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Thank you for choosing us to serve your health care needs. You can trust that we will work extraordinarily hard to provide you with the absolute best in health care services and support. Our goal is simple – to help you feel as good as you can and be as healthy as you can be!

We have designed a number of tailored programs and solutions to deliver a true patient-centered medical home experience just for you:

- Our schedules are open when you need to be seen – ***Just Call Us***!
- Our doctors are on call for your urgent care needs (nights and weekends).
- Annual wellness and comprehensive health review program.
- Care coordination program.
- Post-admission follow-up program.
- And many more!

Appointment Date: ___________________

Appointment Time: ___________________

CHECKLIST FOR FUTURE APPOINTMENTS

- ✓ **Insurance ID Card**
- ✓ **Driver's License**
- ✓ **Prior Medical Records**
  - ■ **Specialists Notes**
  - ■ **VA Reports**
  - ■ **Lab Results**
  - ■ **Imaging Results**
- ✓ **Prescription bottles**
  - ■ **Over the Counter medications**
- ✓ **Self-Monitoring Logs**
  - ■ **Blood Pressure**
  - ■ **Blood Sugar**
  - ■ **Weight / Food / Exercise**
  - ■ **Other - Smoking Cessation**
- ✓ **List of questions for the PCP**

PLEASE PRINT CLEARLY

DEMOGRAPHIC INFORMATION:		
First Name:	**Last Name:**	**Middle Initial:**
Date of Birth (MM/DD/YYYY):	**Gender (Circle): Male / Female / _________**	
Social Security Number:	**Driver's License/State ID#:**	
Mailing Address		
Street:	**City:**	**State: Zip:**
Home Address - Check if Same as Above ▢ OR Complete Below if Different from Above		
Street:	**City:**	**State: Zip:**
Home Phone: ( ) -	**Cell Phone: ( ) -**	**Work Phone ( ) -**
Email Address:		
Ethnicity (Circle One): White Hispanic/Latino Black/African American Native American Asian/Pacific Islander Other:		
Preferred Language:		
Marital Status (Circle One): Single Married Divorced Cohabitating Other		
Spouse's Name:	**Spouse's Cell Phone: ( ) -**	
Emergency Contact:		
Emergency Contact Home Phone: ( ) -		
Emergency Contact Cell Phone: ( ) -		

Previous Primary Care Provider			
Doctor First Name:	**Doctor Last Name:**	**Phone Number:**	
Other Specialists That You Normally Visit			
Doctor First Name:	**Doctor Last Name:**	**Phone Number:**	**For What Condition?**

MEDICAL RECORDS RELEASE

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

PLEASE COMPLETE		
First Name:	**Last Name:**	**Middle Initial:**
Date of Birth (MM/DD/YYYY):	**Gender (Circle): Male / Female / _________**	
Last Four Digits of SSN: * * * - * * -	**Driver's License/State ID#:**	

INTERNAL USE ONLY (Records From)		
Facility Name:	**Fax #:**	**Phone #:**

I authorize and request the disclosure of all protected information for the purpose of review and evaluation from the above-named doctor or healthcare provider to:

Facility Name: OneHealth Primary Phone: Fax:		
Street:	**City:**	**State: FL Zip**

Requested Information (if more than 25 pages please mail/NO DISC PLEASE):

Dates from ________ to ________

- All records
- Office Visit notes – last two only
- Cardiology reports only
- Consults notes only
- Office notes only
- Lab reports only
- Radiology reports only
- Hospital records only
- Other: ____
  ____
- Mental Health
- HIV Test/Results/Treatments
- Alcohol/Substance Abuse

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient. I understand that a copy of this authorization may be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS: I understand the following (see CFR 164.508(c)(2) (i-iii)):
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance on this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

____ ______________________
Signature of Patient or Legally Authorized Representative **Date**

____ ______________________
Name of Legally Authorized Representative for Patient **Relationship to Patient**

MEDICAL HISTORY / FAMILY MEDICAL HISTORY

Patient Name:	Date of Birth:

(Checkmark and Complete Medication for any "Self" Conditions Listed

Condition	Self	Father	Mother	Brother/Sister	Children	Comments
Alcohol or Drug Abuse						
Arthritis						
Bleeding Disorder						
Cancer (Specify)						
Depression						
Diabetes						
Heart Attack						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Liver Disease						
Mental Illness						
Migraine						
Neurological Problems						
Osteoporosis						
Seizures / Epilepsy						
Stroke						
Thyroid Problems						
Valve Disorder						
Accidents (Specify)						
Hospitalizations (Specify)						
Surgery (Specify)						

SCREENING FORM

Please fill in below to the best of your knowledge.

Patient Name:	Date of Birth:

Procedure	Date Completed (MM/DD/YYYY)	Facility Procedure Performed
Blood Work		
Bone Density (DEXA)		
Colonoscopy / Other Colon Cancer Screening		
Eye Exam		
Mammogram		
Pap Smear		
Prostate-Specific Antigen (PSA)		

Immunization	Completed (Circle One)	Date Completed (MM/DD/YYYY)
Influenza (Flu) Vaccine	Yes No	
Pneumonia Vaccine	Yes No	
Shingles Vaccine	Yes No	
Tetanus Vaccine	Yes No	
Tuberculosis Test (PPD)	Yes No	

Question	Yes/Current (Specify How Many)	Yes/Quit (Specify Quit Date MM/DD/YYYY)	No/Never
Have you ever smoked nicotine?			
Have you ever used marijuana?			
Do you drink alcohol?			
Do you use Oxygen/CPAP/BiPAP Machines?		N/A	
Do you need an aide while walking (Ex. walker, cane, etc.)?		N/A	
Do you need help with daily living activities?		N/A	
Do you wear glasses?			
Do you use a hearing aid?			

MEDICATION LIST

First Name:	Last Name:	Middle Initial:	Date of Birth (MM/DD/YYYY):

Pharmacy Name:				
Pharmacy Address	Street:	City:	State:	Zip:

PROVIDE KNOWN ALLERGIES INCLUDING MEDICATIONS
1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Medication	Date Prescribed	Dose	Quantity	Frequency

OFFICE POLICY AGREEMENT

(Initial each)

______ **COMMIT TO A MINIMUM OF ONE ROUTINE APPOINTMENT(S) YEARLY**
And follow up appointments as deemed necessary by your provider.

To provide the quality of care you deserve, you must have a routine office visit with the physician at least once yearly. This does not include urgent or sick appointments. This also includes yearly fasting blood tests and electrocardiograms (EKG). If you do not keep yearly appointments, you may be considered as an inactive patient if the lapse is over 1 year (12 months). At which time you may be asked to establish care with another primary care physician. It is the physician's discretion to allow anyone to re-establish care.

______ **MEDICATION REFILLS**

The physicians try their best to get all medication refills sent to the pharmacy as quickly as possible. Keep in mind this is done between seeing patients or at the end of the day (time permitting). If you see you are running low on medication please call your pharmacy ASAP, as a refill may take 48 to 72 hours.

______ **TARDINESS TO AN APPOINTMENT MAY LEAD TO RESCHEDULING**

In the event that you are 10 minutes late to an appointment, you may be rescheduled. If you are habitually late, you will be rescheduled. If you run into an emergency or know you will be late please call ahead as we may have an appointment later in the day. It is not fair to other patients to be rushed or wait for unknown amounts of time because one person was late.

______ **NO SHOWS / LAST MINUTE CANCELLATIONS / LAST MINUTE RESCHEDULES:**

Providers and staff rely on the pre-scheduled appointments to plan their daily activities and curtails the ability to schedule another patient in your pre-scheduled slot. If you must cancel or reschedule your appointment, please provide us with at least 48 hours' notice.

_____**PAYMENTS FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED:** We accept cash, credit/debit cards and personal checks. Returned checks less that $50 are subject to a service charge (per Florida statute 832.08) of $25. Checks between $50-$300 have a fee of $30. For checks greater than $300 the fee is $40. You may also lose our privilege to write checks in our practice.

_____ **MEDICARE:** You are responsible for your annual deductible and 20% of the allowable charges due at the time of service, unless you have supplementary insurance in which case claims will be filed directly. Please bring with you the Medicare Explanation of Benefits (EOB) showing that you have met your deductible.

FINANCIAL AGREEMENTt: We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. However, you must realize that:

- Your insurance is a contact between you, your employer and the insurance company. We are not a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover.

By signing this form, I am in agreement with the above terms or understand the office policies.

SIGNATURE: ____ DATE: ________________

SUBSCRIBER SIGNATURE: ________________________________ DATE: ________________
(Policy Holder, if different than Patient)

Referral Processing

When your PCP **orders** a service, (specialist, equipment, testing, etc.) our Referral Department will contact you to discuss appointment setting and specialist/provider selection.

When you **request** services, you must discuss this with your Primary Care Physician. If your PCP approves the service, our Referral Department will work with your Health Plan to obtain an authorization.

When your PCP **receives** a request from an outside provider such as a specialist, testing facility or equipment company, it is reviewed by your PCP and our Referral Department staff to ensure all guidelines are met according to your Health Plan, prior to processing.

Please allow 7 - 10 business days for our Referral Department to process orders and outside referral requests. It is a good idea to keep this in mind when you are making appointments with your specialist.

In the event your Primary Care Physician deems a service to be urgent or emergent, it will be prioritized as such.

Thank you for your understanding.

____

Patient Signature

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received **OneHealth Primary** HIPAA Notice of Privacy Practices.

YEARLY AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

______ **RELEASE OF INFORMATION:** I, the below named patient, do hereby authorize any physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g. Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug-related condition and records concerning diagnosis and treatment when requested by such third parties for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

______ **PHYSICIAN INSURANCE ASSIGNMENT:** I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

______ **MEDICARE/MEDICAID:** Patient's certification authorization to release information and payment requests. I certify that the information given by me in applying for payment under Title XVII XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

______ **PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** The assignment will remain in effect until revoked by me in writing.

______ **CONSENT FOR TREATMENT:** I, the below named patient hereby give my consent for treatment to all physicians associated with OneHealth Primary.

______ **CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS**: I, the below named patient, do hereby authorize OneHealth Primary. To discuss my medical condition with, or release my medical records to the below-named person (s):

First Name:	Last Name:	Relationship:	Home Phone: ( ) -
First Name:	Last Name:	Relationship:	Home Phone: ( ) -

By signing below, I acknowledge that I have received, read and understood the HIPAA Notice of Privacy Practices of OneHealth Primary (If you would like a copy for your records please see the front desk) and authorize OneHealth Primary to release or obtain any relevant information to or from any related third-party. I also authorize OneHealth Primary to bill any relevant third party for the services rendered and to bill me for any balances after payment from such third parties. I also authorize OneHealth Primary to bill me for any fees, costs, or charges associated with collecting monies due to them on my behalf. I further authorize OneHealth Primary to provide the person(s) named above and discuss my medical conditions, as necessary.

Signature: ____ Date: ______________________

NOTICE OF PRIVACY PRACTICES
This form does not constitute legal advice and covers only federal, not state, law.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003, and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by asking our [Title, Staff Member Name]. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION: We will keep your health information confidential, using it only for the following purposes: **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health care information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for the services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers, and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law: court or administrative orders, subpoena, discovery request, or other lawful processes. We will use and disclose your information when requested by national security intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury, and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

HIPAA Notice of Privacy Practices:

This form does not constitute legal advice and covers only federal, not state, law.

YOUR PRIVACY RIGHTS AS OUR PATIENT: **Access:** Upon written request, you have the right to inspect and get copies of your health information, and that of an individual for whom you are a legal guardian. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page up to 25 pages, then 25 cents each page thereafter, and the staff time charged will be $50.00 per hour including the time required to locate and copy your health information. If you want the copies mailed if you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your health care information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment, or healthcare operations. You can request non-routine disclosures going back six (6) years starting on April 14. 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003, up to May 15, 2004. Disclosures prior to April 14, 2003, do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our [Title]. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our [Title]. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US: One Health Primary Care 727-807-9754

LIVING WILL / ADVANCE DIRECTIVE

An **ADVANCE DIRECTIVE** is a witnessed statement made by a competent member regarding his/her wishes or desires in regard to future health care, (for example-Provide artificial life support)

A **LIVING WILL** is a formalized version of an **ADVANCE DIRECTIVE**.

Why is it important to sign a living will declaration?

Because your decisions matter. Advance directives protect your rights as a patient and relieve the burden of crisis decision making for your family. They ensure your wishes are met and that you receive the kind of health care you choose.

You may amend or revoke your declaration at any time.
If you should change your mind, here are the ways to revoke or amend your decisions:

1. A signed, dated statement indicating your intention to amend or revoke.
2. Physically canceling or destroying the documents or by having someone else do so in your presence at your request.
3. Verbally expressing your intent to amend or revoke.
4. Create another document which is materially different from the previous one.

Storing your Living Will Declaration/Health Surrogate Forms.
Keep the original copy of your living will and health care surrogate forms in a drawer or closet that can be easily reached in the event of an emergency. Inform your loved ones about the location. Do not put them in a safe deposit box.
Give copies of these declarations to family members or close friends who might be involved in decision-making for you, such as your primary care physicians, clergy person, and attorney.

Please take this information home and carefully review it. If you wish to execute an Advance Directive or Living Will, please notify this office on your next visit.

I have received a copy of Health Care Directives and understand my rights relating to Advance Directive and Living Will.

PLEASE CHECK ONE:

________ I HAVE A Living Will and will provide a copy to this office

________ I DO NOT HAVE A Living Will

Florida Law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare providers, or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility.

Signature: ____ Date: ___________________

Printed Name: ____

Living Will

Declaration made this ____ day of _______ (20__), I ____, willfully voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set for below, and I do hereby declare that, if at any time I am incapacitated and:

________ (Patient initial) I have a terminal condition, or
________ (Patient initial) I have an end-stage condition, or

________ (Patient initial) I am in a persistent vegetative state, and if my primary physician and another consultant physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
I do____, I do not____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional instructions
(optional):____
____

Patient Signed:____________________________________ Date:_______________

***Witness Signature 1:*____**

Street Address____________________________________ City: _______________________________State:_________
Phone: ____

***Witness Signature 2:*____**

Street Address:____ City: ____________________________________State:_________
Phone: ____

Designation of Health Care Surrogate

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I ____ (Name) wish to designate, as my surrogate for healthcare decision:

Name:____

Street
Address:_______________________________________City:________________State:_____Zip:______
Phone:______________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:____

Street
Address:_______________________________________City:________________State:_____Zip:______
Phone:_____________________________

I fully understand that this designation will permit my designee to make Healthcare decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care, and to authorize my admission to or transfer from a healthcare facility.
Additional instructions
(optional):____
____

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Patient Signature: ____________________________________ Date: ______________________________

Witness Name 1: ___________________________________

Date: _________________

Witness Signature 1: ____

Witness Name 2: ____

Date: _________________

Witness Signature 2: ____

Welcome to **One**Health,

Did you know that as a patient at **One**Health, you have the opportunity to participate in clinical research at Tampa Bay Medical Research? Clinical research is what allows us to improve our understanding of diseases and medical conditions and determine the safety and effectiveness of new therapies and treatments. These treatments provide hope to many as they have the potential to be life changing treatments. You have the opportunity to help others and possibly receive the newest treatments along with additional care and attention from our clinical research team.

Your safety is our priority and participation are strictly voluntary.

Please let us know if you would like to be contacted regarding research. Saying yes to be contacted by our research team does NOT commit you to participating in any trials. It just gives you the opportunity to ask questions and to see if any of our current or upcoming trials could be a match for you or your friends/family. Our goal is to better the lives of our patients and to provide advancing innovative treatments as they become available.

Please ask your medical provider to speak with our research team TODAY if you have questions and want to learn more about research studies that may be appropriate for you, or even your family members. We will contact you shortly after your visit.

Please provide your preferred contact method, such as email, phone, letter if you would like to receive information about upcoming research opportunities from Tampa Bay Medical Research. If you do not want information regarding research, please indicate this. Your response will in no way affect the care provided to you by our medical team.

________________________________ ___________________________________

Name (Print) Signature

Please Indicate below if you do or do NOT wish to be contacted by our clinical research team at Tampa Bay Medical Research.

_____________ Yes, please contact me to discuss research opportunities

Preferred method of contact:

Phone Number: _______________________

Email Address: ________________________

_____________ No, I prefer not to be contacted

If you have any questions about Tampa Bay Medical Research or any of the trials that they have, please call the staff at 727-724-3316. Or the recruiter is Vince LeMay and his email is vlemay@tbmr.net