### DIVISION OF CHILD SUPPORT SERVICES



Waiver of Personal Service,

Daycare Verification (if applicable).

Telephone: 1-877-423-4746 (DCSS Contact Center - Toll Free)

Re: Child Support Case No \_\_\_ Non Custodial Darant

Non-Custodiai Parent	,
Custodian	
Children:	
Support Order Date:	Date of Last Review:
REQUEST FOR F	REVIEW OF CHILD SUPPORT ORDER
	Instructions
Use this form to ask the Division of Child Su (change).	pport Services (DCSS) to review your case for possible modification
Except for your signature, print your respons	ses. Use a black or blue ink ball point pen only.
Sign and return all required forms to your Ch	nild Support Services office.
Attach copies of your last two federal income tax returns or pay stubs, attach a separat	e tax returns and copies of your last three pay stubs. If you do not have te sheet explaining why:
Complete and return the following forms:	
<ul> <li>This form. Return both pages.</li> </ul>	
<ul> <li>Personal/Financial Affidavit (3 pages)</li> </ul>	),
<ul> <li>Confidential Information Form,</li> </ul>	

Please provide a certified copy of your order. Failure to provide a certified copy may result in termination of the review.

your case): ☐ My wages changed. ☐ At least one of the children in my case turns 18 within 6 months. ☐ The other parent's wages changed. ☐ At least one of the children in my case lives in a different home. ☐ A health insurance requirement needs to be added to my order. ☐ I am disabled or imprisoned. □ Other (give details):\_

I want DCSS to review my support order for modification because: (check the boxes below that affect

**Note:** A modification review may be conducted for persons who receive TANF benefits without the request of either parent.

If you have any questions, please call 1-877-423-4746. Or you may view your case information on the Customer Service Online website at https://services.georgia.gov/dhr/cspp/do/Logon First time users are required to register to obtain a user ID and password. Your IRN is required to register.

I understand and agree that:

- All forms must be signed and notarized where required or they will be returned to you, which may cause delays or possible termination of the modification review.
- DCSS only reviews child support and health insurance modifications for the children.
- DCSS does not represent me or the other party to my support order.
- DCSS uses information I provide to establish, modify, or enforce child support.
- After DCSS reviews my request, DCSS will determine if my case meets requirements for modification.
- Both parties have the right to have an attorney represent them in court under the provision of GA law O.C.G.A. 19-6-19.
- The judge decides the start date.
- I have the right to ask a court to modify or adjust my support order on my own.
- My modified or adjusted support order can result in higher, lower or remain unchanged support payments.
- Must notify DCSS of any changes to my name, address, phone number(s) or any other information that is needed to proceed with my request for a review and modification.
- I understand that a \$100 modification fee will be required if my monthly gross income (before taxes) is equal to or greater than \$1,000 and I requested the review and modification. The fee is waived if I am receiving TANF. If I receive Medicaid for my children and not for myself and my monthly gross income (before taxes) is equal to or greater than \$1000 per month the fee must be paid. The fee, if applicable, will be required when the review is complete and the order is adopted by the court.
- I understand that I am responsible for providing proof of my income and expenses. Failure to provide the required information within the specified time frame(s) may result in termination of the review process or an Agency Recommendation that may adversely affect my interests.
- I understand that legal documents including the Agency Recommendation and a petition will be personally served to me by my local sheriff's department or process server at my place of residence unless I sign and return the attached Waiver of Personal Service.

Under the penalty of perjury, I do hereby swear and affirm that the information I provided is accurate and true to the best of my knowledge. I understand the criminal penalties for making false statements and false swearing under Georgia Law, O.C.G.A §16-10-71 is punishable by a fine of not more than \$1,000 or by imprisonment of one year or more, or both. I do hereby attest to the truthfulness of the information provided.

Date	Signature
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No person because of race, color, national origin, creed, religion, sex, age, or disability, shall be discriminated against in employment, services, or any aspect of the program's activities. This form is available in alternative formats upon request.

FOR CHILD SUPPORT AGENCY USE ONLY					
Agency representative's Signature	Date				
Agency Street Address	City	State	Zip Code		

## **Review and Modification Checklist**

Please note that you are responsible for providing proof of any information that you wish to be considered in a review of your court order. If you fail to do so or fail to respond, the review will be based on information available to us. The Division of Child Services is not responsible for proving your allegations. You must obtain this proof.

When completing the documents attached to the Notice of Child Support Review, the following must be provided, if applicable:

Income Verification:
Pay stubs (last five or more)
Tax records (last two years)
If you receive Social Security benefits, you will need to provide the following:
Proof from the Social Security Administration showing type benefits received Proof from the Social Security Administration showing the monthly amount received Proof from the Social Security Administration showing that child(ren) is/are eligible for benefits from your account, and if so the date that child(ren) became eligible and type benefit(s) received (IF APPLICABLE) Proof from the Social Security Administration that a claim is pending, including the date that your claim was filed and the date of any hearing Proof of military pension (VA BENEFITS) or disability including the date(s) received and the monthly amount
If you are paying child support under a pre-existing order to another individual, state or foreign jurisdiction, you must provide: (Note: Information for child support being paid through Georgia DCSS is not required)
Copy of the court order
Payment history detailing payments made to any court, individual, or agency.
If you have qualified children (excluding stepchildren) in your home, you must show proof by providing the following:
Copies of birth certificate(s)
Adoption order, if applicable.
School records
If you are providing medical insurance for the child(ren)
Copy of the insurance card verifying coverage
Insurance company name, address, phone number, sponsoring employer, (if group coverage) name or the
person(s) providing insurance
Group number and policy number
Names of covered members
Total cost of insurance and frequency (monthly, weekly, bi-weekly, etc.)
Cost of insurance for the child or children's portion on this case

rare providing vision and for dental coverage
Copy of the insurance card verifying coverage
Insurance company name, address, phone number, sponsoring employer, (if group coverage) name or the
person(s) providing insurance.
Group number and policy number
Names of covered members
Total cost of insurance and frequency (monthly, weekly, bi-weekly, etc.)
Cost of insurance for the child or children's portion on this case
have life insurance with the child(ren) as a beneficiary
Proof of life insurance from your insurance company with the child or children listed as beneficiaries
Proof of the monthly cost of the life insurance
have expenses associated for work related child care
The attached Day Care Verification Form must be completed by your provider.
have expenses for other activities for the child(ren) such as music, choir, art, or sports, etc., you will need
ovide evidence of these costs per month.
Statement from school, or provider showing the costs of participating in these activities. These must show the cost for each child being considered in the case being reviewed.
have extraordinary medical expenses and/or educational expenses. You must provide:
Proof from the medical and /or educational provider showing the amount(s) being paid per child each month and
the balance left owing on the debt.
are the non-custodial parent and seeking a review based on job loss or financial instability:
Separation notice from my last employer detailing my circumstances for job loss
Statement detailing the reasons for your current financial instability if currently employed
If you are currently disabled, please provide a statement from your doctor noting if your disability is permanent or
temporary. If temporary, we will need the date of your anticipated return to work.

# PROVIDE DOCUMENTS THAT MAY DEMONSTRATE A BASIS FOR A DEVIATION IN THE AMOUNT OF CHILD SUPPORT. THESE DOCUMENTS MAY INCLUDE, BUT ARE NOT LIMITED TO:

- **a.)** An order of visitation. To be a deviation it may have to be extended visitation that is more than the usual amount. Joint or shared physical custody;
- b.) Insurance for the child, including health, dental, vision or life insurance where the child is the beneficiary;
- **c.)** Work related child care costs;
- **d.)** High income of either parent;
- e.) Low income of either parent (demonstrating extreme economic hardship or no earning capacity);
- f.) Substantial Travel Expenses for visitation;
- **g.)** Alimony;
- h.) Mortgage payments made to the custodial parent for the benefit of the child;
- i.) Permanency or Foster Care Plan;
- **j.)** Extraordinary expenses for the child(ren) like educational costs as well as special expenses for raising the child and extraordinary medical expenses.

Your response must be completed and notarized where appropriate. If you fail to do so, the review may be delayed or terminated without further notice.

# **PERSONAL / FINANCIAL AFFIDAVIT**

# CUSTODIAL PARENT [ ]

Your name:

NON CUSTODIAL PARENT [ ] NON PARENT CUSTODIAN [ ]

### PERSONAL INFORMATION:

Last	First		Middle		Maiden
Other married r	names, nicknames, etc:				
Marital status: [	_] Single [_] Married	Spouse:			[_] Divorced
Social Security	Number:		Sex: [_] Male	[_] Female	
Date of birth: _	/ Place of bir				
		City	State	County	<i>r</i> Country
Eyes:	Hair:	Weight:	Height:	ftin	
Home address:					
	Street address	City	State	County	Zip
Mailing address		0:4	01-1-	0	7'
A ( ( )	Street address	·	State	•	Zip
	since:// E-r				
				Work phone#:	
Last permanent	t address:	City	State	County	Zip
Driver's license		•		•	·
	no: State		•		
License tag:			State:	_	
FEDERAL B	ENEFITS / SOCIAL SE	CURITY HISTO	RY		
[_] Receives milit Does the child(re	ial security disability [_] tary pension or disability [_] en) receive benefits from parer efit amount and from which par	Never received ANY of account? [_] Yes [	of the above benefits _] No   If Yes, ar	S	
ADOPTION / FO	•				
[_] Currently red	ceive [_] Never receivn / Foster Care Plan		? \$		
YOUR EMPLOY	MENT:				
[_] Unemployed * If you are self-em	[_] Self-employed aployed you MUST provide a copy	• •	irns filed for your busin		
IF UNEMPLOYED	D: (please provide a copy of y	our separation notice	) <b>Dates:</b> from://		propriotoromp.
Did you receive: [	] Disability from://_ to	_//_ [ ] Settle	ement Amount: \$		
•					
Contact person:			Work pho	ne no: ()	
Employer address					
	Street address	City		State	County Zip
GROSS income: \$	\$ (Attach pay stubs)	Pay frequency: [_] We	eekly; [_] Bi-weekly; [_	_] Monthly; [_] Semi-	monthly

### **INSURANCE INFORMATION:** Do you provide health insurance? [\_]Yes [\_] No Total number of people included in policy? \_\_\_ Monthly Cost: \$\_\_\_\_ Each child's portion: \$ Who is currently covered by Health Insurance? Insurance company name: Insurance company phone no.: (\_\_\_\_\_\_\_\_ Policy / Group No.:\_\_\_\_\_ Address: City Do you provide life insurance with the child on this case as the beneficiary? [\_]Yes [\_] No Monthly Cost: \$\_\_\_\_\_ Do you provide dental insurance? [ ]Yes [ ] No Monthly Cost for children included in this case: \$ Do you provide vision insurance? [ ]Yes [ ] No Monthly Cost for children included in this case: \$ NAME OF BANK / CREDIT UNION: Account type & no.:\_\_\_\_\_ Account type & no.: **FAMILY HISTORY:** [Note: even if parents are deceased] Phone no.: ( ) -Your mother: [\_] Deceased on \_\_\_\_/\_\_\_/ Date of birth: /\_\_\_/ Place of birth: \_\_\_\_ Address: County Street address Citv State Zip Phone no.: ( ) Your father: Date of birth: \_\_\_\_/\_\_\_ Place of birth: \_\_\_\_\_ [ ] Deceased on / / Address: Street address City State County Zip \_\_ Relationship: \_\_ Other close relative/Family/Friends: \_\_\_\_\_ Address: County Street address Citv State Zip Phone number or other contact address: HAVE YOU EVER BEEN IN PRISON OR ON PROBATION? Incarcerated from \_\_\_\_/\_\_\_ to \_\_\_\_/\_\_\_ Probation period to end: \_\_\_/\_\_/\_\_ Institution name: \_\_\_\_\_ Probation / parole officer: \_\_\_\_\_ Probation / parole officer's no.: Institution address: YOUR TANF (WELFARE) HISTORY: [ ] Formerly on TANF [\_] History unknown [\_] Never on TANF [\_] Currently on TANF [ ] Receives Medicaid Only; [ ] Receives Food Stamps only; TANF received from \_\_\_/\_\_\_\_ to \_\_\_/\_\_\_\_ PREVIOUS EMPLOYMENT (LAST 3 YRS): Provide city, state & employer name. Complete addresses are not required. **EDUCATIONAL HISTORY:** Schools (High school, Trade, Colleges) attended: State Zip Phone Number Name Street City

# **Your Financial Summary**

Gross Income Source (before taxes)	Average Monthly Gross Amount	Expense Source	Average Monthly Gross Amount
Salary / Wages (do not include TANF)	\$	Rent or mortgage payment	\$
Commissions, fees & tips	\$	Utilities (electric, natural / propane gas, telephone)	\$
Self-Employment Income	\$	Child care (proof is required)	\$
[Refer to O.C.G.A. §19-6-15 (f)(1)(B) for details]		Alimony Paid	\$
Bonuses	\$	Food	\$
Overtime Payments	\$	Medical bills or expenses (not covered by insurance) (proof is required)	\$
Severance Pay	\$	Probation / parole fines	\$
Recurring income from Pensions or retirement plans	\$	Vehicle payment	\$
Interest Income	\$	Clothing	\$
Income from dividends	\$	Transportation/Visitation costs	\$
Trust income	\$	Child support paid by previous court order	\$
Income from annuities	\$	Property taxes	\$
Capital Gains	\$	Recreation	\$
Social Security Disability or Retirement (Do not include SSI or payment for children)	\$	Insurance (Health) (proof is required)	\$
Worker's Compensation benefits	\$	Insurance (Life) (proof is required)	\$
Unemployment Compensation benefits	\$	Insurance (Automobile, Homeowners)	\$
Judgments from Personal Injury or other Civil Cases	\$	Insurance (Dental/Vision) (proof is required)	\$
Gifts (cash or other gifts that can be converted to cash)	\$	Bankruptcy	\$
Prizes / Lottery winnings	\$	Extraordinary Educational Expenses	\$
Alimony & maintenance from persons not on this case	\$	(i.e., tuition, books, room & board) (proof is required)	
Assets which are used for support of family	\$	Child's extraordinary medical expenses	\$
Fringe Benefits (if significantly reduce living expenses)	\$	(co-pays, deductibles) (proof is required)	
Any other income including Imputed Income:	\$	Special expenses for child rearing	\$
(Do not include means-tested public assistance, such		(i.e., camp, band, music, art, clubs)	
as TANF or Food Stamps)		(proof is required)	
		Other:	\$
TOTAL MONTHLY GROSS INCOME:	\$	TOTAL MONTHLY EXPENSES:	\$

I understand the criminal penalties for making false statements and false swearing under O.C.G.A. §16-10-71 and do hereby attest to the truthfulness of the information provided. So sworn and affirmed:

Your signature:	SSN Date://
Notary Public signature:	Commission expiration date://
NOTARY SEAL:	

Confidential Information Form					
☐ Divorce/Separation//Non-paren	tal Custody/Paternity/N	Modifications  Other			
☐ Information Change (Check if you are updating information)					
$oxedsymbol{\square}$ A restraining order or protection order is in effect protecting $oxedsymbol{\square}$ the non-custodial parent					
the custodial parent  the children.					
The following information about the parties is required in all cases:					
(Use an <u>additional</u> Confidential Information Form to list additional parties or children)  [ ] Non-Custodial Parent [ ] Non-Parent Custodian					
[ ] Non-Custodial Parent	[ ] Custod	dial Parent	[ ] Non-Parent Custodian		
Name (Last, First, Middle)					
Race	<u> </u>	Sex	Birth date		
Racc		JCX	Birtii date		
Driver's Lic. or Identicard (# and	State)	Employer			
Mailing Address (P.O. Box/Stree	t City State Zin)	Employer Address a	and Phone Number		
Training Tradress (T.O. Bow Sire	t, City, State, Zip)	Employer radicss t	and I none (vamoe).		
Relationship to Child(ren)		Your Phone Number:			
relationship to child(ren)		Tour Frome Frameer.			
		Your E-mail address:			
The following informa	tion is required if th	nere are children invo	olved in the proceeding.		
1) Child's Name (Last, First, Mid	dle)				
Child's Race/Sex/Birthdate					
Child's Present Address or Where	eabouts				
2) Child's Name (Last, First, Mid	dle)				
Child's Race/Sex/Birthdate					
Child's Present Address or Where	eabouts				
T ' / /1 1 1	11 6.1	*,1 1 .1	1'11/ \1' 1 1 ' -1		
List the names and present	addresses of the pe	ersons with whom th	e child(ren) lived during the		
last five years:					

Please list qua	<u>llified children: (you</u>	r biological children residing in your home):
1) Child's name:		2) Child's name:
Residential Address (Str	eet, City, State, Zip)	Residential Address (Street, City, State, Zip)
Date of Birth:		Date of Birth:
Please li	st children in which	you have court ordered child support:
1) Child's name:		1) Child's name:
County of Order and Civ	il Action Number	County of Order and Civil Action Number
Support Order Amount: itional information:		Support Order Amount: \$
itional information:  Additional Confidential Intify under penalty of perjury perning myself and is accurated.	nformation Form attac under the laws of the e to the best of my kn	hed. state of Georgia that the above information is true and accowledge as to the other party, or is unavailable. The information
itional information:  Additional Confidential Itify under penalty of perjury	nformation Form attac under the laws of the e to the best of my kn	hed. state of Georgia that the above information is true and accowledge as to the other party, or is unavailable. The information

# DAYCARE VERIFICATION FORM To be completed by a DAYCARE, AFTERSCHOOL, or SUMMERCARE Provider

To be used by the Division of Child Support Services in legal actions.

### To the Childcare Provider:

The legal custodian of the named child(ren) states that (s)he pays childcare costs for the child(ren) while (s)he works or attends classes for future employment. Under the Georgia Law these costs figure prominently in calculating the support that the child's other parent should pay. Please help us to determine a fair support award, by completing this form.

Thank you, DCSS Representative

Case Child(ren)	<u>Birthdate</u>	Type Of Ser	vices You Provid	<u>e</u>
	_, DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
	, DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
	, DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
	, DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
	_, DOB:	[_] Daycare	[_] Afterschool	[_] Summer Care
What is the COST\Type of care you provide for	or the named child(ren):			
[_] Daily, such as for preschoolers		Weekly Cost: \$_		_
[_] Afterschool and holidays		Weekly Cost: \$_		_
[_] Summer Care		Weekly Cost: \$_		_
[_] Irregularly How often:		<u>Average</u> Weekly	cost: \$	
Does the named Custodian pay the full amount of	of the cost? [_] Yes [_] No	, , ,	party or agency pa	ys part or all of the childcare, please
[_] Daycare is provided through DFCS, in the am	ount of \$		stodian pays: \$	
[_] Another person pays (Relationship to child(re	n):	Am	ount they pay: \$_	<del></del>
Is it your understanding that the Custodian is wo	rking or in classes during the per	iod you provide care: [_]	Yes [_] No	
Where:				
Does the above cost include other children of thi	s Custodian? If so, please name	them.		
Your Name:	Title			
Name of your facility:	or	[_] Home Daycare		
Address				
Phone number:				
If possible, attach a printout of the receipts o	ver the last 12 months			

## **INFORMATION AFFIDAVIT**

You may submit this form <u>by mail</u> with attached EVIDENCE, but you MUST show that a <u>Substantial</u> <u>Change</u> has occurred <u>since</u> the original Support Amount was set by court order or since the last review was conducted.

The following facts should be considered the same:	d when determining if my c	nild support amount should	d go up, down, or remai
Were the parents of the case child(ren) of	divorced from one another?	[ ] No, [ ] Never married	
[_] Yes, County:,	State:Year:	[_] Still married, no	t yet divorced
Please indicate the number of Document	s you have attached to PRC	VE the above statements:	
I understand the criminal penaltie law, O.C.G.A. §16-10-71 and do he			
So sworn and affirmed,			
Your Signature:	SSN	Date:/	<i>J</i>
Notary Public Signature:		_ Commission Expiratio	n Date:
/			
NOTARY SEAL:			

### STATEMENT OF MEDICAL NEED\COST

(Use to show SPECIAL MEDICAL CONDITIONS that have occurred since the last support amount was ordered)

THIS INFORMATION IS REQUIRED:

ATTACH PROOF OF THE N	MEDICAL EXPENSES, SHOW PORTION NOT	COVERED BY INSURANCE.
Signed:	, [] CP Date://	-
Name of primary Physician:	Doctor's #: (	)
,	How much of this cost is YOUR	•
Name all REGULAR monthly office visits, me	dications, and treatments which this condition rec	quire
What kind of continued treatment is included:		
	oility to function normally:	
Medical Condition:	Date of (injury\first tre	atment):
Patient's Name:	Relationship to You: _	
Name of primary Physician:	Doctor's #: (	
What is the TOTAL monthly cost: \$	How much of this cost is YOUR pe	ortion: \$
Name all REGULAR monthly office visits, me	dications, and treatments which this condition rec	quire
•	bility to function normally:	
How long is this expected to last:		
(Make additional copies of this form as neede	MEDICAL PROBLEM, EVEN IF IT IS FOR THE \$ ed)Relationship to You:	
insurance has been paid, etc The more do	cumentation you provide, the more weight this wi	il carry with the Judge.
-	it is expected to continue, How much YOUR porticularities of the continue, the more weight this with the more weight this with the more weight the continue of	
	usual medical needs of yourself or child. Please a	-
f Spouse provides insurance; Spouse's Name:	Spouse's employer:	Work Phone:
	ble for the named child(ren) As provided by [_]NCP [_]	CP [_] Your Spouse's military benefits
Extraordinary Medical Expenses: [	, Amounts:; [ ] Deductibles, Amounts: _	<del></del>
	_]Vision; [ ]Life; Insurance Co:	
_]CP provides: [_]Medical; [_]Dental; [_]Vision; [_]	Life; Insurance Co:	[_]Medicaid [_]Peach Care
	]Life; Insurance Co:	•
Medical Insurance provided for the children :	(CHECK <b>all</b> known sources of medical insurance	e for these children )

ATTACH A DOCTOR'S STATEMENT DIAGNOSIS, PROGNOSIS, & LENGTH OF EXPECTED TREATMENT

### STATEMENT OF EMPLOYMENT AND INCOME HISTORY

(Use to show how your income has changed since the last support amount was ordered)

#### Instructions:

A person who is seeking a review for possible recommendation of modification or objecting to an increase in support, must show that changes in income are not due to his\her own actions and are expected to last over a year. This form will help you to show the facts.

- 1. Attach copies of <u>Separation Notices</u>, <u>Doctors' Statements</u> (if you left due to an injury), etc... The more documentation you provide, the more weight this will carry with the Judge.
- 2. Complete addresses are mandatory.
- 3. PROOF is required, or a Less-than-36-Month Review will not be justified.

Employer:	Address:
Phone:(	_)
Paid: \$	per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly:
Describe a	tual job duties:
Reason fo	ob termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:
Did you re	eive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:// to//
Proof of In	ome for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:
Proof of w	I left this job: [_] Separation Notice; [_] Doctor's or Medical Statements; [_] Other:
Employer:	Address:
Phone:(	_)
Paid: \$_	per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: \$
Describe a	tual job duties:
Reason fo	ob termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:
Did you re	eive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:// to//
Proof of In	ome for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:
Proof of w	I left this job: [] Separation Notice; [] Doctor's or Medical Statements; [] Other:
Employer:	Address:
Phone:(	_)
Paid: \$_	per [_]Hr [_]Wk [_]Biwkly [_]Yrly Total of all bonuses, commissions, per diem, etc; received Yrly: \$
Describe a	tual job duties:
Reason fo	ob termination: [_] Quit [_] Fired [_] Laid Off [_]Other Details:
Did you re	eive: [_] Unemployment [_] Disability [_] Settlement Amount: \$ From:// to//
Proof of In	ome for this job: [_] W2's, 1099's, Tax Returns; [_] pay stubs; [_] Other:
Proof of w	I left this job: [] Separation Notice; [] Doctor's or Medical Statements; [] Other:
Signed:	, Date:/
Please in	cate the number of Documents attached to PROVE the above statements: