AMERICAN HEALTHCARE RECRUITING, INC.

"Coast to Coast Excellence in Recruiting and Staffing"

You are paid one week after your first week worked and weekly thereafter. For your convenience our fax number is listed below.

Please fax copies of the first seven items listed below with this letter:

1. **Curriculum Vitae:** ☐

2. Wallet Size Practice License **COPY:** ☐ __ __ __ __ __ Exp_____

3. Drivers License **COPY:** ☐ State _____ Number: __ __ __ __ __ __ __ _

4. **Credential Verification:** ☐ Include National Provider Identifier Number or apply online ☐
Takes about 20 minutes

5. **Gate Clearance:** ☐

6. **Digest of Laws:** ☐

7. Malpractice Insurance Certificate COPY: ☐ 1 million per incident-3 million per aggregate
Insurance Co. Name_____ Expiration_____

8. Social Security Number: __ __ __ - __ __ - __ __ __ _

9. Date of Birth: __ __/ __ __ / __ __ __

TB results copy	may be required
Fingerprinting (live scan)	may be required
Application	include or to follow (due by start date)
W-9 Signed	include or to follow (due by start date)
Direct Deposit Form	include or to follow (optional)
Voided Check	include or to follow (optional)

Kind Regards,

Bill Frey,
Chief Executive Officer
American Healthcare Recruiting, Inc.
Phone: 951.609.1160
Fax: **909.494.4336**
Email: BillFrey@ahcr.net

American Healthcare Recruiting, Inc.
27132-B Paseo Espada, Suite 1222
San Juan Capistrano, CA 92675
951.609.1160 Office
909.494.4336 Facsimile
Email: BillFrey@ahcr.net

Document Check List

Any "yes" answers must be accompanied by a back up statement of explanation. In cases of disciplinary actions both past and present please provide support documentation and legal documentation. If there was a settlement in your name, we will need the amount and insurance company and broker information.

Please complete the application in its entirety. If a question does not apply to you write "N/A". If additional space is required for any section, attach all information on a separate sheet of paper. With the exception of your name, if the data below is on your CV, simply write "See CV".

Last Name _____ First Name _____ Initial_____
Birth Name _____
Home address_____
City/state/zip code _____
Telephone number ( )_____
Email address_____
Date of birth _____ Place of birth _____
Social security number_____Citizenship_____
Office address _____
Office telephone number( )_____
Ste # _____ Federal ID number _____
Drivers License # _____ State _____
Degree: M.D. ( ) Ph.D. ( ) Psy.D ( ) Other ( )_____

EMERGENCY CONTACT INFORMATION

Name _____
Relationship _____
Telephone number ( ) _____
Address _____
City, State, Zip code_____

HEALTH STATUS

Have you ever had or do you now have any physical or mental condition that would compromise your ability to practice medicine or perform clinical assignments?
Yes ( ) No ( )

MILITARY STATUS

Have you ever served in the United States Military? Yes ___ No ___
If yes, which branch? _____
Type of Discharge? _____
Are you a: Disabled veteran? Yes ( ) No ( )
Veteran of the Vietnam Era? Yes ( ) No ( )
Veteran (other, Please explain): _____

Primary Practice Specialty: _____
Sub Specialties: _____
Other medical interests in practice (research, forensics, academics, etc.)_____
_____
Date you are available to work? _____
Are you interested in permanent placement opportunities? Yes ( ) No ( )
What type(s) of practice opportunities would you prefer?
In-patient ___ Out-patient ___ Urgent Care ___ Hospital _____ Solo practice ___
Multi-Specialty Group ___ Clinic ___ Government Facility ___ Other _____
Do you have any geographic preferences? _____
Would you be willing to license in States that you are not currently licensed, should an interesting opportunity arise? No ( ) Yes ( ) States_____

EDUCATION
Pre-Medical College/University _____
Address _____
Degree (s) _____
Honors/Awards_____
Date of graduation _____

MEDICAL EDUCATION
Medical School _____
Address _____
Degree (s) _____
Honors/Awards _____
Dates Attended (MM/DD/YY) _____thru_____
Date of graduation _____

INTERNSHIP
Hospital/ Institution _____
Address _____
Dates attended (MM/DD/YY) _____thru_____
Program Chairperson _____
Type of Internship _____

RESIDENCY
Hospital Institution _____
Address _____
Dates attended (MM/DD/YY) _____thru _____
Type of Residency _____
Program Chairperson _____

CONTINUED EDUCATION
Fellowship(s) _____
Institution _____
Address _____
Dates Attended (MM/DD/YY) _____thru_____
Program Chairperson _____

Type of fellowship _____
Board Certification(s) _____
Specialty/Board _____
Certification Date _____
Re-certification Date _____
Board Eligibility _____

PROFESSIONAL ASSOCIATIONS / MEMBERSHIPS

List all professional associates and / or memberships that you are currently a member of:

_____
_____
_____

WORK HISTORY

List Employers in reverse chronological order, beginning with the most recent employer. All dates from medical school to present must be accounted for. Should you have any gaps in your work history, list all dates and reasons on a separate sheet of paper. Also, if additional space is necessary, please attach on a separate sheet of paper.

Name of Institution _____
Address _____
Telephone number ( ) _____
Dates Employed (MM/DD/YY) _____ Position _____
Name of Institution _____
Address _____
Telephone number ( ) _____
Dates Employed (MM/DD/YY) _____ Position _____

HOSPITAL AFFILIATION

List all hospital affiliations, in reverse chronological order, beginning with the most recent. If additional space is required, include a separate sheet of paper.

Name of Hospital _____
Telephone Number ( ) _____
Address _____
Staff Category: _____ Dates (MM/DD/YY): _____
Name of Hospital _____
Telephone Number ( ) _____
Address _____
Staff Category: _____ Dates (MM/DD/YY): _____

Reason for leaving most recent employer? _____
_____

PROFESSIONAL REFERENCES

Provide at least (3) three references from physicians who have had clinical contact with, and are capable of assessing your professional skills within the past 18 (eighteen) months.
Reference: _____
Address: _____

Telephone: ( ) _____ E-mail: _____
Reference: _____
Address: _____
Telephone: ( ) _____ E-mail: _____
Reference: _____
Address: _____
Telephone: ( ) _____ E-mail: _____

LICENSURE AND CLAIMS HISTORY

(If you answer "Yes" to any question, please provide a detailed explanation on a separate sheet of paper.)

1) Have you ever been the subject of disciplinary or investigative proceedings or reprimanded by a governmental, administrative agency, hospital or professional association? Yes ( ) No ( )

2) Have you ever had any State professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or voluntary surrender of same? Yes ( ) No ( )

3) Have your hospital privileges and / or professional services ever been denied, revoked, suspended, refused, limited, placed on probation, or placed under and disciplinary action? Yes ( ) No ( )

4) Have there been or are there any pending malpractice claims, judgments, suits, settlements, or notice of intent to commence action involving you and / or your medical practice? Yes ( ) No ( )

5) Have you ever been convicted of an act committed in violation of any law or ordinance other than a traffic violation? Yes ( ) No ( )

6) Do you have now or have you ever had any problems with or been treated for drug or alcohol dependency? Yes ( ) No ( )

7) Have you ever had any professional liability insurance company cancel, decline, refuse to renew, or accept only on special terms, their malpractice insurance? Yes ( ) No ( )

ATTESTATION AND AUTHORIZATION

I certify that the information on the application is true and complete to the best of my knowledge. I authorize National Locum Solutions, Inc. to release information contained in this application to its Risk Management Department, insurance companies, and medical facility clients.

I hereby authorize the disclosure by any institution (including but not limited to the Federation of State Medical Boards and State Licensing Boards) information regarding me, including my education, medical training and employment, skills, experience, fitness to practice medicine, character, work habits, job performance, certification, licensure, hospital staff or clinical privileges, DEA authorization and medical malpractice claims. The undersigned releases the above from any claims resulting from the disclosure of such opinions to National Locum Solutions, Inc..

_____

Signature/Date

_____

Print Name

AUTHORIZATION AND WARRANTY

I authorize the release of all information from Medical Schools, Colleges, Universities, Medical Institutions, Hospitals, Clinics, Physicians, State Medical Boards, Medical Malpractice Carriers, All Government Agencies, and any other source necessary to assist with my credentialing process.

I understand that all information will be used to evaluate my professional qualifications, assist with credentialing at Health Care Facilities, and for use when applying to State Medical Boards for licensing are necessary.

_____

Signature/Date

_____

Print Name

State of California
Department of Corrections and Rehabilitation
P.O. Box 942883
Sacramento, California 94283-0001

DIGEST OF LAWS RELATED TO ASSOCIATION WITH PRISON INMATES

For information and guidance of persons visiting or working with or around prison inmates of the Department of Corrections and Rehabilitation, following is a digest of laws and rules related to association with inmates.

1. A warning sign is posted at the entrance to all public and business roadways onto the grounds of institutions, camps and other department facilities where inmates or parolees are housed indicating that by entering these grounds you consent to the search of your person, property and vehicle.

   References: Sections 3173 (e), 3288 Title 15, Div.3, Cal. Code of Regulations; Mathis v. Appellate Dept. 28 Cal App 3d 1039.

2. Entry on institution property for unauthorized purposes will be considered trespass as provided in section 602(j) of the Penal Code. Refusal or failure to leave the property when requested to do so by an official will be considered trespass as provided in section 602(p) of the Penal Code.

   Reference: Section 3289, Title 15, Div.3, Cal. Code of Regulations.

3. It is a felony for anyone to assist inmates to escape. Bringing firearms, deadly weapons, explosives, or tear gas on prison grounds, or giving firearms, deadly weapons, explosives, liquor, cocaine, or other narcotics or any kind of drugs, including marijuana, is a crime.

   Reference: Sections 2772, 2790, 4533, 4534, 4535, 4550, 4573, 4573.5, 4573.6, 4574, 4600, Penal Code.

4. Giving letters to inmates or taking letters out for inmates is a misdemeanor.

   Reference: Section 4570 Penal Code, Section 3401, Title 15, Div. 3 Cal. Code of Regulations

5. Giving gifts or presents to inmates is not permitted.

   Reference: Section 2541, Penal Code, Section 3399, Title 15, Div 3, Cal. Code of Regulations.

6. Receiving gifts from inmates is not permitted.

   Reference: Section 2540, 2541, Penal Code; Secs. 3399, 3424, Title 15, Div. 3. Cal Code of Regulations.

7. Anyone who falsely identifies himself or herself to gain admission to a prison is guilty of a misdemeanor. Persons previously convicted of a felony in this state who come upon the grounds of a prison without permission of the official in charge are guilty of a felony.

   Reference: Section 4570.5, 4571, Penal Code; Section 3173(n), Title 15, Div.3, Cal Code of Regulations.

8. Refusal of visitors to submit to search and inspection of their person and of vehicles and property brought onto institution grounds by such persons may be cause for denial of visit.

   Reference: Section 2601(d), 5054, 5058 Penal Code; Section 3285, 3415, Title 15. Div.3, Cal Code of Regulations.

9. For "cause" a person may be barred from entering an institution or facility.

   Reference: Section 5054, 5058, Penal Code; Section 3176, Title 15, Div.3, Cal Code of Regulations.

10. Persons who are not departmental employees but are assigned to or engaged in work in any departmental facility must observe all rules, regulations and laws governing the conduct of employees. Failure to do so may lead to exclusion.

    Reference: Section 5054, 5058, Penal Code; Secs. 3285, 3415, Title 15. Div. 3, Cal Code of Regulations.

11. In the event of an emergency situation that effects a significant portion of the inmate population at an institution, the visiting program and other program activities may be suspended during the period of emergency.

12. Employees must not permit inmates or others to use hostages to escape from custody or otherwise interfere with orderly institution operations. Hostages will not be recognized for bargaining purposes. All inmates, visitors and staff will be informed of this regulation.

    Reference: Section 5054, 5058, Penal Code;
    Section 3304, Title 15, Div. 3, Cal. Code of Regulations.

13. No person shall make verbal or written statements concerning a discharged inmate for the purpose of depriving him/her of employment or of procuring same, or for extortion.

    Reference: Section 2947, Penal Code.

I have read and understand the implications of the above information

_____

Signature: Date:

_____

Printed Name:

Presented by American Healthcare Recruiting Inc - Phone 951.609.1160 – Fax 909.494.4336

VOLUNTEER/CONTRACT EMPLOYEE CLEARANCE FORM
PLEASE READ AND FILL OUT COMPLETELY AND ACCURATELY

Purpose of Visit: _____

Occupation: _____ Employer: _____ (____) _____
(Print Name) Phone #

Division Where Assigned: _____ Length of Time Needed: _____(mos) (ie., 3mos, 6 mos, 12 mos)

Date & Time of Visit: _____/_____/_____ _____

Mr./Mrs./Ms. _____(print) Home Phone#: (____)_____

Address: _____
[Number] [Street Name] [City] [State] [Zip]

Date of Birth: ____/____/_____ Circle one: Male / Female Social Security #: _____-_____-_____

Drivers License#: _____ Height: _____ Weight: _____ Hair: _____ Eye: _____ Race: _____

Identifying Marks/Scars: _____
Alias or Maiden Name (if Married): _____

Have you ever been arrested?	Yes ____ No ____
Are you now on probation or parole?	Yes ____ No ____
Do you know or are you related to any inmate or parolee?	Yes ____ No ____
Do you visit any other CDC Facility?	Yes ____ No ____

IF YES TO ANY OF THE ABOVE, PLEASE USE REVERSE SIDE TO EXPLAIN.

THE FOLLOWING ARE SOME OF THE RULES AND REGULATIONS ENFORCED WITHIN THIS INSTITUTION.

- No visitor will carry, convey, or make accessible, to any inmate within this Institution any intoxicant, drugs, firearms, weapon or any other contraband.
- No visitor is permitted to carry or convey messages, written or oral without permission from the Institution.
- No visitor is permitted to give or receive any article, gift, food, or money to or from inmates without written permission from the WARDEN or designee.

NO BLUE DENIM ALLOWED. MUST HAVE A CURRENT CALIFORNIA DRIVERS LICENSE OR PICTURE ID.

I have read the above rules and agree to comply. I understand that I am subject to a search at any time. All information is true and complete to the best of my knowledge. I understand that any false information given will prohibit me from entering this institution.

_____ _____
Volunteer/Contract Employee Signature Requesting Staff Signature

_____ _____
Print Name Date: Print Name Ext Date:

_____ _____
AA/PIO Date: Division Head Ext. Date:

☐ APPROVED ☐ DENIED

Official Use:
CI&I:
Process Date:
Issue ID Card:
Expiration Date:

THIS INFORMATION MUST BE COMPLETED AND SIGNATURES OBTAINED BEFORE STATE PRISON PERSONNEL WILL ISSUE AN ID CARD

PSYCHOLOGIST/SOCIAL WORKER

MEDICAL STAFF CREDENTIAL VERIFICATION

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

Signature of Hiring Authority	Date
Name of Institution	

Please Check One:

☐ Civil Service ☑ Contractor / Registry ☐ 2-Year Reappointment

☐ Lateral Transfer from:_____ ☐Other:_____

Application for the Position of: ☐ **Chief Psychologist** ☐ **Supervising Senior Psychologist**
☐ **Senior Psychologist, Specialist** ☐ **Psychologist**
☐ **Supervising Social Worker** ☐ **Clinical Social Worker**

Applicant's Name (Last) (First) (Middle)	Social Security Number
Home Address E-Mail Address	Contact Number(s)
City State Zip Code	Date of Birth
Other Names Used	Gender ☐ Male ☐ Female

United States Citizen: ☐ Yes ☐ No. If no, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

If you hold permanent immigrant status in the U.S., please attach a copy of your green card or approval letter.

National Identification Number: _____ Country of Issue _____

Professional School(s):

Name of School	Degree	Year Graduated

Professional License(s)/Certification(s)/Registration(s):

License number: _____ State: _____ License number: _____State: _____

*Please attach additional license information on a separate page if needed.

☐ Unlicensed Hours accrued toward licensing: _____ NPI Number:_____

*Applicants applying unlicensed must submit official transcripts to:

Department of Corrections and Rehabilitation
Plata Support Division
P. O. Box 4038, Suite: 315
Sacramento, CA 95812-4038
Attn: Credentialing and Privileging Unit

QUESTIONS THAT HAVE A YES ANSWER WILL REQUIRE ADDITIONAL INFORMATION EXCLUDING QUESTION 15. IF QUESTION 15 HAS A NO ANSWER, DESCRIBE THE CIRCUMSTANCES. PLEASE PROVIDE ANY ADDITIONAL INFORMATION ON A SEPARATE SHEET OF PAPER.

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? □ Yes □ No
2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? □ Yes □ No
3. Have you ever been asked to surrender your license? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___)

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4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program, for example, Medicare, Medicaid or CHAMPUS? □ Yes □ No
5. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____)

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6. Have you ever been named as a defendant in any criminal proceedings? □ Yes □ No
7. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? □ Yes □ No
8. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? □ Yes □ No
9. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____, ____)

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10. Have any profession liability claims or suits ever been filed against you or are any presently pending? □ Yes □ No
11. Have any judgments or settlements been made against you in professional liability cases? □ Yes □ No
12. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? □ Yes □ No
13. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ___, ___)

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14. Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment, or supply house or other business to which patients from the CDCR might be referred or recommended?

□ Yes □ No

15. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the CDCR to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? □ Yes □ No *If no, please explain on a separate sheet of paper*.
16. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? □ Yes □ No

☐ Additional information is attached for the above section (questions ___, ____, ____)

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this Medical Staff Credential Verification, whether intentional or not, may constitute sufficient cause for rejection of this verification resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____

Signature of Applicant Date

DIRECT DEPOSITS START AFTER 2ND PAYROLL/PAYCHECK

DIRECT DEPOSIT AUTHORIZATION FORM

The authorization form provided below gives **American Healthcare Recruiting** and your financial institution authority to deposit your pay directly into your account.

INSTRUCTIONS:

1. Fill in your name, your bank's name, location and the date.
2. Mark the box to indicate whether your pay will be deposited in your checking or savings account.
3. Please fill in your bank's routing and account numbers.
4. Please be sure to **sign the form.**
5. **Please include a copy of a "voided check"**
6. Return the completed form to: FAX 909-494-4336

I authorize **American Healthcare Recruiting** and the bank indicated below to deposit my net pay automatically each payday. If monies to which I am not entitled are deposited to my account, I authorize my company to direct the bank to return said funds. This authority will remain in effect until I have cancelled it in writing.

*Bank Name:*_____ *Savings* ☐

*Branch Address:*_____ *Checking* ☐

*City, State, Zip Code:*_____

*Bank Routing Number (**PLEASE CALL YOUR BANK OR GO ONLINE**)*

Bank ID Number *& Account Number*

SOCIAL SECURITY NUMBER

*Name (Please Print):*_____*Date:*_____

*Signature:*_____

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other .....

☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Note: *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ - ___ - ____

or

Employer identification number
___ - _______

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) **that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person _____ Date _____

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

PLEASE NOTE:
THE BANK USES THE ABOVE ADDRESS FOR MAILING YOUR CHECKS & 1099. COMPLETED W-9 TO INCLUDE YOUR SIGNATURE AND DATE. THANK YOU.