITEMS CHECKED			
ANO-RECTAL			
<input type="checkbox"/> HEMORRHOIDS	<input type="checkbox"/> PROLAPSE	<input type="checkbox"/> FISSURES	<input type="checkbox"/> FISTULA
DESCRIBE ITEMS CHECKED			
OTHER LABORATORY FINDINGS (ATTACH WRITTEN REPORT OF X-RAYS, EKG, OR OTHER LABORATORY FINDINGS)			
DIAGNOSIS (physical) : Diagnosis and GAF (Global Assessment of Functioning): (mental health)			
PRIMARY			
SECONDARY			
KNOWN MEDICATIONS			
SUMMARIZE FINDINGS WITH EMPHASIS ON FUNCTIONAL CAPACITY			
IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE	
DETERMINATION OF INCAPACITY: In my opinion this individual (<input type="checkbox"/> does <input type="checkbox"/> does not have) a mental and/or physical disability which prevents him/her from engaging in that employment or gainful activity for which his/her age, training, experience or education will fit him/her. When evaluating a child, the physical or mental impairment has to compare in severity to an impairment that would make an adult disabled and evidence of marked restriction in daily age appropriate activities must exist.			
DURATION OF INCAPACITY: In my opinion, the expected duration of disability/incapacity will be:			
<input type="checkbox"/> 1 month	<input type="checkbox"/> 3-5 months	<input type="checkbox"/> 13 or more months	
<input type="checkbox"/> 2 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> Permanent.	
THE ABOVE FINDINGS AND STATEMENTS ARE BASED ON MY EXAMINATION AND/OR RECORDS.			
SIGNATURE OF PHYSICIAN (Please print physician's name beneath signature)			DATE