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SEP 11 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS

PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
9600 Gateway Drive, Reno, Nevada 89521
Phone (775) 688-2559

Date Received by Board _____ License No. _____

File No. _____

(For Board Use Only)

Identity:

1. Present Legal Name Segal (Last) David (First) Harvey (Middle) _____ (Maiden)

List any other name(s) ever used _____

Address:
The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address 1221 Ocean Avenue Apt 1101 (Street) Santa Monica, (City) Los Angeles (County) CA (State) 90401 (Zip)

☒ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____ (Street) _____ (City) _____ (County) _____ (State) _____ (Zip)

4. Telephone Numbers (319) 423-7200 (Office) (319) 423-7315 (Fax) (____) _____ (Home) _____ (Cellular (Optional))

Email address _____

5. Date of Birth /1966 (Month / Day / Year) Place of Birth _____, New York, USA (City, State, Country) Gender ___F X M

6. Citizenship: U.S. Citizen X Alien Registration # _____ Employment Authorization # _____ Visa _____

Non U.S. Citizen (without the foregoing): Individual Taxpayer Identification Number (ITIN) _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Non Citizens (without the foregoing) submit an Original ITIN assignment letter from the IRS. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board, however, AB275 (2019) provides that an applicant who does not have a social security number must provide an Individual Taxpayer Identification Number (ITIN) when completing an application for licensure.
NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

Questions:

For the purposes of the following questions, these phrases or words have these meanings:
"Ability to practice medicine" is to be construed to include all of the following:
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) X Yes ____ No

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? (If "Yes," attach explanation on separate sheet.) X Yes ____ No ____ N/A

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No X N/A

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

X Yes _____No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

X Yes _____No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.) Supreme Court State of NY Orange County

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Date claim was closed/settled or dismissed: _____
Month/Year

Amount of judgment or settlement $ 0

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time: Physicians Reciprocal Insurers (PRI)

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Arrest Question:

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.) X Yes ____ No

Nevada License History:

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

Medical School and Postgraduate Training History:

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
SUNY Health Science Center at Brooklyn	Brooklyn, New York		7/87-6/91

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
SUNY Health Science Center at Brooklyn	Brooklyn, New York/Kings	May 16, 1991

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY-1	Mount Sinai Medical Center	New York, NY	I	General Surgery	7/1/1991- 6/30/1992
PGY-2-6	Mount Sinai Medical Center	New York, NY	R	Neurological Surgery	7/1/1992- 6/30/1997

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: _____

Examinations:

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. STATE Written Examination:

Location	Date (Mo./Yr.)	Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

(If more space is needed, please attach a separate sheet of paper.)

21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Date (Mo./Yr.)	Results (FLEX weighted average)

(If more space is needed, please attach a separate sheet of paper.)

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Step Taken	Number of Attempts	Date (Mo./Yr.)	Results (Three Digit Scores)

(If more space is needed, please attach a separate sheet of paper.)

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Part Taken	Date (Mo./Yr.)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Date (Mo./Yr.)	Results (Score)

Specialty:

22. State your scope of practice / specialty(ies) Neurological Surgery (nonsurgical since disability in 2016)

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS).** INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS.

ABMS Primary Board	Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and Recertification (Mo./Yr.)
American Board of Neurological Surgery			20026	5/1/20 Certification 1/1/11 Recertification

Activities:

24. Account for, **in chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** Activities include Postgraduate Training, Medical Practice/Physician, Non-Medical (such as seeking employment or vacation), Military Assignment, and Working at a Federal Facility. **Curriculum Vitae cannot be submitted in lieu of your answer to this question.**

Activities	Location (City/State/Country)	From (Mo./Yr.) To (Mo./Yr.)	Percent Clinical (%)
Neurosurgical Residency	New York, NY USA	7/91-6/97	100%
Hudson Valley Neurosurgery	Suffern, NY USA	7/97-8/07	100%
Maryland Brain and Spine	Annapolis, MD USA	10/07-7/09	100%
Eastern Iowa Brain and Spine Surgery	Cedar Rapids, IA USA	8/09-7/16	100%
University of Iowa College of Law	Iowa City, IA USA	8/16-6/19	0%

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.) To (Mo./Yr.)
Mercy Medical Center	701 10th Street SE Cedar Rapids, IA 52403	8/09-6/19
St. Luke's Medical Center	1026 A Ave NE Cedar Rapids, IA 52402	8/09-6/19

(All information must begin on the application, if more space is needed, please attach separate sheet.)

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26. List any and all licenses **YOU HOLD OR HAVE HELD** (including postgraduate training/resident licenses) to practice medicine in any state, territory or country. Note: You will not be required to verify your training licenses by direct source.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
Iowa	38342	6/09	Active
Maryland	66756	10/07	Inactive
Delaware	8532	10/07	Inactive
New York	192849	7/93	Inactive

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Disciplinary Questions:

27. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) X Yes ____ No

28. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of disciplinary action? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

31. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) ____ Yes X No

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____ Yes X No

(If "Yes," attach explanation on separate sheet.)

33. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
none			

(All information must begin on the application, if more space is needed, please attach separate sheet.)

Attestations/Affirmations:

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

X (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. X Yes _____ No

http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. X Yes _____ No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: David Harvey Segal

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? _____Yes X No
If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☐ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

4&5-Dates of service in the Military:
4-From: ____/____/____ (DD / MM / YYYY) **5-To:** ____/____/____ (DD / MM / YYYY)

6-Are you still serving? _____Yes _____No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

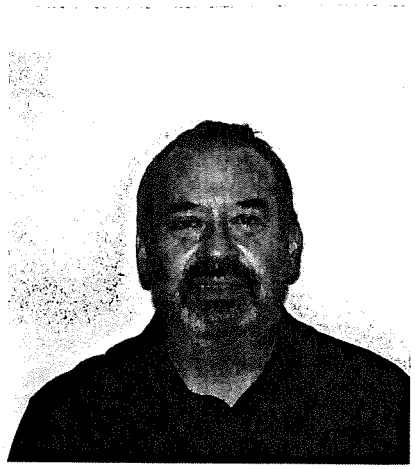
9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? _____Yes _____No _____N/A

APPLICANT PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.



I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ _____ 9/2/20
Signature of applicant **Date**

APPLICATION AFFIRMATION

I, David Harvey Segal,

(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant — **Date** 9/8/20

SUZETTE SOTO
Notary Public – California
Los Angeles County
Commission # 2184823
My Comm. Expires Feb 26, 2021

(NOTARY SEAL)

SUZETTE SOTO
Notary Public – California
Los Angeles County
Commission # 218482?
My Comm. Expires Feb 26, ?

State of CALIFORNIA County of LOS ANGELES

Subscribed and sworn to before me this 8 day of September, 2020

Notary Public for the State of CALIFORNIA

My Commission Expires: 02/26/2021

Residing at: SANTA MONICA, CALIFORNIA
City State

Signature of Notary

END OF APPLICATION

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name David Harvey Segal

Sign your name _____

Date September 2, 2020

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: David H. Segal, MD

Insurance Company: Columbia Casualty Insurers
Address: 333 South Wabash Avenue
Chicago, Illinois 6060

Phone Number:
Fax Number:
Policy Number:
Dates: October 2007 -June 2017

Insurance Company: Physicians Reciprocal Insurers
Address: 1800 Northern Boulevard
Roslyn, NY 11576

Phone Number:
Fax Number:
Policy Number:
Dates: July 1997- June 2008

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

(If more space is needed, please copy this page or attach a separate sheet.)

FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: David Segal, MD No Current malpractice insurance needed

Insurance Company: CNA
Address: 3350 Riverwood Pkwy SE
Atlanta, GA 30339

Phone Number:
Fax Number:
Policy Number:
Dates: 11/12/2007 – 7/1/2016

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:

Phone Number:
Fax Number:
Policy Number:
Dates:

(If more space is needed, please copy this page or attach a separate sheet.)