37 y
M

Wyckoff
Wyckoff Heights Medical Center

Member
NewYork-Presbyterian Healthcare System
Affiliate: Weill Medical College of Cornell University

374 Stockholm Street, Brooklyn, New York 11237

MRN

M 37y
Inpatient 11-29-22
ACC:

37
316A
12-12

CONSENT

PERMISSION FOR OPERATION. ANESTHESIA, SPECIAL TREATMENTS OR PROCEDURES

1. **PERMISSION GRANTED** I grant my permission to WHMC or his/her colleagues associates or assistants at Wyckoff Heights Medical Center, to perform on the Patient named above the following:
Peripherally Inserted Central Catheter (PICC)
Line Insertion
TYPE OR PRINT NAME OF PROCEDURE
2. **NATURE, PURPOSE, BENEFITS AND ALTERNATIVES HAVE BEEN EXPLAINED** The physician has explained to me the nature of the operation or procedure and the reasons why it is recommended. He/she has also explained the benefits which may be expected from the operation or procedure and has advised me of any possible alternatives to the proposed treatment, including the risks & benefits of those alternatives.
3. **RISKS AND COMPLICATIONS HAVE BEEN EXPLAINED** The physician has informed me that there are certain risks and material complications which may occur as a result of the operation or procedure. I have been told what these risks and complications are, and the discomforts that each will cause. I have also been advised that there are certain risks, some of which are rare but may be very serious, which are associated with any surgical operation or procedure of this type, and these risks have been explained to me as well.
4. **UNFORESEEN CONDITIONS WHICH MAY ARISE** I understand that during the course of the operation or procedure, unforeseen conditions may arise, which were not anticipated by my physicians. If this happens, additional procedures may be necessary to correct whatever problem develops. I therefore consent to the performance of such additional procedures under these circumstances.
5. **CONSENT TO ANESTHESIA** I consent to the use of anesthesia to be applied by and under the direction of the anesthesiologist. I give permission for the use of whatever type of anesthesia the anesthesiologist recommends. I have been advised that certain risks and complications may result from anesthesia and those risks and complications have been explained to me.
6. **CONSCIOUS SEDATION** I hereby authorize and direct the above named physician and/or his associates to provide the administration and maintenance of conscious sedation. I have been advised of the benefits, alternatives and risks associated with conscious sedation.
7. **BLOOD TRANSFUSIONS** Blood Transfusions may be required. In this case, I have been advised that there is some risk of hepatitis, AIDS, or other reactions (No test exist which can prevent every possibility of hepatitis or AIDS.) I have been advised that I can refuse Blood Transfusions.
8. **DISPOSAL OF ORGANS OR TISSUES** The hospital may examine and retain, for medical, scientific, or educational purposes, any organs or tissues removed from the patient. The hospital may then dispose of them in accordance with its usual practice.
9. **NO GUARANTEE** No guarantees or assurances have been made to me concerning the results intended from the operation or procedure. The physician has discussed the likelihood of achieving the expected outcome.
10. **PHOTOGRAPHING** I give permission for such photographing, videotaping, televising or other observation of the procedure(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.
11. **FOR PATIENTS WHO HAVE DNR ORDERS** I understand and agree that the Do Not Resuscitate Order will be (check one):
☐ **Maintained** ☐ **Suspended** for the following period: (*check one*): ☐ In the Operating and Recovery Rooms
☐ Other (specify): _____
12. **UNDERSTANDING OF THIS FORM** I have read and fully understand this form. All blank spaces have been completed. I have asked the physician any questions I may have had. The physician has answered any questions I asked to my satisfaction.

PATIENT/PERSON LEGALLY AUTHORIZED TO CONSENT

(SIGNATURE)

(PRINT NAME)

(RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN THE PATIENT)

WITNESS

(SIGNATURE)

(PRINT NAME)

(DATE) 12/9/22 (TIME)

Interpreter used ☐ Yes ☐ No ☐ Language Line Name: _____

PHYSICIAN'S CERTIFICATION

I herby certify that I have explained the nature, purpose, benefits, risks of, alternatives to: conscious sedation, blood transfusion proposed procedure/operation; have offered to answer any questions and have fully answered all such questions. I believe the patient person legally authorized to consent fully understands what I have explained and answered.

Physician: _____ Date: 12/09/22

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

(***"PHYSICIAN"*** AS USED HERE INCLUDES DENTISTS, ORAL SURGEONS AND PODIATRISTS)

Wyckoff
Wyckoff Heights Medical Center

MRN:

M 37y
Inpatient 11-29-22
ADM

CONSENT

PERMISSION FOR OPERATION, ANESTHESIA, SPECIAL TREATMENTS OR PROCEDURES

1. **PERMISSION GRANTED** I grant my permission to Dr. Guberman or his/her colleagues associates or assistants at Wyckoff Heights Medical Center, to perform on the Patient named above the following: incision and debridement of Right foot 4th toe abscess Bedside
TYPE OR PRINT NAME OF PROCEDURE

2. **NATURE, PURPOSE, BENEFITS, RISKS, COMPLICATIONS, LIKELIHOOD OF ACHIEVING THE GOALS** and any **POTENTIAL FOR PROBLEMS IN THE RECUPERATION HAVE BEEN EXPLAINED** to me by the physician and why he/she is recommending it. He/she has also explained the expected outcomes and advised me of any possible alternatives, including the risks and benefits of those alternatives, including the alternative choice of no operation/procedure.

3. **DISCUSSION OF THE RISKS AND COMPLICATIONS** included those complications which may occur as a result of the operation or procedure. I have been told what these risks and complications are and the discomforts that each could cause. I have also been made aware of certain risks which are rare, but very serious, and are associated with any surgical operation or procedure of this type. These have been explained to me, as well.

4. **UNFORESEEN CONDITIONS** which may arise have been discussed. I understand that during the course of the operation or procedure, unforeseen conditions may arise, which were not anticipated by my physicians. If this happens, additional procedures may be necessary to correct whatever problem(s) develop. I therefore consent to the performance of any such additional procedures under these circumstances.

5. **CONSENT TO ANESTHESIA:** I consent to the use of anesthesia to be applied by and under the direction of the anesthesiologist. I give permission for the use of whatever type of anesthesia the anesthesiologist recommends. I have been advised that certain risks and complications may result from anesthesia and those risks and complications have been explained to me.

6. **CONSCIOUS/MODERATE SEDATION:** I hereby authorize and direct the above-named physician and/or his/her associates to provide the administration and maintenance of conscious/moderate sedation. I have been advised of the benefits, alternatives and risks associated with conscious/moderate sedation.

7. **BLOOD TRANSFUSIONS:** Blood transfusions may be required. In this case, I have been advised that there is some risk of hepatitis, HIV/AIDS, or other reactions. (No tests exist which can prevent every possibility of hepatitis or HIV/AIDS transmission.) I have been advised that I have the right to refuse blood transfusions.

8. **DISPOSAL OF ORGANS AND/OR TISSUE:** The hospital may examine and retain, for medical, scientific, or educational purposes, any organs and/or tissues removed from the patient. The hospital may then dispose of them in accordance with its usual practices.

9. **NO GUARANTEES:** No guarantees or assurances have been made to me concerning the results intended from this operation or procedure. The physician has discussed the likelihood of achieving the expected outcomes.

10. **PHOTOGRAPHY:** I give permission for such photographing, videotaping, televising or other recording/observation of the operation/procedure as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that the patient's identity will remain anonymous and protected.

11. **FOR PATIENTS WITH DNR ORDERS:** I have thoroughly discussed my wishes with the physician(s). I understand and agree that the Do Not Resuscitate Order will be (check one): ☐ **Maintained** ☐ **Suspended** for the following period: ☐ In the O.R. and PACU
☐ Other: (Specify) _____

12. **RECOVERY AND RECUPERATION:** The physician has discussed the expected recovery/recuperation timeframes and limitations, including any impact on the activities of daily living.

13. **UNDERSTANDING OF THIS FORM:** I have read and fully understand the contents of this form. All blank spaces have been completed. I have asked the physician any questions that I may have had. The physician has answered those questions to my satisfaction.

PERSON LEGALLY AUTHORIZED TO CONSENT

Signature — Date/Time 12/1/22 9:40 am

Print Name — Date/Time 12/1/22 9:40am

Relationship, if signed by person other than the patient

WITNESS

Signature

Print Name and Title

12-1-22 0940 Date and Time

INTERPRETER USED ☐ Not Applicable ☐ Yes: _____ (Identify by Name or ID#)

PHYSICIAN/PROVIDER CERTIFICATION/ATTESTATION

I hereby certify that I have explained the nature, purpose, benefits, risks, complications, likelihood of achieving the goals and any potential for problems in the recuperation. In addition, I have explained the alternative, including the option of no operation/procedure and the risks and benefits associated with the alternatives. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/person legally authorized to consent for the patient. fully understands all that I have explained and answered.

Physician/Provider Signature — Date: 12/1/2022 Time: 9:40am

Physician's/Providers Printed Name/ID Stamp

Reviewed By:

Attending/Operating Physician Signature — Date: _____ Time: _____

Attending/Operating Physician Print/ID Stamp

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.
("PHYSICIAN" ALSO DENOTES DENTISTS, ORAL ...

Wyckoff
Wyckoff Heights Medical Center

CONSPROC

MRN

M 37y
Inpatient
ADM 11-29-22

CONSENT

PERMISSION FOR OPERATION, ANESTHESIA, SPECIAL TREATMENTS OR PROCEDURES

1. **PERMISSION GRANTED** I grant my permission to Dr. D'orazi or his/her colleagues associates or assistants at Wyckoff Heights Medical Center, to perform on the Patient named above the following:
bone biopsy Right 4th toe
TYPE OR PRINT NAME OF PROCEDURE

2. **NATURE, PURPOSE, BENEFITS, RISKS, COMPLICATIONS, LIKELIHOOD OF ACHIEVING THE GOALS** and any **POTENTIAL FOR PROBLEMS IN THE RECUPERATION HAVE BEEN EXPLAINED** to me by the physician and why he/she is recommending it. He/she has also explained the expected outcomes and advised me of any possible alternatives, including the risks and benefits of those alternatives, including the alternative choice of no operation/procedure.

3. **DISCUSSION OF THE RISKS AND COMPLICATIONS** included those complications which may occur as a result of the operation or procedure. I have been told what these risks and complications are and the discomforts that each could cause; I have also been made aware of certain risks which are rare, but very serious, and are associated with any surgical operation or procedure of this type. These have been explained to me, as well.

4. **UNFORESEEN CONDITIONS** which may arise have been discussed. I understand that during the course of the operation or procedure, unforeseen conditions may arise, which were not anticipated by my physicians. If this happens, additional procedures may be necessary to correct whatever problem(s) develop. I therefore consent to the performance of any such additional procedures under these circumstances.

5. **CONSENT TO ANESTHESIA:** I consent to the use of anesthesia to be applied by and under the direction of the anesthesiologist. I give permission for the use of whatever type of anesthesia the anesthesiologist recommends. I have been advised that certain risks and complications may result from anesthesia and those risks and complications have been explained to me.

6. **CONSCIOUS/MODERATE SEDATION:** I hereby authorize and direct the above-named physician and/or his/her associates to provide the administration and maintenance of conscious/moderate sedation. I have been advised of the benefits, alternatives and risks associated with conscious/moderate sedation.

7. **BLOOD TRANSFUSIONS:** Blood transfusions may be required. In this case, I have been advised that there is some risk of hepatitis, HIV/AIDS, or other reactions. (No tests exist which can prevent every possibility of hepatitis or HIV/AIDS transmission.) I have been advised that I have the right to refuse blood transfusions.

8. **DISPOSAL OF ORGANS AND/OR TISSUE:** The hospital may examine and retain, for medical, scientific, or educational purposes, any organs and/or tissues removed from the patient. The hospital may then dispose of them in accordance with its usual practices.

9. **NO GUARANTEES:** No guarantees or assurances have been made to me concerning the results intended from this operation or procedure. The physician has discussed the likelihood of achieving the expected outcomes.

10. **PHOTOGRAPHY:** I give permission for such photographing, videotaping, televising or other recording/observation of the operation/procedure as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that the patient's identity will remain anonymous and protected.

11. **FOR PATIENTS WITH DNR ORDERS:** I have thoroughly discussed my wishes with the physician(s). I understand and agree that the Do Not Resuscitate Order will be (check one): ☐ Maintained ☐ Suspended for the following period: ☐ In the O.R. and PACU
☐ Other: (Specify) _____

12. **RECOVERY AND RECUPERATION:** The physician has discussed the expected recovery/recuperation timeframes and limitations, including any impact on the activities of daily living.

13. **UNDERSTANDING OF THIS FORM:** I have read and fully understand the contents of this form. All blank spaces have been completed. I have asked the physician any questions that I may have had. The physician has answered those questions to my satisfaction.

PERSON LEGALLY AUTHORIZED TO CONSENT

Signature — Date/Time 12/8 11:13AM

Print Name — Date/Time 12/8 11:13AM

Relationship, if signed by person other than the patient

WITNESS

Signature

Print Name and Title RN

12-08-22 11:13AM
Date and Time

INTERPRETER USED ☐ Not Applicable ☐ Yes: _____
(Identify by Name or ID#)

PHYSICIAN/PROVIDER CERTIFICATION/ATTESTATION

I hereby certify that I have explained the nature, purpose, benefits, risks, complications, likelihood of achieving the goals and any potential for problems in the recuperation. In addition, I have explained the alternative, including the option of no operation/procedure and the risks and benefits associated with the alternatives. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/person legally authorized to consent for the patient, fully understands all that I have explained and answered.

Physician/Provider Signature — Date: 12/8/22 Time: 11:13 AM

Physician's/Provider's Printed Name/ID Stamp

Reviewed By:

Attending/Operating Physician Signature — Date: _____ Time: _____

Attending/Operating Physician Print/ID Stamp

0542 REV 4/14

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.
("PHYSICIAN" ALSO DENOTES DENTISTS, ORAL SURGEONS AND PODIATRISTS)

MRN:

M 37y

Inpatient 11-29-22
ADM

Wyckoff
Wyckoff Heights Medical Center

Patient Property List

Clothing Disposition:

Clothing sent home with (Name/Phone Number/Relationship):

ELECTRONIC DEVICES (Describe Items) Y/N:

Cellular Phone:

Tablet:

Laptop:

MP3 Player:

Other Devices:

Device Disposition:

Valuables Envelope #

Electronics sent home with (Name/Phone Number/Relationship):

Medications Y/N: Medication Disposition:

Medication sent home with (Name/Phone Number/Relationship):

Signature		Date: 11/30/2022
Witness		

The Hospital is not responsible for any clothing or property left in the Hospital, or any money or jewelry left at the bedside.

Rev. 6/2012

Wyckoff
Wyckoff Heights Medical Center

Patient Property List

Completed by Signature:
Print Name:

Pt. educated about use of in room safe? (N/A ED and Peds.)

VALUABLES (Y/N):
Checks: # to #

Money: $ 257. with patient

IDs and Credit Cards:

(2) metro plus health medicard. NY license

Jewelry (Describe Items):

Valuables Disposition:

Valuables Envelope #

Samsung watch black

Valuables sent home with (Name/Phone Number/Relationship):

Dentures:

Denture Disposition: NO

Dentures sent home with (Name/Phone Number/Relationship):

Comment: (If glasses or hearing aid, list here.)

CLOTHING (Describe Articles) Y/N:

Shirt (1) black
Pants: black sweats
Shoes: black sandle
Dress: - black Hoody and blue sweats
Coat: N
Scarf: N
Gloves: N
Hat: Black
Other: shoulder bag (black
player game. (Nintendo Switch)

Rev. 6/2012

Wyckoff
Wyckoff Heights Medical Center
374 Stockholm Street, Brooklyn, New York 11237

NON - OR PROCEDURE VERIFICATION SHEET

MRN:W850095359 5S 516
Carrillo, Jose M 37
Depaz, Hector Inpatient 11-29-2
ACC:W00851146725 ADM 06-26-198

Location / Clinic Fifth floor WHMC

Procedure _____ Date 12/8/22 Time _____

PROCEDURE SUPPORT STAFF	SIDE LEFT	SIDE RIGHT	SIDE N/A	YES	NO	SIGNATURE
1. Verify patient's full name.		✓				
2. Verify patient's date of birth.		✓				
3. Verify consent with patient as to procedure/side/site.		✓				
4. Verify procedure/side/site with appropriate medical record documentation.		✓				
ANESTHESIA PERSONNEL PRESENT	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE**
Present: ☐ Yes ☑ No						
1. Verify planned procedure and site with patient.		✓				
2. Verify consent as to procedure/site/side.		✓				
PROVIDER PERFORMING PROCEDURE	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE**
1. Reconfirm procedure/side/site and consent with patient.				✓		
2. If appropriate, mark site/side with indelible pen, mark to be visible after draping.				✓		
3. Verify presence of appropriate clinical studies, if applicable.				✓		
4. ASA status and MP classification verified				✓		
5. No sedation indicated				✓		
IMMEDIATE PRE-PROCEDURE VERIFICATION (TIME OUT)	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE**
1. Availability of Needed Supplies/ Equipment/Implants				✓		
2. Correct Patient Position						
CONFIRMED	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE**
1. Provider Performing Procedure				✓		
2. Anesthesia Staff, if Present					✓	
3. RN if Present				✓		
4. Other Staff, if Present			✓			
DISPUTE RESOLUTION INITIATED					✓	
DESIGNATED STAFF COMPLETING FORM:	Print Name:					
	Title: DPM			Date: 12/8/22		Time:

FORM 00-0852 4/14

Wyckoff
Wyckoff Heights Medical Center

374 Stockholm Street, Brooklyn, New York 11237.

MRN:W850095359 5S 516-A
Carrillo, Jose M 37y
Depaz, Hector Inpatient 11-29-22
ACC:W00851146725 ADM 06-26-1985

NON – OR PROCEDURE VERIFICATION SHEET

Location/Clinic: 516A Wyckoff Hospital **Date:** 12/1/2022 **Time:** 9:40am

Procedure: incision and debridement of Right foot (6th toe abscess) inpatient

PROCEDURE SUPPORT STAFF	LEFT	RIGHT	N/A	YES	NO	SIGNATURE & TITLE
1. Verify patient's full name				✓		
2. Verify Patient's date of birth				✓		
3. Verify consent with patient as to procedure side & site				✓		
4. Verify procedure side & site with appropriate medical record documentation				✓		
5. Pre-procedure vital signs done and reviewed, intravenous access checked & functional				✓		
ANESTHESIA PERSONNEL PRESENT	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE & TITLE**
Present: ☐ Yes ☒ No						
1. Verify planned procedure & site with patient.						
2. Verify consent as to procedure / site / side						
PROVIDER PERFORMING PROCEDURE	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE & TITLE**
1. Reconfirm procedure side/site & consent				✓		
2. If appropriate, mark site/side with indelible pen, mark to be visible after draping.				✓		
3. Verify presence of appropriate clinical studies, if applicable				✓		
4. ASA status and Mallampati classification verified			✓			
5. Reviewed and evaluated patients History & physical including medications			✓			
IMMEDIATE PRE-PROCEDURE VERIFICATION (TIME OUT)	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE & TITLE**
1. Availability of needed supplies/equipment/implants				✓		
2. Correct patient, position & site				✓		
3. Immediately, prior to induction/ administration of sedation patient was reevaluated				✓		
CONFIRMED	**LEFT**	**RIGHT**	**N/A**	**YES**	**NO**	**SIGNATURE & TITLE**
1. Provider Performing				✓		
2. Anesthesia Staff, if Present			✓			
3. RN, if Present				✓		
4. Other Staff, if Present				✓		
DISPUTE RESOLUTION INITIATED						
DESIGNATED STAFF COMPLETING FORM:	**PRINT NAME:**			**SIGNATURE:**		
	TITLE: DPM			**DATE:** 12/1/22		**TIME:** 9:40am

FORM 00-852 4/14. Revised GP 10/2022

Wyckoff
WYCKOFF HEIGHTS MEDICAL CENTER
374 STOCKHOLM STREET
BROOKLYN, NEW YORK 11237

MRN:W850095359 5S 520-A
Carrillo, Jose M 37y
Depaz, Hector Inpatient 11-29-22
ACC:W00851146725 ADM 06-26-1985

PROGRESS NOTES

DATE AND TIME	◀ START M.D. NOTES HERE	◀ START R.N. AND ALL OTHER NOTES HERE
10:22AM - 12/12/2022		***Peripherally Inserted Central Catheter (PICC) Wave Form***
		PICC-TIP 3CG CONFIRMATION (See Below). No x-ray required.
		Inserted by Erwin D. Tangonan, RN VEIN UTILIZED: Right Brachial
		Catheter Measurements: EXTERNAL 0cm ***INTERNAL*** 37cm

MRN:W850095359
Carrillo, Jose
Depaz, Hector Inpatient
ACC:W00851146725 ADM
5S 520-A
M 37y
11-29-22
06-26-1985

PowerPICC SOLO2™ Catheter with Sherlock 3CG™ Tip Positioning System (TPS) Stylet
REF 1194108D5 (01)00801741155192
LOT REGQ1419 (17)230831
2023-08-31 (10)REGQ1419

Patient Chart

Sherlock 3cg™
Tip Confirmation System

PID1:

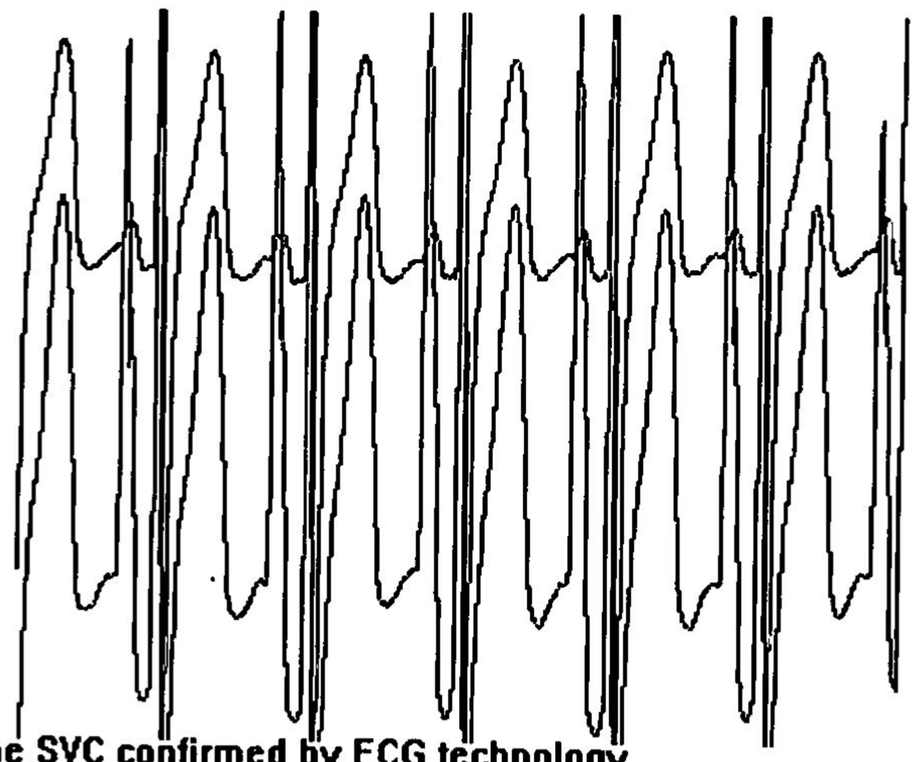
PID2:

Exit Site Marking:

2022-12-12 13-06-37

EXTERNAL

INTRAVASCULAR



PICC tip location in the SVC confirmed by ECG technology

Wyckoff

Wyckoff Heights Medical Center

374 Stockholm Street, Brooklyn, New York 11237

NON - OR PROCEDURE VERIFICATION SHEET

[redacted]

MRN:W850095359 5S 520-A

Carrillo, Jose M 37y

Depaz, Hector Inpatient 11-29-22

ACC:W00851146725 ADM 06-26-1985

PowerPICC SOLO2™ Catheter with Sherlock 3CG™ Tip Positioning System (TPS) Stylet

REF 1194108D5 (01)00801741155192

LOT REGQ1419 (17)230831

2023-08-31 (10)REGQ1419

BARD Patient ID

Location / Clinic 5 SOUTH - 520A

Procedure Insertion of a Peripherally Inserted Central Catheter (PICC) by Nurse Date 12/12/2022 @ 1022 AM

[redacted]						
1. Verify patient's full name.				✓		
2. Verify patient's date of birth.				✓		
3. Verify consent with patient as to procedure/side/site.		✓		✓		
4. Verify procedure/side/site with appropriate medical record documentation.		✓		✓		
[redacted]						
Present: ☐ Yes ☐ No						
1. Verify planned procedure and site with patient.		✓				
2. Verify consent as to procedure/site/side.		✓				
[redacted]						
1. Reconfirm procedure/side/site and consent with patient.		✓		✓		Erin Pagueran
2. If appropriate, mark site/side with indelible pen, mark to be visible after draping.		✓		✓		Erin Pagueran
3. Verify presence of appropriate clinical studies, if applicable.	[redacted]			✓		Erin Pagueran
4. ASA status and MP classification verified	[redacted]		✓			
5. No sedation indicated	[redacted]			✓		Erin Pagueran
[redacted]						
1. Availability of Needed Supplies/ Equipment/Implants		✓		✓		Erin Pagueran
2. Correct Patient Position	[redacted]			✓		Erin Pagueran
[redacted]						
1. Provider Performing Procedure		✓		✓		Erin Pagueran
2. Anesthesia Staff, if Present						
3. RN if Present		✓		✓		Erin Pagueran X A.V
4. Other Staff, if Present						
DISPUTE RESOLUTION INITIATED	[redacted]					

DESIGNATED STAFF COMPLETING FORM:	Print Name: Erwin D. Tangonan, RN #18579	
	Title: Vascular Nurse Specialist	Date: 12/12/2022