



Dear Dental Applicant:

Thank you for contacting the Free Clinic of the New River Valley's Dental Clinic. You are important to us and we want to provide you with the best possible services. In order to ensure that you are eligible for our program and that we meet your needs, we ask that you provide us with the following documents:

- 1) Dental Clinic Application: Please use blue or black ink only. We can help you with this application if requested.
- 2) Proof of Income and Tax forms: See Required Proof of Income
- 3) Prepaid \$25.00 administrative fee before each appointment. We do not accept checks. We accept cash or money order only. (If you need assistance with the fees, contact New River Community Action at (540) 382-6186)

Once we receive all of your paperwork and you have prepaid \$25.00, we will place your name on the waiting list. Please note that due to the large demand for dental services you may not receive an appointment for several months. We will contact you when we have an available appointment.

We are doing our best to improve dental care access for our community. We ask that you be patient with us as we attempt to meet the overwhelming need with a limited number of dental resources.

As a dental patient, you can help us maximize these resources by:

- Providing all requested information, documentation, and dental fees
- Arriving on time for a scheduled dental appointment
- Following through with any recommendations made by our dental staff regarding your oral health care.

Sincerely,

Dental Department



Free Clinic Dental Department Required Proof of Income

Listed below are the types of income that must be provided to complete your application. You will need to provide copies of all the income that is received in the household. If you have any questions, please contact the Dental Clinic at (540) 381-0820. If you do not provide all of the required documents we cannot process your application.

- Copy of W-2 and 1040 Tax Forms

OR

- 4506-T Form – If you did not file taxes – We can provide you with this form.

You will need to provide us with your current household income:

- Current Employment:
 - Up to 4 paycheck stubs for you and/or your spouseOR
 - An official letter from your employer stating how often you work, rate of pay and how often you are paid
- Government Benefits:
 - Social security award letter
 - Disability award letter
 - SSI award letter
 - Food Stamp letter
 - TANF letter
- Child Support
- Self-Employed:
 - Receipts, record book, check book, etc. equal to two months of work
- Unemployment Benefit Statement

If you have no income you will need:

- Support Letter Form (We can provide you with this form)

Free Clinic

of the New River Valley
Working to Build a Healthier Community

Patient Medical History

Patient Name: _____ Date of Birth: _____ S.S # _____

Current Medications you are taking: _____

Hospitalizations/Surgery (When, Where, Why?): _____

Counseling: _____

CONDITION	PATIENT HISTORY (Be Specific!)	FAMILY HISTORY (Parents/Siblings Only)
AIDS and/or HIV positive		
Alcoholism		
Allergies (*including drug allergies)		
Anemia (Low hemoglobin/ red blood cell count)		
Anxiety or Depression		
Arthritis		
Asthma/ COPD/ Emphysema		
Blood Clots/ DVT		
Blood Transfusions		
Bone Problems (e.g. Osteoporosis)		
Cancer (note type)		
Chronic Back Pain		
Diabetes		
Epilepsy/ Seizure Disorder		
Gall Bladder Disease		
Gastrointestinal Problems (GERD, ulcers, etc.)		
Headaches/ Migraines		
Heart Disease (Heart Attacks, heart murmur, etc.)		
High Blood Pressure		
High Cholesterol		
Kidney/ Urinary Tract Infection (frequent)		
Liver Disease (e.g. Mono, Hepatitis)		
Pneumonia		
Pregnancy (note years)		
Rheumatic Fever		
STD (Chlamydia, G.C., herpes, syphilis, warts, etc.)		
Stroke/Neurological Problems		
Thyroid Problems		
Tuberculosis or Lung Problems		

HABITS:

Alcohol _____ Drinks/week

Cigarettes _____ Packs/day x _____ years

Chewing Tobacco/ snuff _____ Times/day x _____ years

Other Drugs _____ Times/week

Caffeine (coffee, tea, soda) Cup _____ Cups/day

Exercise (describe) _____

Exposure to Environmental Hazards _____

(what, when, duration) _____

Notes:



Dental Health History

Patient's Name: _____ Date: _____

DOB: ___/___/___ Age: ___ Sex (circle one): Male or Female

When was your last dental visit? _____

What was the reason for it and who did you see?

Do you brush daily? YES or NO times per day: _____

Do you floss daily? YES or NO times per day: _____

What type of dental services do you need?

How would you rate your current dental health? Good Fair Poor

Are you currently in discomfort? YES or NO

Have you been to the ER in the last year for dental issues? YES or NO

If yes, when and where did you go?

Have you gone to the ER several times for the same problem? YES or NO

If yes, how many times? _____

Do you require antibiotic pre-medication prior to dental work? YES or NO

Do you have sensitivity to:

heat cold sweet discomfort when biting

recurring sores or blisters in/on your mouth, tongue, lips, etc.



Medical History

Patient's Name: _____ Date: _____

Date of Birth: ___/___/___ Age: ___ Sex (circle one): Male or Female

Do you currently have medical insurance? Yes No

If yes, check one of the following: Private Medicaid Medicare Other

Do you have a personal physician? Yes No

If yes, please provide us with the following information:

Name of Physician: _____

Location: _____

Phone: _____ - _____ - _____

Date of last visit: ___/___/___

How is your current overall health? Good Fair Poor

Have you had any of the following? Serious Illness Surgeries

Are you currently under the care of your physician? Yes No

If yes, why? _____

Have you ever had a blood transfusion? Yes No

If yes, what date(s): _____

Do you use any tobacco? Yes No

Do you use recreational drugs? Yes No

Do you consume alcohol? Yes No

Have you ever used methamphetamine (meth)? Yes No

Are you allergic to any of the following?

- | | | | | |
|---------------------------------------|---------------------------------|---------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Tetracycline | | <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Sedatives | | | | |

Any known allergies not listed? _____

Are you currently taking any of the following?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Diuretics | <input type="checkbox"/> Anti-diuretics | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Insulin/Diabetic medications | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-psychotics | |
| <input type="checkbox"/> Nitroglycerin (angina medication) | <input type="checkbox"/> Steroids (prednisone/cortisone) | <input type="checkbox"/> Aspirin | |
| <input type="checkbox"/> Thyroid medications | <input type="checkbox"/> Beta blockers | <input type="checkbox"/> Tranquilizers | |
| <input type="checkbox"/> Blood pressure medications | <input type="checkbox"/> Blood thinners (anticoagulants) | | |

Please indicate if you have had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Lupus | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Mitral valve prolapsed | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Post traumatic stress disorder | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Artificial bones | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Fever blisters |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Colitis | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Concussions | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial valves | <input type="checkbox"/> SARS | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Jaw fracture/pain | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cough (frequent) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Venereal disease |
| | | <input type="checkbox"/> STD's |

For women:

Are you pregnant? Yes No Unsure

If yes, number of weeks: _____ Are you currently nursing? Yes No

Are you presently taking birth control pills? Yes No



Dental Program Informed Consent

As our patient, you have a right to be informed about your diagnosis and the planned dental procedures or oral surgery so that you can make a decision whether to undergo a procedure after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you can give your informed consent to the procedure.

Possible complications of: (may be variable in occurrence)

1. All oral surgeries

- a. Soreness, swelling, bruising, and restricted mouth opening during healing; sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
b. Bleeding, usually controllable, but may be prolonged and require additional care.
c. Drug reactions or allergies.
d. Infection; possibly requiring additional care.
e. Possible lip and skin abrasion.

2. All tooth extractions

- a. Dry socket; discomfort occurring a few days after extraction; requires further care.
b. Damage to adjacent teeth or fillings.
c. Sharp ridges or bone splinters; may require additional surgery to smooth area.
d. Portions of tooth remaining. Sometimes fine root tips break off and may be deliberately left in place to avoid doing damage to nearby vital structures such as nerves or the sinus.
e. Numbness: Due to the proximity of roots to the nerve (especially wisdom teeth), it is possible to injure the nerve during the removal of the tooth. The lip, chin, gums, or tongue could thus feel numb (resembling local anesthetic injection), and this could remain for days, weeks, or very rarely, permanently.
f. Sinus Involvement: Due to the closeness of the roots of upper back teeth to the sinus or from a root tip being displaced into the sinus, a possible sinus infection and or sinus opening may result, which may require medication and/or later surgery to correct.
g. Possible fracture (alveolar, mandibular, maxillary)

3. Anesthesia

- a. Local anesthesia: Certain possible risks exist that, although rare, could include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions which could result in heart attack, stroke, brain damage, and/or death.

I hereby authorize all licensed dentists at the Free Clinic to perform any necessary dental procedures or procedures that I request, and to administer the anesthesia I have chosen. I have read the preceding information and will discuss any questions or concerns I have with the dentist before the procedures are done. I believe I have been given sufficient information to give my consent to the planned dental procedures. I understand that I should not drive a motor vehicle immediately after taking narcotic pain medicines.

Patient's (or legal guardian's) signature Date

Doctor's signature Date



Free Clinic Patient Agreement

I UNDERSTAND AND AGREE TO THE FOLLOWING:

All Medical, Dental, Pharmacy, and Mental Health Programs

1. I will be respectful and considerate of staff and volunteers. I will conduct myself in a non-threatening (physical or verbal) manner whether on site, over the phone or in written communication. With this noted, I understand that this behavior could cause immediate dismissal as a patient at the Christiansburg, Radford, or Pearisburg clinic sites.
2. I am currently uninsured and I will provide appropriate documentation during eligibility screening, as well as any additional documentation that the Free Clinic needs throughout the year to update my tax or income information.
3. I will inform the Free Clinic immediately of changes in my insurance, income, marital status telephone number, or address.
4. I will receive an eligibility card only when I have provided all necessary documentation and I am approved for services. The card is for my use only and I am responsible for its safekeeping. I will present this card each time I request medical, mental health, dental, or pharmacy services at the Free Clinic, and each time I am referred outside of the Free Clinic for medical care.
5. I will not use my Free Clinic eligibility card to inappropriately obtain any prescription medications or medical care at community pharmacies or health care practices.
6. I understand that my eligibility in all Free Clinic programs is good for one year. Within a year after my initial eligibility screening, I will provide appropriate documentation and schedule necessary screening appointments to continue my eligibility.
7. I will follow through with recommended testing and treatment.
8. I understand that program fees and eligibility requirements are subject to change.

Pharmacy Program

1. I understand that the Free Clinic pharmacy will not dispense medications to any patient that has not provided all necessary documentation and been approved for services.
2. At the time I receive my medication from the Free Clinic pharmacy, I will pay a \$4.00 fee for each prescription or diabetic supply. The pharmacy accepts cash and money orders for pharmacy fees. Payment is required at the time of pick up, and patients may not run balances or pick up medications on credit. If you cannot pay, please contact the clinic immediately for information concerning other means of acquiring assistance to pay for your prescription(s).
3. Refills must be called in according to the Pharmacy's schedule. If I have refills left on my bottle, I will call the Free Clinic Monday – Wednesday, when I have a 10-day supply of medication

remaining. My refill will be ready to pick up on Friday of the week after I call it in. If I have NO refills, I will return to the prescribing doctor to get a new prescription.

4. I understand that the Free Clinic will not prescribe or dispense any controlled substances, and I will not request controlled substances from the Free Clinic pharmacy.
5. The medication bottles that I receive from the Free Clinic may not have childproof caps. I understand that I must specifically request childproof caps to ensure that my medications are safe in the presence of children.
6. I understand that the Free Clinic pharmacy has a limited formulary and may not be able to provide all medications prescribed by volunteer specialist physicians.
7. Participating drug stores may be used to fill a prescription when determined necessary by Free Clinic staff.

Primary and Specialty Medical Care

1. I will keep my appointments with the Free Clinic and any specialists to whom they refer me. If I must cancel an appointment, I will call the Specialist's office at least 24 hours before the scheduled appointment time.
2. A \$5.00 donation will be requested each time I see a practitioner, whether at a walk-in clinic or a scheduled daytime appointment.
3. For walk-in clinics (Christiansburg, Radford, Pulaski, or Giles), I will sign in between 5:00 pm and 5:30 pm. Patients are seen in order of medical priority. There may be considerable waiting time, and if I am not available when my name is called, my turn may be delayed.
4. All referrals to a specialist will be arranged by the Free Clinic. I understand that I can be held responsible for the cost of any services that I receive outside the Free Clinic that were not authorized by Free Clinic medical staff. If I am billed in error for a visit arranged by the Free Clinic, I will bring the bill to Free Clinic staff, who will attempt to assist me in getting the costs taken care of. I understand that the Free Clinic will not pay any patient bills.
5. The Free Clinic cannot be held financially responsible for patient bills from Emergency Room visits. If I am admitted to a hospital E.R., I will notify the Free Clinic and apply for charity care through the hospital's established program.
6. Each time the Free Clinic refers me for specialty care or lab work, I will present my eligibility card and the referral form that I have been given to the place of service. The Free Clinic strongly encourages patients to give a \$5.00 donation per visit for specialty referral appointments, and specialists may enforce this donation as they wish.

Program for Special Medical Care

1. When I enroll in the Program for Special Medical Care (PSMC), a private primary care doctor will be assigned to me. I understand that I am responsible for making appointments with my assigned doctor and for informing his or her practice each time that I make an appointment that I am a Free Clinic PSMC patient.
2. I will present my eligibility card at each visit with my primary care doctor.
3. A \$5.00 donation will be requested each time I visit my primary care doctor.

4. I will see my doctor for all my primary medical care. All specialty referrals will be arranged by the Free Clinic. The Free Clinic is NOT financially responsible for specialist visits unless the appointments were made through the Free Clinic.
5. If I am not able to keep my scheduled appointment, it is my responsibility to call and cancel or reschedule it myself. I must follow my primary care doctor's policy for appointment cancellations and rescheduling.
6. My doctor can discharge me from his or her practice if he or she feels our relationship is not beneficial. I can change PSMC doctors by making arrangements with the Free Clinic.

□ Dental Program

1. There is a \$25.00 administrative fee for each visit to the Dental Clinic. The clinic accepts only cash or money order, and the fee must be paid before an appointment can be scheduled. Patients that need assistance with the \$25.00 fee may contact New River Community Action.
2. I will arrive at the Dental Clinic 10 minutes before my scheduled appointment. Arriving early allows clinic staff to take extra time to meet patients' needs. If I am more than 10 minutes late for my dental appointment, the dentist will not be able to see me that day. The first time I am late, I will reschedule my appointment for another day. If I am late a second time, I understand that I must pay another \$25.00 fee to reschedule my appointment.
3. I will call at least 24 hours in advance if I need to cancel an appointment. I understand I will be able to reschedule the first appointment that I cancel with no penalty, but if I cancel a second time I must pay another \$25.00 fee before rescheduling the appointment.
4. I understand that if I miss an appointment and have not given the Dental Clinic at least 24 hours notice, I must pay another \$25.00 fee to reschedule the appointment. Missing a second appointment without advance notice may end my eligibility as a Dental Clinic patient.

I have received a full explanation of the Clinic's services and I understand and agree to all of the above. I understand I may be terminated from the Clinic if I give false or misleading information, or if I do not comply with the agreed terms listed above.

Patient's Signature: _____ **Date:** _____

Screener's Signature: _____ **Date:** _____



Dental Program Service Disclaimer

The following is a list of conditions that may result in termination of services:

- 1. Patient has allowed their Free Clinic eligibility to elapse past 30 days.
2. Failure to report eligibility status changes (including name, address, income, and insurance) to the Free Clinic staff within 30 days of status change.
3. Disrespect or use of threatening or abusive language toward the Free Clinic staff, volunteers, or other patients.
4. Inappropriately seeking prescription medications.
5. Providing false or misleading information of any kind.
6. Inappropriate use of your Free Clinic card to obtain medical, dental, or pharmaceutical services without prior authorization.

I understand that the above terms may result in the loss of my Free Clinic Dental Program eligibility status. I further understand that my patient status may be terminated immediately for any of the above situations.

Patient's Signature: _____ Date: _____

Patient's Name (print): _____ Date: _____



Dental Program Appointment Policies

Arriving Late

If you arrive more than 15 minutes late for your dental appointment, the dentist will not be able to see you that day.

- The first time you arrive late, we can reschedule your appointment for another day.
- If you are late a second time you must pay another \$25.00 fee before your appointment can be rescheduled.

Broken Appointments (No-Shows)

If you do not show for your scheduled appointment and you have not given the Dental Clinic at least 24 hours advance notice, you must pay another \$25.00 fee to reschedule your appointment.

- If you miss a second appointment without advance notice, you will no longer be eligible to be seen as a dental patient at the Free Clinic.

Cancellations

If you need to cancel your appointment, you must contact the Dental Clinic at least 24 hours in advance.

- The first time you cancel an appointment you may reschedule.
- If you cancel a second appointment, you must pay another \$25.00 fee before the appointment can be rescheduled
- You may have to wait several months for the next available appointment.

I have read and understand the Free Clinic's dental policies regarding late arrivals, broken appointments, and cancellations.

Patient's Name (print): _____ Date: _____

Patient's Signature: _____ Date: _____



Letter of Support

I certify by my signature on this form that I provide the following services for

(Patient's Name) _____

Please check all spaces that apply:

- ___ Shelter
• ___ Utilities
• ___ Food
• ___ Clothing
• ___ Transportation
• ___ Miscellaneous necessities/expenses

I have provided these services since: _____

Name of Provider (print) _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Signature of Provider _____ Date _____

Signature of Patient _____ Date _____

The Free Clinic of the New River Valley reserves the right to contact the provider of support to verify this information.

Request for Transcript of Tax Return

(Rev. January 2011)

OMB No. 1545-1872

Department of the Treasury
Internal Revenue Service

► **Request may be rejected if the form is incomplete or illegible.**

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return**. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
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2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
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3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)

4 Previous address shown on the last return filed if different from line 3 (See instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Caution. If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days

b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days.

c **Record of Account**, which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days

7 **Verification of Nonfiling**, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days

Caution. If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** For transcripts being sent to a third party, this form must be received within 120 days of signature date.

Telephone number of taxpayer on line 1a or 2a

Sign Here ► _____
Signature (see instructions) Date

► _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

► _____
Spouse's signature Date