

ST. LUCIE PUBLIC SCHOOLS

THIS FORM VALID FOR USE DURING THE 2024-2025 SCHOOL YEAR
ATHLETIC PAPERWORK WILL BE COMPLETED ONLINE AT

www.AthleticClearance.com

WITH THE EXCEPTION OF:

- The EL2 (physical form) must be completed by the Physician and signed by the parent and student.

Along With

- Parent Player Agreement Pages 1 & 2 (Pg. 2 must be notarized)

Both must be completed and uploaded to www.AthleticClearance.com

STUDENT ATHLETES MUST COMPLETE THE FOLLOWING COURSES AND UPLOAD CERTIFICATES OF COMPLETION TO WWW.ATHLETICCLEARANCE.COM

- Concussion in Sports

<https://www.nfhslearn.com/courses/concussion-for-students>

- Heat Illness Prevention

<https://www.nfhslearn.com/courses/heat-illness-prevention-2>

- Sudden Cardiac Arrest

<https://www.nfhslearn.com/courses/sudden-cardiac-arrest>

On nfhslearn.com website: at the top, select "Florida" and click "Order Course". You will need to create an account (or login if you already have one) and will then be able to take the courses. There is no charge.

Florida

\$0

Order Course

Once a student has been selected for a team, they must PAY A PROCESSING FEE **TBD PER SEASON** at **TBD** and present the receipt or screenshot of the receipt to the Athletic Office to be rostered.

ONLINE ATHLETIC CLEARANCE

1. Visit www.AthleticClearance.com and click on the Florida button.
2. Click on **“Create an Account”** and follow steps. Or click **“Sign In”** if you have previously created an account. If you need help, click to watch the tutorial video. Please create your account using a valid email (which will become your username) and valid password.
3. Sign in using the email address and password that you registered with.
4. Select **“Start Clearance Here”** to start the process.
 - **Choose the School Year** in which the student plans to participate.
Ex: Football in Sept 2024 would be the 2024-2025 School Year.
 - **Choose the School** where the student attends and will compete.
 - **Choose the Sport**. For multiple sports, click **“Add New Sport”** (Chose All Sports you are interested in.)
Electronic signatures will be applied to the additional sports/activities.
5. Complete all required fields for Student Information, Educational History, Medical History and Signature Forms (if you have gone through the AthleticClearance.com process before, you will select the Student and Parent/Guardian from the dropdown menu on those pages).
6. All data will be electronically filed with your school’s athletic department for review.
7. **YOU WILL NEED TO PICK UP CLEARANCE CARD FROM THE ATHLETIC OFFICE AND GIVE TO THE COACH.**

Online Athletic Clearance FAQ

What is my username?

Your username is the email address that you registered with.

What if the student participates in multiple sports?

On the first step of the process, you can “**Add New Sport**”. If you use this option, you fill out the clearance one time and it is applied to the sport selected.

If you complete a clearance and come back later to add a sport, you will “**Start New Clearance**” and then autofill student and parent information using the dropdown menus on those pages.

Where are the physical forms?

The physical form can be downloaded on Files page.

Why haven't I been cleared?

Your school will review the information you have submitted and Clear for practice or deny your student for participation. You will receive an email when the student's status is updated.

What if my sport is not listed?

Please contact your school's Athletic Department and ask for your sport to be activated.



PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ____/____/____
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

List past and current medical conditions:

Have you ever had surgery? If yes, please list all surgical procedures and dates:

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

Patient Health Questionnaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

GENERAL QUESTIONS			Yes	No	HEART HEALTH QUESTIONS ABOUT YOU			Yes	No
HEART HEALTH QUESTIONS ABOUT YOU			Yes	No	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			Yes	No
1	Do you have any concerns that you would like to discuss with your provider?				8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?			
2	Has a provider ever denied or restricted your participation in sports for any reason?				9	Do you get light-headed or feel shorter of breath than your friends during exercise?			
3	Do you have any ongoing medical issues or recent illnesses?				10	Have you ever had a seizure?			
4	Have you ever passed out or nearly passed out during or after exercise?				11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)			
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			
7	Has a doctor ever told you that you have any heart problems?								

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Page 2 of 4)

This medical history form should be retained by the healthcare provider and/or parent.

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

Student's Full Name: _____ Date of Birth: ___ / ___ / ___ School: _____

BONE AND JOINT QUESTIONS		Yes	No	MEDICAL QUESTIONS (continued)		Yes	No
14	Have you ever had a stress fracture?			26	Do you worry about your weight?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			27	Are you trying to or has anyone recommended that you gain or lose weight?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?			28	Are you on a special diet or do you avoid certain types of foods or food groups?		
MEDICAL QUESTIONS		Yes	No	29	Have you ever had an eating disorder?		
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?			Explain "Yes" answers here: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?						
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?						
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?						
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?						
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?						
23	Have you ever become ill while exercising in the heat?						
24	Do you or does someone in your family have sickle cell trait or disease?						
25	Have you ever had or do you have any problems with your eyes or vision?						

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ (printed) Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ (printed) Parent/Guardian Signature: _____ Date: ___ / ___ / ___



PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)
*This medical history form should be retained by the healthcare provider and/or parent.
 This form is valid for 365 calendar days from the date signed below.*

EL2

Revised 4/24

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ / ___ / ___ School: _____

HEALTHCARE PROFESSIONAL REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	• Have you experienced performance changes, felt fatigued, and/or experienced times of low energy during the past year?

Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION

Height: _____ **Weight:** _____

BP: ___ / ___ (___ / ___) **Pulse:** _____ **Vision:** R 20/ _____ L 20/ _____ **Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

This form is not considered valid unless all sections are complete.

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

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PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) print legibly

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ___/___/___
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

The preparticipation physical evaluation must be administered by a practitioner licensed under Florida chapter 458, chapter 459, chapter 460, §464.012, or registered under §464.0123, and in good standing with the practitioner's regulatory board. (§1006.20(2)(c), F.S.)

- Medically eligible for all sports without restriction
Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: (use additional sheet, if necessary)

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Recommendations: (use additional sheet, if necessary)

I hereby certify that I, or a clinician under my direct supervision, have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/___
Address: _____ Phone: (____) _____
Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp (if required by school)

Medications: (use additional sheet, if necessary)

List: _____

Relevant medical history to be reviewed by athletic trainer/team physician: (explain below, use additional sheet, if necessary)

- Allergies Asthma Cardiac/Heart Concussion Diabetes Heat Illness Orthopedic Surgical History Sickle Cell Trait Other

Explain: _____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

This form is not considered valid unless all sections are complete.



PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/24

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Biological Sex: _____ Age: _____ Date of Birth: ___ / ___ / ___
 School: _____ Grade in School: _____ Sport(s): _____
 Home Address: _____ City/State: _____ Home Phone: (____) _____
 Name of Parent/Guardian: _____ E-mail: _____
 Person to Contact in Case of Emergency: _____ Relationship to Student: _____
 Emergency Contact Cell Phone: (____) _____ Work Phone: (____) _____ Other Phone: (____) _____
 Family Healthcare Provider: _____ City/State: _____ Office Phone: (____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

- Medically eligible for all sports without restriction as of the date signed below
- Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

Medically eligible for only certain sports as listed below:

Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / ___

Address: _____ Phone: (____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*

THIS FORM IS VALID FOR USE DURING THE 2024-25 SCHOOL YEAR
ST. LUCIE PUBLIC SCHOOLS, FLORIDA
PARENT AND PLAYER AGREEMENT, PERMISSION AND RELEASE

Name of Student Athlete (Please Print) _____

Home Address _____

Home Phone _____ Date of Birth _____ Place of Birth _____

Parent/Guardian Work Phone _____ Emergency Phone _____

School _____ Grade _____ Sport(s) _____

I, the undersigned Parent(s)/Guardian(s) of the above-named student (Student Athlete), acknowledge that competing in interscholastic athletics in the St. Lucie County Schools is entirely voluntary and subject to the eligibility rules and regulations of the Florida High School Athletic Association. We further acknowledge that we have not violated and, in the future, will abide by all the rules set down by the School Board of St. Lucie County, the Florida High School Athletic Association and the school in which the Student Athlete is enrolled. All infractions of the Code of Student Conduct shall be reported to school administration. All infractions are subject to the appropriate Discipline Response as defined in the School Board of St. Lucie County Code of Student Conduct.

Student Athletes and parents or guardians of Student Athletes should have a thorough understanding of the responsibilities and implications of participating in voluntary extracurricular activity. For this reason, each Student Athlete in the St. Lucie Public Schools and his/her parent(s) or guardians(s) shall read and sign this agreement, permission and release prior to the Student Athlete being allowed to participate in any form of athletic practice or contests.

I, the undersigned Parent(s)/Guardian(s) of the above name Student Athlete:

1. Understand that I must complete the FHSAA pre-participation Evaluation and the FHSAA Consent and Release of Liability Certificate to participate as a student athlete in St. Lucie County.
2. Understand that only a supplementary insurance premium for the Student Athlete is to be paid from school board funds. This insurance will have a \$500.00 deductible. This deductible will be applied concurrent with primary coverage which will be paid at 100% Reasonable and Customary. If there is no primary coverage, this insurance will pay 100% of Reasonable and Customary after the \$500.00 deductible.
3. Understand that in the event of accident or injury, the required accident forms will be completed by school officials, and that all claims under any applicable insurance policy for injuries received while participating in athletic activities or travel incidental to such activities shall be processed by the Parent(s)/Guardian(s) of the Student Athlete through the company agent handling the Student Athlete's insurance policy and NOT through school officials.
4. Understand that a NON-REFUNDABLE ATHLETIC FEE established by the School Board of St. Lucie County must be paid for each sport for which I am selected and must be paid prior to participation in any competitions. I also understand that additional fees may be assessed to participate in a specific sport due to financial limitations and the uncertainty of financial times.
5. Understand that an official St. Lucie County School Board Receipt will be given for any fees that are not paid electronically.
6. Accept financial responsibility for any athletic equipment lost or damaged by the Student Athlete.
7. Understand that if the behavior of this Student Athlete results in a fine being imposed by the FHSAA, that the fine will be assessed to the student and must be paid prior to further participation. Minimum fine for gross unsportsmanlike conduct is \$250.00.
8. Authorize the school to transport the Student Athlete and to obtain, through a physician of the school's choice, and emergency medical care that may become reasonably necessary for the student during athletic activities or travel incidental to such activities and agree that the expenses for such transportation and treatment shall not be borne by the School Board of St. Lucie County or its employees.
9. Accept full responsibility and grant permission for the Student Athlete to travel on any trips including overnight trips approved by the school's principal.
10. Consent to the release of educational records relating to the student's name, date of birth, and eligibility for athletics to the Florida High School Athletic Association and its service provider Home Campus, for the purposes of reporting eligibility to participate in athletics and authorize the release of student transcripts to colleges or their representatives for recruiting purposes.
11. Consent to the release of the student's name, photo, voice, video, height, weight, name of school attending, grade level and athletic position and statistics for public access including but not limit to inclusion on District and school website, social media, broadcasting in athletic programs.

NOTICE TO PARENTS/GUARDIANS OF MINOR CHILD PARTICIPANTS

Valid for 2024-25 School Year ONLY

READ THIS FORM COMPLETELY AND CAREFULLY. YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF THE SCHOOL DISTRICT OF ST LUCIE COUNTY, ITS OFFICERS, DIRECTORS, EMPLOYEES AND AGENTS USE REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM, YOU ARE GIVING UP YOUR CHILD’S RIGHT AND YOUR RIGHT TO RECOVER FROM THE ST LUCIE COUNTY SCHOOL DISTRICT IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND THE ST. LUCIE COUNTY SCHOOL DISTRICT HAS THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I/WE, THE UNDERSIGNED PARENT/GUARDIAN OF THE NAMED STUDENT ATHLETE ACKNOWLEDGE HAVING RECEIVED ADEQUATE OPPORTUNITY TO REVIEW THIS AGREEMENT, PERMISSION AND RELEASE AND TO ASK QUESTIONS OF SCHOOL OFFICIALS. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT; THAT I AGREE TO ITS TERMS; THAT I WILL COMPLY WITH ALL SCHOOL BOARD AND STATE ASSOCIATION RULES. IT IS UNDERSTOOD THAT THE STUDENT ATHLETE IS REQUIRED TO COMPLY WITH ALL SAFETY RULES AND INSTRUCTIONS PROVIDED WITH EACH SPORT, COMPETITION, AND PRACTICE WHILE ENGAGING IN SUCH ACTIVITIES. FURTHER I UNDERSTAND THAT A 2.0 CUMULATIVE MINIMUM GRADE POINT AVERAGE IS REQUIRED FOR PARTICIPATION.

I/WE UNDERSTAND THAT PARTICIPATION IN INTERSCHOLASTIC ATHLETICS IS A PRIVILEGE. FURTHERMORE, I/WE UNDERSTAND THAT THE PRINCIPAL OR DESIGNEE HAS THE SOLE DISCRETION TO WITHDRAW MY ELIGIBILITY AT ANY TIME DUE TO AN ON-CAMPUS OR OFF-CAMPUS BEHAVIOR THAT IS DEEMED BY THE PRINCIPAL OR DESIGNEE TO BE UNBECOMING OF A STUDENT ATHLETE.

-----PARENT/GUARDIAN ACKNOWLEDGEMENT-----

State of Florida }
County of _____ }

The Foregoing instrument was acknowledged before me by means of

- _____ Physical Presence
- _____ Online Notarization

This ____ day of _____, 20____, by

(Signature of Parent/Guardian Acknowledging)

(Signature of Notary Public-State of Florida)

(Printed Name of Notary Public)

(Place Notary Seal Stamp Above)

- ___ Personally Known
 - ___ Produced Identification
- Type of Identification Produced:
