RESOLUTION NO. 11-07

A RESOLUTION AUTHORIZING A "THEN AND NOW" CERTIFICATE AND DECLARING AN EMERGENCY

WHEREAS, pursuant to Ohio Revised Code Section 5705.41(D), the issuance of a then and now certificate is permitted; and

WHEREAS, the Jackson City Council now desires to approve the then and now certificate

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF JACKSON, STATE OF OHIO, as follows:

Section 1. The Jackson City Council hereby authorizes and approves the Then and Now Certificate, in accordance with the material attached hereto as Exhibit "A", and made a part hereof.

Section 2. This Resolution is hereby is hereby declared to be an emergency Resolution necessary for the immediate preservation of the public peace, health, or safety of the City of Jackson, and for the further reason that the Jackson City Council must act promptly in approving the Then and Now Certificate. Therefore, this Resolution shall go into effect upon passage and approval by the Mayor, as provided in Ohio Revised Code Section 731.30.

Section 3. In the event this Resolution receives a majority vote for passage but fails to receive the required number of votes to pass as an emergency, then this Resolution shall be deemed to have passed but with no emergency clause, and shall take effect at the earliest time permitted by law.

Section 4. This Council finds and determines that all formal actions of this Council concerning and relating to the passage of this resolution were taken in an open meeting of this Council and that all deliberations of this Council that resulted in those formal actions were in meetings open to the public, all in compliance with the law.

Date: 2/20/07

Ronald B. Spaulding
PRESIDENT OF COUNCIL

Dina L Brown
CLERK OF COUNCIL

Approved:

Date: 2-20-07

MAYOR

EXHIBIT "A"

DISTRIBUTION

PT. 1-WHITE - VENDOR
PT. 2-YELLOW - FILE
PT. 3-PINK - AUDITOR

CITY OF JACKSON

145 BROADWAY STREET
JACKSON, OHIO 45640-1654

PURCHASE ORDER

DELIVER AND SHIP TO THIS DEPT. AND DIVISION

PURCHASE ORDER DATE

CONTRACT NO.

GUARANTEED DELIVERY DATE

EXCISE OR SALES TAX DO NOT APPLY TO CITY

TERMS:

CASH DISCOUNTS WILL BE FIGURED FROM DATE ACCOUNTING OFFICE RECEIVES VENDOR'S INVOICE

NAME AND ADDRESS OF VENDOR

By shipping the goods below or by acknowledging receipt of this order or by performing the work below you agree to the terms and conditions of sale which appear on the face. Any different or additional terms in your acceptance of this offer are hereby objected to.

LINE NO.	DESCRIPTION	ACCOUNT CODE	QUANTITY		UNIT PRICE	AMOUNT
001	DRUG SURVEILLANCE	711-7545-563023	1.00		.00	50.00
					TOTAL AMOUNT NOT TO EXCEED	50.00

INSTRUCTIONS TO VENDORS

1. THIS ORDER IS NOT VALID UNLESS SIGNED BY THE CITY AUDITOR FOR AVAILABILITY OF FUNDS.
2. MAIL INVOICES IN DUPLICATE TO THE ACCOUNTS PAYABLE OFFICE.
3. DELIVERY MUST BE PREPAID TO DESTINATION SHOWN ABOVE. THE CITY WILL NOT PAY FREIGHT OR EXPRESS FEES.
4. NO CHANGE MAY BE MADE IN THIS ORDER WITHOUT WRITTEN CONSENT OF THE FINANCE DIRECTOR.

AUDITOR'S CERTIFICATE

It is hereby certified that the amount of $_____ required to meet the contract, agreement, obligation, payment of expenditure for the above, has been lawfully appropriated or authorized or directed for such purpose and is in the City Treasury or in process of collection to the credit of the _____fund free from any obligation or certification now outstanding.

Feb 6 2017 _____AUDITOR

DATED

This order not valid unless City Auditor's Certificate is signed.

IMPORTANT PLEASE NOTE ▶ THE PURCHASE ORDER NUMBER MUST APPEAR ON ALL INVOICES, PACKAGES, PACKING SLIPS, SHIPPING PAPERS AND ON ALL CORRESPONDENCE

CITY OF JACKSON
Memorial Building
JACKSON, OHIO 45640
286-2201

RECEIVING FORM
63128

DATE 2-5-07

PURCHASE ORDER NO. OR RETURNED GOODS

RECEIVED FROM Ohio Valley Pkg.

PREPAID

ADDRESS

COLLECT

VIA

FREIGHT BILL NO.

	QUANTITY	ITEM NUMBER	DESCRIPTION
1	Invoice		150 lbs.
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

REMARKS: CONDITIONS, ETC.

NO. PACKAGES	WEIGHT	RECEIVED BY	CHECKED BY	DELIVERED BY

BE SURE TO
MAKE THIS RECORD
ACCURATE AND COMPLETE

PLEASE DO NOT STAPLE IN THIS AREA

CITY OF JACKSON
145 BROADWAY ST
JACKSON, OH 45640

PICA

MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

(Medicare #) | (Medicaid #) | (Sponsor's SSN) | (VA File #) | (SSN or ID) | (SSN) | (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HUTCHINSON, RANDY		HUTCHINSON, RANDY
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: JACKSON; STATE: OH	8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	CITY: JACKSON; STATE: OH
ZIP CODE: 45640; TELEPHONE (Include Area Code): (0000000000)		ZIP CODE: 45640; TELEPHONE (INCLUDE AREA CODE): (0000000000)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: CITY OF JACKSON
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 11/30/2005

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 24 07		11	01	80100		1	50 00	1				
				drug screen								
				Account #								

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN / EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
311778412	EIN [X]	13043	YES [X] NO [ ]	$ 50 00	$ 0 00	$ 50 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
HESS, MD, ROBERT A		OHIO VALLEY PHYSICIANS 1037 6TH AVE HUNTINGTON, WV 25708 304 523-0266
SIGNED: Robert A Hess MD DATE: 01/25/07		PIN# 311778412 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500.
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)