**A close-up of a logo

Description automatically generated**

Advance Care Provider  
45 Tyler avenue  
SS15 5UR  
Laindon  
Essex

24/7 Phone 07411338361  
Landline +441268961188  
[info@advancecareprovider.co.uk](mailto:info@advancecareprovider.co.uk)  
[www.advancecareprovider.co.uk](http://www.advancecareprovider.co.uk)

**PERSONAL DETAILS**

|  |  |
| --- | --- |
| Address |  |
|  |  |
| Town/City |  |
| County |  |
| Postcode |  |
| Date moved to this address: | Month       Year |
| Email: |  |
| Tel: Home |  |
| Tel: Mobile |  |
| How Did You  Hear of us: |  |
|  |

|  |  |
| --- | --- |
| Title |  |
| First Name |  |
| Known As |  |
| Middle Name(s) |  |
| Last Name |  |
| Maiden Name |  |
| Gender | Male  Female |
| Date of Birth |  |
| Nationality |  |
| Marital Status |  |
| Date of Marriage |  |

|  |  |
| --- | --- |
| Work Status |  |
| Self Employed or PAYE |  |
| National Insurance No |  |
| Passport No |  |
| Passport Expiry Date |  |
| Driving License | Yes  No |
| Car Owner | Yes  No |

\* PLEASE ATTACH A LIST OF PREVIOUS ADDRESSES FOR LAST 6 YEARS – FORM ATTACHED

Contact Availability: We are open 24 hours a day

|  |  |
| --- | --- |
| Please specify times at which you are not to be contacted |  |
| Is it ok to contact you at work | Yes  No |

**CAREER HISTORY**

Please confirm your career history details for the last 10 years. Please list using most recent first.

|  |  |  |  |
| --- | --- | --- | --- |
| Employer: |  | | |
| Address: |  | | |
| Phone number: |  | | |
| Date started: |  | Date left: |  |
| Job title: |  | Full or part time: |  |
| Grade: |  | Dept/Ward: |  |
| Reason for leaving: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer: |  | | |
| Address: |  | | |
| Phone number: |  | | |
| Date started: |  | Date left: |  |
| Job title: |  | Full or part time: |  |
| Grade: |  | Dept/Ward: |  |
| Reason for leaving: |  | | |

**CAREER HISTORY CONT**

|  |  |  |  |
| --- | --- | --- | --- |
| Employer: |  | | |
| Address: |  | | |
| Phone number: |  | | |
| Date started: |  | Date left: |  |
| Job title: |  | Full or part time: |  |
| Grade: |  | Dept/Ward: |  |
| Reason for leaving: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer: |  | | |
| Address: |  | | |
| Phone number: |  | | |
| Date started: |  | Date left: |  |
| Job title: |  | Full or part time: |  |
| Grade: |  | Dept/Ward: |  |
| Reason for leaving: |  | | |

**QUALIFICATIONS & TRAINING**

|  |  |
| --- | --- |
| Date Qualified: |  |
| NMC Pin Number: |  |
| Expiry Date: |  |
| Where did you train? |  |
| Please give details of training undertaken and qualifications obtained: | |
|  | |
|  | |
|  | |
|  | |
|  | |

You should supply any certificates such as ENB or Diplomas etc -please note that we require manual handling/CPR certifications that have been updated in the last 12 months.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BAND (NEW TERMINOLOGY) 1-8** | | | | | | | | | | | | | | |
| 2 | 3 | | 4 | 5 | 6 | | 7 | | 8 |  | |  | | |
| **TYPE OF WORKER** | | | | | | | | | | | | | | |
| RNLD | | RHV | | EN | | RSCN | | RFN | | | RM | | RGN | |
| RMN | | RH | | ENM | | ENG | | ENMH | | | RNMH | |  | |
| **RECORDABLE QUALIFICATIONS** | | | | | | | | | | | | | | |
| RN1-1st Level General Nursing | | | | | | | | | | YES | | | NO |  |
| RN2-2nd Level General Nursing (England & Wales) | | | | | | | | | | YES | | | NO |  |
| RN3-1st Level Mental Illness | | | | | | | | | | YES | | | NO |  |
| RN4-2nd Level Mental Illness (England & Wales) | | | | | | | | | | YES | | | NO |  |
| RN5-1st Level Learning Disabilities | | | | | | | | | | YES | | | NO |  |
| RN6-2nd Level Learning Disabilities (England & Wales) | | | | | | | | | | YES | | | NO |  |
| RN7-2nd Level Nurses (Scotland & Wales) | | | | | | | | | | YES | | | NO |  |
| RNB-1st Level Sick children | | | | | | | | | | YES | | | NO |  |
| RN9-Fever Nurse | | | | | | | | | | YES | | | NO |  |
| RN12-1st Level Adult Learning | | | | | | | | | | YES | | | NO |  |
| RN13-1st Level Mental Nursing | | | | | | | | | | YES | | | NO |  |
| RN14-1st Level Learning Disability | | | | | | | | | | YES | | | NO |  |
| RN15-1st Level Children | | | | | | | | | | YES | | | NO |  |
| MRM-Midwifery | | | | | | | | | | YES | | | NO |  |
| HRHV-Health Visiting | | | | | | | | | | YES | | | NO |  |
| SPAN-Special Practitioner Adult Nursing | | | | | | | | | | YES | | | NO |  |
| SPMH-Special Practitioner Mental Health Nursing | | | | | | | | | | YES | | | NO |  |
| SPCN-Special Practitioner Children’s Nursing | | | | | | | | | | YES | | | NO |  |
| SPLD-Special Practitioner Learning Disabilities | | | | | | | | | | YES | | | NO |  |
| SPGP-Special Practitioner General Practice | | | | | | | | | | YES | | | NO |  |
| SPCM-Special Practitioner Community Mental Health | | | | | | | | | | YES | | | NO |  |
| SCLD-Special Practitioner Community Learning Disabilities | | | | | | | | | | YES | | | NO |  |
| SPCC-Special Practitioner Community Children’s Nursing | | | | | | | | | | YES | | | NO |  |
| SPOH-Special Practitioner Occupational Health | | | | | | | | | | YES | | | NO |  |
| SPSN-Special Practitioner School Nursing | | | | | | | | | | YES | | | NO |  |
| SPDN-Home/District Nursing with integrated nurse prescribing | | | | | | | | | | YES | | | NO |  |
| V100-Independent Nurse Prescribing V100 | | | | | | | | | | YES | | | NO |  |
| V200-Extended Nurse Prescribing V200 | | | | | | | | | | YES | | | NO |  |
| V300-Extended/Supplementary Prescribing | | | | | | | | | | YES | | | NO |  |
| TTTT-Lecturer/Practice Educator | | | | | | | | | | YES | | | NO |  |
| **MIDWIFES ONLY** | | | | | | | | | |  | | |  |  |
| Practising | | | | | | | | | | YES | | | NO |  |
| Intention to practice completed (you cannot work without this as a Midwife) | | | | | | | | | | YES | | | NO |  |
| Expiry Date: | | | | | | | | | |  | | |  |  |
| Mentor Name & Address: | | | | | | | | | |  | | |  |  |
|  | | | | | | | | | |  | | |  |  |

**MEDICAL HISTORY**

Have you ever suffered from any of the following:

|  |  |  |
| --- | --- | --- |
| Heart/Circulatory Illness/Hypertension | YES | NO |
| Diabetes | YES | NO |
| Asthma/Hay fever | YES | NO |
| Bronchitis/Pneumonia/Pleurisy | YES | NO |
| Epilepsy | YES | NO |
| Headaches/Migraine | YES | NO |
| Tuberculosis | YES | NO |
| Psychiatric Illness/Anxiety/Depression | YES | NO |
| Dermatitis/Psoriasis/Eczema | YES | NO |
| Back problems | YES | NO |
| Recurrent infections | YES | NO |
| Hepatitis/Jaundice | YES | NO |
| Are you taking any prescription drugs? | YES | NO |

If you have answered yes to any of the above questions, please give details on separate paper attached to the back of the application form.

Have you ever been vaccinated, immunized, or tested for/against any of the Following?

|  |  |  |
| --- | --- | --- |
| Varicella | YES | NO |
| Tuberculosis including BCG | YES | NO |
| Heaf, Mantoux or Tine | YES | NO |
| Rubella (German Measles) | YES | NO |
| Poliomyelitis | YES | NO |
| Hepatitis B | YES | NO |
| Hepatitis | YES | NO |
| HIV | YES | NO |
| Tetanus | YES | NO |
| Typhoid | YES | NO |
| Any Other Please State: | | |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name Of GP: |  | | | |
| Address: |  | | | |
|  |  | | Postcode: |  |
| Telephone: |  |  | | |

**REFERENCES**

Our agency requires 2 professional references.

It is essential that you have had professional dealings with both of your references within the last 2 years.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name Of Referee: |  | | | Place Of Work | |  |
| Position |  | | | | | |
| Work Address: |  | | | | | |
|  |  | | | | | |
| Country: | |  | Postcode: | |  | |
| Telephone Number: | |  | Fax: | |  | |
| Email: | |  | Mobile Phone: | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name Of Referee: |  | | | Place Of Work | |  |
| Position |  | | | | | |
| Work Address: |  | | | | | |
|  |  | | | | | |
| Country: | |  | Postcode: | |  | |
| Telephone Number: | |  | Fax: | |  | |
| Email: | |  | Mobile Phone: | |  | |

**OPT-OUT AGREEMENT**

**DEFINITIONS**

In this Agreement the following definitions apply:-

“Assignment” means the period during which the Temporary Worker is engaged in services to a Client.

“Client” means the person, firm or corporate body that has engaged the services of the Temporary Worker.

“Employment Business” means our agency.

“Temporary Worker” means a Qualified Nurse, care assistant or other Temporary Worker.

“Working Week” means an average of 48 hours each week as calculated over any 17 week period.

**THE AGREEMENT**

The Working Time Regulations of 1998 state that a Temporary Worker shall not work on an Assignment with a client in excess of the Working Week unless they agree in writing that this limit should not apply.

The Temporary worker, by signing the declaration below, agrees that the Working Week shall not apply to their Assignments.

The Temporary Worker can end this Agreement at anytime by giving the Employment Business 14 days notice in writing. After the 14-day notice period has expired the Working Week shall apply immediately.

It should be noted that any notice ending this Agreement does not mean that a Temporary Worker has ended an Assignment with a Client.

These laws are governed by English Law and are subject to the jurisdiction of the English Courts.

**THE DECLARATION**

I have read and fully understand the above OPT OUT AGREEMENT.

I hereby consent that the Working Week limit shall not apply to my Assignments.

I understand that I can end this Agreement by giving the Employment Business 14 days notice in writing.

**SIGNED :**

**PRINT NAME :**

**DATE :**

**NEXT OF KIN**

**TEMPORARY WORKER DETAILS**

NAME OF TEMPORARY WORKER :

REGISTRATION NUMBER :

HOME TELEPHONE :

MOBILE NUMBER :

ADDRESS :

**NEXT OF KIN DETAILS**

FULL NAME :

RELATIONSHIP TO TEMPORARY WORKER :

HOME TELEPHONE :

MOBILE NUMBER :

ADDRESS :

**ANY OTHER OR SPECIAL NOTES**

**DISCLOSURES**

**Rehabilitation of Offenders Act**

Due to the nature of the work for which you are applying, this post is exempt from the provisions of section 4.2 of the rehabilitations of offender’s act 1974 (exemption order 1975). Applicants are therefore, not entitled to withhold information about convictions which for other purposes are ‘spent’ under the provisions of the act and in the event of employment. Failure to disclose such convictions could result in dismissal or disciplinary action.

Any information given will be completely confidential and will be considered only in elation to an application for positions in which the order applies, and should be entered at the end of any particulars you give in support of your application.

A copy of our written policies is available upon request. A criminal record will not necessary be a bar to obtaining a position.

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

**Have you ever been convicted of a criminal offence?**

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

**Do you have any spent or unspent criminal convictions or cautions?**

With an enhanced disclosure, under section 4.2 of the rehabilitation of offender’s act 1974 (exemption order), all previous cautions, warnings and convictions will always be detailed regardless of how long ago

Any conviction, caution, reprimand will require a written statement of each event and how it does not affect your suitability for the role you are applying for.

**Have you supplied additional information with this application for any spent/ unspent convictions, cautions or reprimands?**

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

**Have you ever been involved in court proceedings?**

Please give any additional information which you think may be relevant in support of your application on a separate page.

**IF YOU HAVE A CONVICTION/CAUTION RELATING TO A VIOLENCE OR THEFT OFFENCE, WE WILL BE UNABLE TO PROGRESS WITH YOUR APPLICATION.**

**DECLARATION**

I confirm that the information I have provided in support of this application is complete and true and understand that knowingly to make a false statement could be a criminal offence.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

I consent to the agency checking the details I have provided against the various data sources in order to verify my identity and process the application. These details may be recorded and used to assist other organisations for identity verification purposes such as the CRB/DBS, regulatory bodies such as NMC or GSCC.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

Our agency retains the right to hold this application and any other data required to process this application (whether in the UK, European Union or elsewhere) and keep for as long as necessary in line with the data protection act.

Please send the completed application form to the following address:-

The Registration Manager

Advance Care Provider  
45 Tyler avenue  
SS15 5UR  
Laindon  
Essex  
Phone 07411338361  
Landline +441268961188  
[info@advancecareprovider.co.uk](mailto:info@advancecareprovider.co.uk)  
[www.advancecareprovider.co.uk](http://www.advancecareprovider.co.uk)

**ADDITIONAL INFORMATION/CHECKLIST**

On receipt of a satisfactorily completed application form, our agency will provide/send the following:-

1. Assist you with your CRB/DBS application for an enhanced CRB/DBS. The charge for this will be **£44.00** (cheques to be made payable to …………………..).

**Please bring this Application Form to your interview along with the following ORIGINAL documentation for us to view and take copies. Without this information we cannot progress with your application.**

|  |  |
| --- | --- |
|  | Please Tick Boxes |
| NMC pin card and your statement of entry |  |
| Valid Passport |  |
| Valid Visa/Work Permit/Certificate of British Nationality (if applicable) |  |
| National Insurance Number Card |  |
| 2 additional forms/proof of Identity & Address  - (Driving Licence or copy bills etc.) |  |
| Full Immunisation record : |  |
| Hep B |  |
| MMR 1 |  |
| MMR 2 |  |
| Varicella |  |

|  |  |
| --- | --- |
| Hep B (IVS) HBSAg |  |
| Hep C (IVS) |  |
| HIV (IVS) |  |
| Training Certificates including: |  |
| Moving and Handling (practical) |  |
| BLS / ILS / ALS |  |
| Complaints Handling |  |
| Conflict Resolution (inc management of violence & aggression) |  |
| Fire Safety |  |
| Information Governance (including Caldicott Protocols and Data Protection) |  |
| Health & Safety at Work (including COSHH and RIDDOR) |  |
| Infection Control (including MRSA and C-Diff) |  |
| Lone Worker Training (if applicable) |  |
| Food Hygiene (if applicable) |  |
| IV Certificate (if applicable)  Full CV |  |
| Addresses covering the past 6 years and dates of residency |  |

|  |  |
| --- | --- |
| 2 Passport size photos |  |

**We will also need details of your Bank / Building Society account for our Payroll Department**

We try to make our registration process as swift and painless as possible but we are sure that you understand that owing to the sensitive nature of your profession that our checks have to be thorough.

**PLEASE CONTACT US ON**

Advance Care Provider  
45 Tyler avenue  
SS15 5UR  
Laindon  
Essex  
Phone 07411338361  
Landline +441268961188  
[info@advancecareprovider.co.uk](mailto:info@advancecareprovider.co.uk)  
[www.advancecareprovider.co.uk](http://www.advancecareprovider.co.uk)

**Thank you.**

**ADDITIONAL ADDRESSES**

Address 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Address 3:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Address 4:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Address 5:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Address 6:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_