



Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: <http://pr.mo.gov/healingarts.asp>

Connie Clarkston
Executive Director

Dear Clinical Perfusionist Licensure Applicant:

Enclosed are the materials for application to obtain a Provisional License as a Clinical Perfusionist in the State of Missouri. Included in the packet are:

1. The application with specific instructions for completing it;
2. Documents and Fee Sheet;
3. Agreement to Supervise form;
4. Licensure Verification forms (if more than one copy is needed you may make additional copies);
5. Authorization for Release of Medical Records.

All applicants are encouraged to read the Perfusion statutes and rules in their entirety before beginning the application process.

An affirmative response to question numbers 10 through 18 on the application form does not preclude applicants from obtaining a Missouri license. The Missouri Advisory Commission for Clinical Perfusionists and the Missouri Board of Healing Arts will review each file on an individual basis.

Please be advised that no application will be processed without the fee. You will be notified in writing one (1) time if the application is deficient in anyway. Thereafter it is the applicant's responsibility to assure the completion of the application file. In addition to the material you are required to submit, the Board makes independent inquiries into your professional background. Therefore, you should allow a minimum of thirty (30) days for the processing of your application once you have filed the completed application, fee and the required documents in this office.

It is unlawful to misrepresent any material fact, in anyway, in connection with your application for a Missouri license. Proof that a Perfusionist has misrepresented any material fact is grounds for denial of licensure. If you have any questions, during the process, which are not answered in the enclosed materials you may contact the Board of Healing Arts, Clinical Perfusionist Section at (573) 751-0098 or toll free at (866) 289-5753 or email at licensure@pr.mo.gov

Sincerely

Licensure Section

INSTRUCTIONS FOR COMPLETING YOUR CLINICAL PERFUSIONIST PROVISIONAL LICENSURE APPLICATION

The Commission and Board wishes to stress that you should provide complete details, dates, names and addresses as required in your application. Answer all questions. If you do not, the processing of your application may be delayed indefinitely. **Please type or print your application in black ink.** The following information is provided to assist you in answering the questions.

Question #1 - Print your full name and list email address.

Question #2 - Provide address to which all licensure material should be sent.

Question #3 - Indicate both home and office telephone numbers.

Question #4 - Indicate city and state of birth and the month, day and year of birth. Indicate Social Security number. State law mandates the submission of Social Security numbers on professional applications. A citizen of any international country applying for licensure in Missouri who does not hold a United States Social Security number may submit his/her Visa or Passport Identification number in lieu of the Social Security number.

Question #5 - Indicate intended Missouri employment address. If unknown, please indicate the reason why a Missouri license is needed.

Question #6 - List in chronological order the name and location of each perfusion educational institution attended. Please indicate the dates of attendance, graduation date and type of diploma or certificate awarded, if applicable.

Question #7 - List **all professional** licenses, whether active, inactive, temporary or institutional, in order of attainment.

Question #8 - A) Please indicate if you have taken any part of the American Board of Cardiovascular Perfusion (ABCP) Examination. If so, list number of times taken. B) Please indicate if you have taken any State Board Examination. If so, list date(s) and the state(s) in which the exam(s) were given.

Question #9 - A) Indicate if you are currently certified as a Clinical Perfusionist by the American Board of Cardiovascular Perfusion; B) Indicate your certification number; C) Indicate the issue date of your certification.

Questions #10-12 - If your answer is "yes", provide full details, names, dates, addresses, etc. on a separate notarized statement.

Question #13 - If your answer is yes, provide full details on a separate notarized statement. Furnish a Certified Court Copy, with court seal affixed, of the original complaint, answer, and disposition.

Question #14 - If your answer is "yes", provide full details on a separate notarized statement of the arrest, the dates, places and disposition of the case. Furnish a Certified Court Copy, with court seal affixed, of the original charge, the judgment, the sentence and/or dismissal order, or other such documents, which reflect the disposition of the matter.

This does not include any minor traffic or parking violation fines which are under \$100. We suggest that if you have ever had an arrest (no matter how minor), you answer the question "yes" on the application and furnish all details of the incident leading up to and including the arrest and disposition of the case.

Questions #15-18 - If your answer is "yes", provide full details and dates, including the names and addresses of individuals who treated you and any hospitals/institutions where you have been treated on a separate notarized statement. The Board also requires a letter from your treating

professional indicating your diagnosis, prognosis and if your illness or condition affects your ability to practice. The enclosed form titled "AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS" must be completed for each physician/ therapist/hospital or institution, authorizing them to release whatever information the Board may request.

Question #19 - A provisional licensee may have more than one supervising clinical perfusionist. If a provisional licensee has more than one supervising licensed clinical perfusionist, then one supervising licensed clinical perfusionist shall be designated as the primary supervising perfusionist and the other supervising licensed perfusionists as secondary.

Question #20 - Applicant's Oath. You must sign this oath before a Notary Public who shall complete his/her portion and sign, date and seal your signature. You must also include a photograph taken within the two-year period prior to application.

DOCUMENTS AND FEE REQUIRED FOR CLINICAL PERFUSIONIST PROVISIONAL LICENSE

1. **FEES** – Please submit the application fee of **\$25.00** to the Board in the form of a Cashier s Check or Money Order made payable to the Missouri Board of Healing Arts, drawn on or through a United States Bank. **All fees are nonrefundable.**
2. **NOTARIZATIONS** – Affidavits and Statements submitted with an application must be notarized as “Subscribed and Sworn to” before a Notary Public. The Notary Public must sign, date and affix his/her notary seal on each page of the Affidavit and/or Statement.
3. **ACTIVITY STATEMENT** – All applicants are required to submit a chronological listing of professional and non-professional activities from high school graduation (or its equivalency) to the present date **or** for the last ten years, whichever date is the most recent. All time periods must be accounted for or the processing of the application will be delayed. Applicants should report in chronological order their employment position(s), complete name(s), address(es) and zip code(s) of employer(s) companies; and specify the beginning and ending dates of employment and/or schooling, etc. **This Statement must be submitted in addition to the information on your application.**
4. **TRANSCRIPTS** – Applicants are required to submit official certified transcripts of their perfusion education from every program attended, specifying the courses taken and grades received. If your final transcript specifies all the courses taken and grades received from all programs attended that transcript will be accepted without the other transcripts. Transcripts should be sent to the Board directly from the educational program, but can be submitted with the application if it is in a sealed envelope, indicating that it was sealed by the educational program.
5. **NAME CHANGE DOCUMENTATION** – All applicants are required to submit legal documentation verifying any name change that occurred since birth, as follows:
MARRIAGE – Furnish a copy, no larger than 8½" x 11", of the marriage license and/or certificate. This can be obtained from the Clerk s office in the County in which the marriage occurred.H
DIVORCE – Furnish a copy, no larger than 8½" x 11," of the divorce decree.
ADOPTION – Furnish a copy, no larger than 8½" x 11", of the adoption order.
COURT ORDER – Furnish a certified court copy of the name change document.
NATURALIZATION – Furnish the original Naturalization Certificate to the Board for inspection, since it is unlawful to copy that document. After inspection, the Board will return the original by certified mail.
6. **PHOTOGRAPH** – Please attach a recent photograph no larger than 3½" x 5" in the space provided on the application. The photograph must have been taken within the two-year period prior to application.
7. **AGREEMENT TO SUPERVISE FORM** – Applicants requesting provisional licensure must have the **PRIMARY** supervising licensed Clinical Perfusionist complete the enclosed *Agreement to Supervise* Form before a provisional license can be issued.
8. **SOCIAL SECURITY CARD** – Furnish a copy of your Social Security card. (Do NOT fax) A citizen of an international country applying for licensure in Missouri, who does not hold a United States Social Security number, shall submit his/her Visa or Passport in lieu of the Social Security card.
9. **LICENSURE VERIFICATION(S)** – All applicants are required to report on the application form all states, countries and/or territories in which he/she is or has ever been licensed to practice perfusion or any profession. The state and/or issuing agency must submit verification of such licensure, registration or certification to include type of license, effective dates of license and report whether or not any disciplinary action has been taken against the license, or if an investigative action is pending. The Board will provide forms for this purpose but verification can be submitted directly from the issuing agency provided all the required information is disclosed and the verification contains an original signature and appropriate state seal. Internationally trained applicants must have verification of licensure or verification of licensure eligibility submitted from the country in which they graduated.

Please be advised that you should not make any firm commitment to begin practicing until you have received notification of licensure in writing from this office.

Please be advised that **incomplete** applications on file in this office for **one (1) year will be discarded.**



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
**CLINICAL PERFUSIONIST PROVISIONAL
 LICENSURE APPLICATION**

ADVISORY COMMISSION FOR CLINICAL PERFUSIONISTS
 BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MISSOURI 65102
 (573) 751-0177 OR TOLL FREE (866) 439-3897

Pursuant to Section 324.010 RSMo:

CHECK THIS BOX ONLY IF IN ALL OF THE LAST THREE (3) YEARS: YOU WERE NOT A MISSOURI RESIDENT, YOU DID NOT HAVE ANY MISSOURI INCOME, AND YOU ARE NOT SUBJECT TO ANY TYPE OF MISSOURI INCOME TAX.

False statements are subject to criminal penalties and/or license discipline.

If you have any questions regarding taxes contact the Department of Revenue at 573-751-7200 or e-mail income@dor.mo.gov.

1. APPLICANT NAME (LAST, FIRST, MIDDLE, MAIDEN)	E-MAIL ADDRESS
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2. ADDRESS (PO BOX, STREET, CITY, COUNTY, STATE, ZIP)	3. TELEPHONE HOME OFFICE
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4. PLACE OF BIRTH	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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5. PROPOSED MISSOURI EMPLOYMENT ADDRESS

6. EDUCATION - STATE IN CHRONOLOGICAL ORDER THE NAME AND LOCATION OF EACH PERFUSION EDUCATIONAL INSTITUTION ATTENDED:

NAME AND LOCATION OF INSTITUTION	YEAR FROM	TO	DATE GRADUATED	DIPLOMA OR CERTIFICATE AWARDED

7. DO YOU NOW HOLD OR HAVE YOU EVER HELD A PERMANENT OR TEMPORARY LICENSE, CERTIFICATE OR REGISTRATION TO PRACTICE PERFUSION OR ANY OTHER PROFESSION (I.E. NURSING, PHYSICAL THERAPY, COSMETOLOGY, ETC)? IF YES, LIST THE TYPE OF LICENSE HELD AND EACH STATE WHERE YOU HOLD OR HAVE HELD A LICENSE, CERTIFICATE OR REGISTRATION.

YES NO

A.	B.	C.	D.	E.
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8. HAVE YOU PREVIOUSLY TAKEN THE AMERICAN BOARD OF CARDIOVASCULAR PERFUSION (ABCP) EXAMINATION? YES NO
 IF YES, INDICATE NUMBER OF TIMES ABCP EXAMINATION HAS BEEN TAKEN. _____

HAVE YOU PREVIOUSLY TAKEN A CLINICAL PERFUSION STATE BOARD EXAMINATION? YES NO
 IF YES, INDICATE NUMBER OF TIMES TAKEN AND LOCATION (STATE) TAKEN: _____

1.	2.	3.	4.	5.
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9. ARE YOU CERTIFIED BY THE AMERICAN BOARD OF CARDIOVASCULAR PERFUSION? <input type="checkbox"/> YES <input type="checkbox"/> NO	CERTIFICATION NUMBER	ISSUE DATE
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PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY ARE ANSWERED YES, SEE SEPARATE INSTRUCTIONS.

	YES	NO
10. Have you ever been denied any professional license/permit/certificate or professional privileges or denied the privilege of taking an examination before any professional board in the United States, Canada or other country?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you (professionally), or has any professional license/permit/certificate issued to you, been restricted or disciplined; such disciplinary action to include, but not be limited to: revocation, suspension, probation, censure or reprimand, whether voluntarily agreed to or not, by any State within the United States, territory, federal agency, Canadian province or other country?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had any disciplinary action or corrective action taken against you, or had your right to practice restricted by any professional employer, or any entity at which you have trained, held staff membership or privileges, or acted as a consultant?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been arrested, charged, indicted, found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under laws of any state or of the United States whether or not sentence was imposed, including suspended imposition of sentence or suspended execution of sentence?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you currently addicted to or dependent upon narcotics, intoxicating liquors, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorder?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you in the last ten years or since the age of 18 been treated for or hospitalized for bipolar disorder, schizophrenia, paranoia or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
18. Are you currently experiencing any medical condition or disorder that limits or impairs your judgment or that otherwise affects your ability to practice as a perfusionist in a safe and competent manner?	<input type="checkbox"/>	<input type="checkbox"/>

19. LIST YOUR PRIMARY SUPERVISING LICENSED CLINICAL PERFUSIONIST:

NAME

ADDRESS

LIST ALL SECONDARY SUPERVISING LICENSED CLINICAL PERFUSIONISTS:

NAME

ADDRESS

NAME

ADDRESS

NAME

ADDRESS

ALL APPLICANTS MUST PLACE A PHOTOGRAPH IN THE SPACE PROVIDED THAT HAS BEEN TAKEN WITHIN THE TWO YEARS PRIOR TO APPLICATION.



PHOTO

20. APPLICANT S OATH

State/Province of _____ County/Parish of _____

I, _____, hereby certify under oath that I am the person named in this application for a license to practice perfusion in the State of Missouri; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Commission and Board in connection with this application.

I acknowledge and state that I have read Chapter 324, RSMo, that can be located on the Board s website which contains the Statutes, Rules and regulations governing the practice of perfusion; I have answered all questions truthfully and in compliance with the instructions provided; and I understand that the application fee submitted with this application is non-refundable and cannot be transferred to another application.

I further state that by filing this application for license to practice perfusion in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of perfusion, when in the opinion of the Missouri Advisory Commission for Clinical Perfusionists and/or the Missouri Board of Healing Arts such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by court order.

I authorize and request every person, hospital, clinic, community, government agency (local, state, federal or international), court, association, institution or other organization having control of any documents, records, and other information pertaining to me to furnish to the Missouri Advisory Commission for Clinical Perfusionists and the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Missouri Advisory Commission for Clinical Perfusionists and the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice hereunder.

MUST BE SIGNED IN PRESENCE OF NOTARY	APPLICANT S SIGNATURE ▶	DATE OF SIGNATURE
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NOTARIZATION AND NOTARY INFORMATION

STATE	COUNTY
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The applicant identified him/herself with a government issued photographic identification and bearing true likeness to the above photograph subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____.	USE A RUBBER STAMP IN CLEAR AREA BELOW
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NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSEER SEAL
NOTARY PUBLIC PRINTED NAME		



STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION
STATE BOARD OF REGISTRATION FOR THE HEALING ARTS

BOARD OF REGISTRATION FOR THE HEALING ARTS
P.O. BOX 4
JEFFERSON CITY, MO 65102
TELEPHONE (573) 751-0177
TOLL FREE (866) 439-3897

CERTIFICATION

During the period of time in which the Board is processing my application and determining whether to issue me a license, I will inform the Board of any change in information included in my application for licensure, including but not limited to malpractice suits, discipline imposed by another state, administrative agency, hospital or other entity, arrests, and criminal convictions. I understand that failure to disclose this information could result in discipline pursuant to section 334.100.2(11).

Applicant Signature

Applicant Printed Name

Date

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STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
CLINICAL PERFUSIONIST AGREEMENT TO SUPERVISE

ADVISORY COMMISSION FOR CLINICAL PERFUSIONISTS
 BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MISSOURI 65102
 (573) 751-0177 OR TOLL FREE (866) 439-3897

To be completed by the PRIMARY licensed Clinical Perfusionist who will be supervising you in the State of Missouri.

I, _____, clinical perfusion license number _____, hereby accept responsibility for the supervision of _____, while s/he is practicing under a provisional license in accordance with the provisions of Chapter 324.147, RSMo. During the assigned supervision period, I understand that I must:

1. Maintain my license in good standing;
2. Supervise no more than two provisional licensees;
3. Insure supervision is readily available, at all times, to the provisional licensee;
4. Verify the issuance of the provisional license prior to allowing the provisional licensee to begin practicing under my supervision.
5. In the event of termination, I must submit written notification of termination of supervision to the board and the provisional licensee within 10 days of when supervision ceased.

NAME (PLEASE PRINT OR TYPE)

LICENSE NUMBER

TELEPHONE NUMBER

SIGNATURE (MUST BE SIGNED IN PRESENCE OF NOTARY)

DATE

NOTARIZATION AND NOTARY INFORMATION

STATE

COUNTY

The individual who signed above identified him/herself with a government issued photographic identification and subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____.

USE A RUBBER STAMP IN CLEAR AREA BELOW

NOTARY PUBLIC SIGNATURE

COMMISSION EXPIRES

NOTARY PUBLIC EMBOSSEER SEAL

NOTARY PUBLIC PRINTED NAME



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
CLINICAL PERFUSIONIST VERIFICATION OF LICENSURE

ADVISORY COMMISSION FOR CLINICAL PERFUSIONISTS
 BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BLVD.
 P.O. BOX 4
 JEFFERSON CITY, MISSOURI 65102
 (573) 751-0177 OR TOLL FREE (866) 439-3897

I, _____, hereby authorize and request the state
NAME OF APPLICANT (PLEASE PRINT)
 board of _____ having control of any documents, records and other information
 pertaining to me to furnish to the MISSOURI STATE BOARD FOR THE HEALING ARTS, information including
 documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any
 other pertinent information.

SIGNATURE OF APPLICANT	LICENSE NUMBER	ISSUE DATE
NAME IN FULL (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NO. (identification purposes only)
OTHER NAMES USED IN OBTAINING LICENSURE		
CURRENT ADDRESS (street, city, state and zip code)		

THE FOLLOWING SECTION MUST BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MISSOURI BOARD OF HEALING ARTS.

STATE OF	FULL NAME OF LICENSEE	
GRADUATE OF	LICENSE NUMBER	ISSUE DATE
LICENSE METHOD <input type="checkbox"/> ABCP CERTIFICATION <input type="checkbox"/> STATE BOARD EXAM <input type="checkbox"/> RECIPROCITY <input type="checkbox"/> GRANDFATHER CLAUSE <input type="checkbox"/> OTHER (SPECIFY) ▶ _____		

1. HAS THE APPLICANT EVER BEEN NOTIFIED OR REQUESTED TO APPEAR BEFORE ANY LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, PLEASE ATTACH DETAILS.	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
2. HAS THE APPLICANT EVER BEEN THE SUBJECT OF COMPLAINTS OR CHARGES RECEIVED BY A DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, PLEASE ATTACH DETAILS.	<input type="checkbox"/>	<input type="checkbox"/>
3. HAS THE APPLICANT EVER BEEN WARNED, CENSURED OR DISCIPLINED IN ANY MANNER BY A LICENSING OR DISCIPLINARY AUTHORITY IN YOUR STATE? IF YES, PLEASE ATTACH DETAILS.	<input type="checkbox"/>	<input type="checkbox"/>
4. HAS ANY APPLICATION BY THE ABOVE APPLICANT FOR INITIAL LICENSURE OR REINSTATEMENT EVER BEEN DENIED? IF YES, PLEASE ATTACH DETAILS.	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS, IF ANY

BOARD SEAL	SIGNATURE AND TITLE	DATE
	▶ STATE BOARD	



STATE OF MISSOURI
 DIVISION OF PROFESSIONAL REGISTRATION
 STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

BOARD OF REGISTRATION FOR THE HEALING ARTS
 3605 MISSOURI BOULEVARD
 P.O. BOX 4
 JEFFERSON CITY, MO 65102
 TELEPHONE (573) 751-0177
 TOLL FREE (866) 439-3897

I hereby authorize any physician, therapist, counselor, hospital, clinic, or any other health care provider, medical records custodian, or any person or corporation (including insurance companies) which have records relating to medical, psychiatric, counseling or evaluation received by me, to furnish the Missouri Board of Healing Arts, or its representative, oral or written statements or testimony in any hearing, any and all information with respect to any medical, psychiatric, counseling or evaluation and copies of all hospital, medical, psychiatric, counseling, and evaluation records.

A photocopy of this authorization shall be accepted the same as the original in all instances.

PHYSICIAN/THERAPIST, HOSPITAL/INSTITUTION NAME	
ADDRESS	
APPLICANT S NAME (PRINT OR TYPE)	TELEPHONE NUMBER(S)
APPLICANT SIGNATURE	DATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	
<hr/> <hr/>	

IMPORTANT NOTICE

THIS AUTHORIZATION MUST BE NOTARIZED.

NOTARIZATION AND NOTARY INFORMATION		
STATE	COUNTY	
The applicant identified him/herself with a government issued photographic identification subscribed and swore to the truthfulness of this application before me, this _____ day of _____, _____ .		USE A RUBBER STAMP IN CLEAR AREA BELOW
NOTARY PUBLIC SIGNATURE	COMMISSION EXPIRES	NOTARY PUBLIC EMBOSSEER SEAL
NOTARY PUBLIC PRINTED NAME		