



Anderson/Kelly Associates, Inc.
P.O. Box 1129, Andover, NJ 07821
Fax: 973-446-2615
Tel: 973-446-2600

Request for Medical Services

PO 437721

Date: 8/3/2026 To: Passport Health- Cumming Attn: Ashley
Fax: (877) 440-1795 Phone: (770) 830-4446
From: Scheduling Pages: 4
Patient: David Adams DOB: 10/10/1982 SS#: xxx-xx-7711
Appointment Date / Time: 8/3/2026 11:30:00 AM Original Exam Date / Time: 8/6/2026 10:00:00 AM

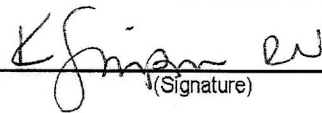
Perform only the services listed. Anderson/Kelly Associates, Inc. will not be financially responsible for any services rendered that we do not authorize in advance, unless medically necessary.

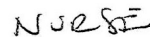
CPT Code	Service or Test
☒ 90715	Tetanus & Diphtheria Toxoids and Pertussis (Tdap)
☒ 90716	Varicella virus vaccine
☒ 90717	Yellow Fever Vaccine (Live) - YF-VAX
☒	Photocopy immunization record PHS-731 (Yellow Book), and fax to Anderson-Kelly.

PLEASE FAX EXAM RESULTS TO OUR OFFICE @ 973-446-2615 AS SOON AS THEY ARE AVAILABLE. THANK YOU.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please sign this fax as confirmation of receipt and fax to 973-446-2615,
or email to CruiseTeam@andersonkelly.com


(Signature)


(Title)

Please submit invoice for services via facsimile or mail to:
Anderson/Kelly Associates, Inc. ■ P.O. Box 1129 ■ Andover, NJ 07821

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

437721

PATIENT NAME: David Adams
DATE OF BIRTH: 10/10/1982
SOCIAL SEC. NO. xxx-xx-7711

REASON FOR AUTHORIZATION

By signing this authorization, you are permitting us to disclose health information about you to your employer and the organizations listed below. You may refuse to sign this form. Note, however, that we are providing a medical examination and/or tests to you solely for the purpose of providing the results to your employer and the organizations listed below. Therefore, if you do not sign this form, the medical exam and/or tests will not be performed.

PATIENT AUTHORIZATION

I, DAVID ADAMS, hereby voluntarily authorize:

Passport Health- Cumming
327 Dahlonega St Suite 801
Cumming, GA 30040

to use or disclose the following information:

my entire medical record, including any information relating to (if the following is part of my medical record):

- medical histories and physical examinations
- laboratory results
- radiology (x-ray) results
- communications with psychiatrists or psychologists (other than psychotherapy notes)
- drug and/or alcohol abuse/treatment
- records pertaining to sexually transmitted diseases, including AIDS/HIV infection

This information will be disclosed to:

Anderson-Kelly Associates, Inc.
65 Newton Sparta Rd, Suite 302
Newton, NJ 07860

- AND -

Norwegian Cruise Lines
7665 Corporate Center Drive
Miami, FL 33126

This Authorization Expires 120 days from the date signed.

Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new Authorization form.

CONSEQUENCES OF SIGNING THIS FORM

Signing this Authorization may cause the health information used or disclosed pursuant to this Authorization to no longer receive the protections of federal privacy laws. Any person or Organization to whom your health information is disclosed pursuant to this Authorization might be able to legally re-disclose that information to others.

REVOCATION

You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a use or disclosure. Your written revocation will become effective when we have knowledge of it. If you wish to revoke this Authorization, please send your written request to:

Passport Health- Cumming
Attn: Privacy Officer
327 Dahlonega St Suite 801
Cumming, GA 30040



PATIENT SIGNATURE

8/3/2026

DATE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information during this medical appointment. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please contact Anderson-Kelly at 973-446-2600 if you have any questions.

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1	8/3/26	YF VAX	UK 494B	OFFICIAL VACCINATION	K. J. J. R. W.
2		SANDFI		GEORGIA	
3				C-40813	
				USA	

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1	8/3/26	0.5 mL	K. J. J. R. W.	4			K. J. J. R. W.
2		U8730AA		5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENT'S IDENTIFICATION (Mechanically Imprint, Type or Print):

Adams

David

SSN xxx-xx-7711

DOB 10/10/1982

MSC-CONMAR

PO 437721

Patient's Name - last, first, middle initial;
Sex; Age or Year of Birth; Relationship to Sponsor;
Component/Status; Department/Service.

Sponsor's Name - last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1	8/3/26	VARICELLA	0.5mL	K. J. J. J.	5				
2		2012120			6				
3					7				
4					8				

SENSITIVITY TESTS (Tuberculin, etc.)

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

REMARKS:

Adams

David

SSN xxx-xx-7711

DOB 10/10/1982

MSC-CONMAR

PO 437721

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO. 2.

USAPPC V1.00

PassportHealth

Consent to Release Records

I hereby authorize and request Passport Health, and/or its affiliates, to transmit my personal health information to Anderson-Kelly Assoc.. This is an ongoing authorization and applies to the following types of records or health information:

vaccine records

I understand I have the right to revoke this consent at any time via email to accounts@passporthealthusa.com.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

David Adams
Client Name

D.A. AL
Signature

8/3/26
Date

PASSPORT HEALTH Consent Form (A = ACCEPT D = DECLINE UTD = UP TO DATE)

Initial	Vaccines	Dose #	of	
	*Hepatitis A I am not allergic to aluminum hydroxide or sodium borate.			A / D / UTD
	*Hepatitis B I am not hypersensitive to yeast.			A / D / UTD
	*Twinrix (A/B combo) I am not allergic to neomycin.			A / D / UTD
	Chikungunya LIVE I am over 18 years of age. I am not pregnant or breastfeeding. I am not allergic to any component of the vaccine.			A / D / UTD
	Cholera I have had nothing to eat or drink within the past hour and will not for 1 hour after administration. I am not allergic to any vaccine component. I have not been on antibiotics in the past 14 days.			A / D / UTD
	*HPV or *HPV 9 I do not have any severe, life-threatening allergies. I am not pregnant or breastfeeding. I am not sick today.			A / D / UTD
	Influenza I am not allergic to eggs. I am not allergic to gelatin.			A / D / UTD
	*Japanese Encephalitis I have not had a past allergic reaction to JE and am not allergic to aluminum hydroxide, vero cells, protamine sulfate, formaldehyde, bovine serum albumin, sodium metabisulphite, sucrose. Dose # of			A / D / UTD
	Measles, Mumps, Rubella (MMR) LIVE I have not had a reaction to MMR vaccine in the past. I am not allergic to neomycin, gelatin or gelatin-containing products, I am not immunosuppressed, I have not received an antibody-containing blood product in the last 11 months. I have no history of thrombocytopenia or thrombocytopenic purpura. I am not pregnant.			A / D / UTD
	Meningococcal I am not allergic to phosphate buffers (Menactra). I am not allergic to yeast (Menveo). I am not allergic to any tetanus toxoid containing vaccine (MenQuadfi).			A / D / UTD
	Meningitis B I am not allergic to latex. I do not have any severe, life-threatening allergies. I am not pregnant or breastfeeding			A / D / UTD
	Pneumococcal (PCV13, PCV15, PCV20, PPSV23): I have not had an allergic reaction after a previous dose or to a vaccine component.			A / D / UTD
	Polio I am not allergic to neomycin, streptomycin, or polymyxin B.			A / D / UTD
	*Rabies I am not allergic to chicken protein, neomycin, gelatin/gelatin-containing products, chlortetracycline, amphotericin B or ovalbumin.			A / D / UTD
	*Shingles Shingrix: I have not had a reaction to a vaccine component.			A / D / UTD
	Tetanus/Diphtheria I am not allergic to aluminum potassium sulfate.			A / D / UTD
DA	Tetanus/Diphtheria/Pertussis (Tdap) I am not allergic to latex. I do not have epilepsy or any nervous system disorder. I have not had Guillain-Barre Syndrome.			A / D / UTD
	*TICOVAC I am not allergic to any vaccine component.			A / D / UTD
	Tuberculosis Test I have not had a positive TB test in the past, I do not currently have TB to my knowledge, and I have not received a live vaccine in the last month.			A / D / UTD
	Typhoid Live (Oral) I do not have acute vomiting or diarrhea. I am not allergic to gelatin or gelatin-containing products. I have not been on antibiotics for the past 72 hours.			A / D / UTD
	Typhoid Typhim (Injectable) I am not allergic to phosphate buffers or phenol.			A / D / UTD
DA	Yellow Fever LIVE I am not allergic to eggs. I am not immunosuppressed. I do not have a history of thymus disorder or dysfunction.			A / D / UTD
DA	*Varicella LIVE I am not allergic to neomycin, gelatin or gelatin-containing products, I am not immunosuppressed, I have not received and antibody-containing blood product in the last 11 months			A / D / UTD
	*Anthrax I am not pregnant. I have never had a serious allergic reaction to a previous dose of Anthrax vaccine. I have never had cutaneous (skin) anthrax.			A / D / UTD
	Vitamin B-12 I do not have early Leber's disease (hereditary optic nerve atrophy) and cardiac disease.			A / D / UTD
	HIB I have not had a previous anaphylactic reaction to the HiB vaccine. I am not allergic to any ingredient in the HiB vaccine.			A / D / UTD
DA	I understand that all vaccines, once drawn, are non-refundable			A / D / UTD

I have been informed about the recommended vaccinations, possible side effects, and contraindications and have had the chance to ask questions. I understand the benefits and risks of the vaccination(s) and request that the vaccines indicated by "A" be given to me. I understand that all vaccines, once drawn, are non-refundable. I understand that Passport Health is not a Medicare provider, and does not have any form of insurance billing or filing of forms. I am responsible for all fees and understand that payment is due at the time of service. All vaccines have the potential to cause an adverse reaction. Even with careful screening, reactions may occur and can vary from trivial and inconvenient (e.g., soreness, itching) to severe and life-threatening (e.g., anaphylaxis). If severe and/or life-threatening reactions occur, staff will initiate PPH's EMS protocol and call 911 for assistance.

*Indicates multi-dose series — prices given are per dose.

3.4.2024

Patient Name: David Adams
Date: 8/3/26

Patient or Legal Guardian Signature: DA

10/10/32 - #22527588

Behamas - 183 days

Hx of chx box

AK5216 - password

Georgia Registry of Immunization Transactions and Services
Passport Health

Complete Immunization Record

Chart _____		Tracking Schedule: CDC/ACIP	
Client Name (L, F M): ADAMS, DAVID		Mother's Maiden Name (L, F): _____	
Birth	10/10/1982	Gend	Male
		Race: Black or African-American Ethnicity: Not Hispanic or Latino	

Primary Physician:		School:	
Count	Date Last Notice Sent:	Sharing Consent: Yes	Contact Allowed: Yes

Relationship: Self		Name (L, F): ADAMS, DAVID	
Mailing Address:			
City:	State:	ZIP	Phone: (858) 776-1198

Funding Programs/Eligibilities: Elig Not Determined/Unknown	
Insurance Providers: No Funding Programs Found	
Client Comments: No Comments Found	

Immun	Date Admin	Series	Trade Name	Mfg Code	Lot #	Bod Rt	Bod St	Provider of Information	React
COVID-19	10/05/2021	1 of 1	Janssen COVID-19	JSN	1822811	IM	LA	District 3-5 Central Health	
	03/15/2022	Booster			FK9895	IM	LD	CVS Pharmacy	

Georgia Registry of Immunization Transactions and Services
Passport Health

Complete Immunization Record

Chart		Tracking Schedule: CDC/ACIP
Client Name (L, F M):	ADAMS, DAVID	Mother's Maiden Name (L, F):
Birth	10/10/1982	Gend Male
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Primary Physician:	School:
Count	Date Last Notice Sent:
Sharing Consent: Yes Contact Allowed: Yes	

Relationship: Self	Name (L, F): ADAMS, DAVID
Mailing Address:	
City:	State: ZIP Phone: (858) 776-1198

Funding Programs/Eligibilities:
Elig Not Determined/Unknown
Insurance Providers:
No Funding Programs Found
Client Comments:
No Comments Found

Immun	Date Admin	Series	Trade Name	Mfg Code	Lot #	Bod Rt	Bod St	Provider of Information	React
COVID-19	10/05/2021	1 of 1	Janssen COVID-19	JSN	1822811	IM	LA	District 3-5 Central Health	
	03/15/2022	Booster			FK9895	IM	LD	CVS Pharmacy	

This file contains confidential information. Disclosing, copying, distributing, or taking any action in reliance on the contents of this information is strictly prohibited.

FQ: GA, DADAMS/LGA, E, GA5352046H - Received 06/09/2026 08:52:08

SOURCE: CCH

FR.GASIR0000.GA06005K4.*07G900H974.TXT
ATN/DADAMS/LGA

Georgia Crime Information Center
3121 Panthersville Road
Decatur, GA 30037
(404) 244-2639

***** CRIMINAL HISTORY RECORD *****

Produced on 2026-06-09

***** Introduction *****

This rap sheet was produced in response to the following request:

State Id Number	GA5352046H (GA)
ARN	2606-068
Purpose Code	E
Attention	DADAMS/LGA

The information in this rap sheet is subject to the following caveats:

****THIS RESPONSE IS BEING PRODUCED FOR YOUR REQUEST SENT: 2026-06-09
(GA; 2007-08-11)**

Important! Criminal history record information is obtained one of two ways: 1) by conducting an inquiry using personal identifiers such as name and date of birth (name search), or 2) by submitting fingerprint cards to the Georgia Crime Information Center (GCIC). When conducting a name search for criminal history record information, there is a possibility that the information returned belongs to a different person with the same, or similar, identifiers. In this case, a positive match of the person whose criminal history record is sought requires submission of fingerprint cards to GCIC. When conducting a fingerprint search for criminal history record information, the information returned does, in fact, belong to the individual. In this case, conducting a name search using the individual's personal identifiers would be the same information. (GA; 2007-08-11)

When the information contained in a criminal history report causes an adverse employment or licensing decision the individual, business or agency making the decision must inform the applicant of all information pertinent to the decision. The disclosure must include information that a criminal history record check was conducted, the specific contents of the record and the effect the record had upon the decision. Failure to provide all such information to the person subject to the adverse decision is a misdemeanor offense under Georgia law. Additionally, any unauthorized dissemination of this record or information herein also violates Georgia law. The plea of nolo contendere may be considered a

Severity Misdemeanor

Court Disposition (Cycle 001)
Case Number 24M-3655-A
Court Agency GA058033J FORSYTH COUNTY STATE COURT
Subject's Name ADAMS, DAVID MICHAEL

Charge 1
Charge Tracking Number 88437851132-001
Charge Literal DRIVING WHILE LICENSE SUSPENDED OR REVOKED
Statute 40-5-121; GA
NCIC Offense Code 5499
State Offense Code 5412
Severity Misdemeanor
Disposition AMENDED TO A NON-FINGERPRINTABLE CHARGE
(2025-07-15; Unknown)

***** INDEX OF AGENCIES *****

Agency FORSYTH COUNTY SHERIFFS OFFICE; GA0580000;
SHERIFF
Agency Telephone (770) 781-2222
Address 202 VETERANS MEMORIAL BLVD
CUMMING, GA 300400000

Agency FORSYTH COUNTY STATE COURT; GA058033J;
JUDGE
Agency Telephone (770) 781-2120
Address 100 COURTHOUSE SQUARE ROOM 010
CUMMING, GA 301400000

* * * END OF RECORD * * *

TRACKING: 06/09/2026, 08:52:04

- MKE: FR
- Source: CCH
- To: ROS0
- REF: ONCPEOP2R7
- ISN: 07G900H994