Renova Worldwide

Maternity Waiver

128 East Main Street, Emmett, Idaho 83617 *Phone: (866) 217-5806* *Internet: www.renovaworldwide.com*

Applicant Information

Please complete this Applicant Information section and the Authorization to Release Information on the back before giving this form to your medical provider.

Name:		Representative Identification Number:
Email Address:		
Primary Phone:		Alternate Phone:
Street Address:		
City:	State:	Zip Code:
Anticipated Delivery Date:		Anticipated Date of Resumption of Business Activities:

Congratulations on the impending arrival of your baby! Please allow us to congratulate you and wish you and your baby the very best! We want you to know how delighted we are for you!

In light of the fact that you have things in your life that are more important than a Renova business, we would like to extend to you the opportunity to defer all of the qualification requirements of the Renova Compensation Plan that are applicable to you during the period of three months prior to and four months following the birth of your baby.

I have carefully read the terms and conditions on the back of this Maternity Waiver. All of the statements I have made are true to the best of my knowledge and belief.

____________________________________ ____________________

Applicant's Signature Date

I understand that the Maternity Waiver is not available to me if I operate my business with a co-applicant. Mail the completed signed original Application and Agreement to: Renova, Representative Application Dept., 128 East Main Street, Emmett, Idaho 83617 or scan the front and back of this form and email it to support@renovaworldwide.com.

Physician Statement (The patient's Authorization to Release Information is on the back of this form.)

The Applicant is currently pregnant:	☐ Yes	☐ No
Date of Delivery:	☐ Actual	☐ Estimated
First date the patient was seen for this pregnancy:		

Printed Name of Physician		Specialty:
Primary Phone:		Alternate Phone:
Street Address:		
City:	State:	Zip Code:
Signature of Attending Physician		Date:

Authorization to Release Information

For the Use and Disclosure of Protected Health Information

TO: Any physician, medical practitioner, hospital, clinic or other medical or medically-related facility or provider of medical services.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all healthcare professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all healthcare professionals.

2. I authorize all healthcare professionals to disclose my protected health information.

3. I authorize only designated staff of Renova, to receive, in writing, by email, photocopy, facsimile, or by telephone, my protected health information.

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be redisclosed and would no longer be protected.

5. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Renova, 128 East Main Street, Emmett, Idaho 83617. This revocation shall become effective on the date it is received by Renova. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

I certify that I have received a copy of this Authorization to Release Information, and I authorize the use and/or disclosure of my protected health information as contemplated herein.

____________________ Signature	____________________ Printed Name	__________ Date