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Assessment of Victims of Child Sexual Abuse in a Rural Setting: A Successful New Program at the Ft. Duchesne Indian Health Center

P. Jane Powers, MS, RN, CS, FNP, Director, Northern Ute Native American Child Protection Telemedicine Program, Ft. Duchesne Indian Health Center, Ft. Duchesne, Utah

Child abuse and/or neglect, in its many forms, is one of the most difficult problems plaguing us in modern times. It recognizes no racial, gender, age, socioeconomic, religious, cultural, or geographic boundaries, and can rapidly exhaust both personnel and financial resources in any community. It can have a lifelong impact for both the victim and the family, from which some never recover.

Meeting the needs of these child victims and their families can be difficult at best, even for large communities where access to specialized medical care is available. The problem is further exaggerated in smaller facilities in rural or remote areas due to transportation issues, weather, geographic obstacles such as mountains, distances to the nearest city, limited availability of resources (including financial), lack of specially trained medical professionals, and many other factors.

Such problems are routinely encountered by many communities, agencies (both private and not-for-profit, from the local to the federal levels), and individual health care providers in their efforts to provide services to victims and families of child abuse/neglect. The following is an example of how one motivated nurse practitioner identified this need and took some very innovative measures to develop a new service to benefit victims of child abuse and neglect, mainly those who suffer child sexual or physical abuse.

The Ft. Duchesne Indian Health Center is located on the Uintah and Ouray (U&O) Indian Reservation in northeastern Utah, which covers approximately three million acres; the center has a user population of 4000 that included members of the Northern Ute Indian Tribe. It lies 150 miles east of Salt

Lake City over the Wasatch mountains and is nestled in an 80 mile wide valley called the Uintah Basin. The reservation has several small communities where the majority of the population resides. The two closest towns, both non-Indian, are Roosevelt, which is 8 miles to the west with a population of approximately 6000, and Vernal, which is 30 miles to the east, with a population of 7500. Denver, Colorado, is 350 miles further east.

Child abuse and neglect is a growing problem for the reservation as well as the surrounding non-Indian communities in northeastern Utah. Culturally sensitive, timely, and quality medical evaluation of young victims of child sexual abuse, in particular, has been very difficult at best. The closest facility with specialists available is Primary Children's Medical Center in Salt Lake City, 150 miles away over mountain passes that are frequently closed in the winter. Because Pri-

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Primary Children's Medical Center is a major referral center for the state of Utah, the wait for an appointment can be as long as 4 to 6 weeks. This situation also requires that the child and family leave their home community, family, friends, and other support systems to have this very sensitive examination done by an unfamiliar person in an unfamiliar, non-Indian setting. Travel expenses, including an overnight stay at times, can be a major financial burden.

Because of these significant obstacles to obtaining care, it was very obvious that the medical needs of the Ute victims/families of child sexual abuse would be better met if they could be provided locally. Through the efforts of Dr. Susan Brown (before she left IHS Headquarters West in Albuquerque, New Mexico), a colposcope with an attached 35 mm camera was obtained for the Ft. Duchesne Indian Health Center at no cost to the Service Unit. Then, a family nurse practitioner at that facility took the initiative to complete both the beginning and advanced colposcopy courses offered through the Indian Health Service to become proficient in its use and application. She also independently pursued the opportunity to complete two "mini-residencies" in the evaluation of physical/sexual abuse of children with Dr. Astrid Heger at the Center for the Vulnerable Child at Los Angeles County/University of Southern California Medical Center, and with Dr. Helen Britton of the Child Protection Team at Primary Children's Medical Center in Salt Lake City. Formal didactic training was obtained by completing the SART/SANE Certification Institute (Sexual Assault Response Team/Sexual Assault Nurse Examiner) at Cabrillo College in Santa Cruz, California. Funding for these activities came from the Phoenix Area Office of the Indian Health Service, the U&O Service Unit, and the family nurse practitioner.

These steps then allowed the Ft. Duchesne Indian Health Center to begin to do child sexual abuse examinations locally and in a timely manner, in a setting that was culturally appropriate and familiar to the child, with family and support systems close at hand. The exams were documented by colpophotography and were then hand carried to Dr. Britton at Primary Children's Medical Center for consultation and review. So came into being what has evolved into the Northern Ute Native American Child Protection Telemedicine Program.

This system was very workable, but presented several problems of its own. The 300-mile round trip to Salt Lake City to bring the photos for review by Dr. Britton required a minimum of six hours driving time, weather permitting, through mountain passes. This meant that eight hours of clinic provider time was lost, as well as the resulting revenues. Sometimes this trip had to be made more than once a month, depending on the legal urgency for interpretation of results. This became a significant problem, especially in the face of increasing clinic volume and demands.

On the same day that one of these trips was made for photo review, representatives from Computer Based Alternatives were on site demonstrating their software program called Sec-

ond Opinion®. This is a Windows®-based image communication software package that can capture high resolution color images and send them over standard communication lines to a distant location for a second opinion or consultation. It features integrated security measures, sophisticated annotation tools, and a fully customizable database. Primary Children's Medical Center was a beta test site for this software and was very excited about it. As a result of this visit, the Ft. Duchesne Indian Health Center became a beta test site. The 35 mm colposcopic photographs are scanned into a personal computer through a color scanner, and the images are sent by modem to a consultant of choice who also uses the same software. The photos can then be reviewed interactively, either immediately or at a later date.

The acquisition of this software package resolved the problems of the 300-mile round trip to Primary Children's Medical Center, the barriers of inclement weather and mountains, and lost provider time and revenues. It has also enabled the health center to develop a referral/consultant network with some of the nation's leading experts in the field of child abuse/neglect who are using this same software.

Improved relationships with leading consultants has not only led to increased credibility for each victim's case in court, but has also to increased provider skills at the local level. This has increased the quality of these services, making the Ft. Duchesne Indian Health Center a unique and pioneering clinic in the Indian Health Service, as well as in rural Utah. This program has increased the conviction rate of investigated cases on the Ute Reservation.

Since coming on-line in October 1996, approximately 45 cases have been evaluated using this system (this includes cases from the reservation, and Uintah and Duchesne Counties). The Ft. Duchesne Indian Health Center was the first facility in Utah, other than Primary Children's Medical Center in Salt Lake City, to develop this telemedicine capability. Currently, the Weber/Morgan County Children's Justice Center in Ogden, Utah is also utilizing this telemedicine program.

Since its implementation, this pilot telemedicine program has been the object of much interest, both at the local as well as the national level. The program at Ft. Duchesne, along with the one at Primary Children's Medical Center, was featured in an editorial in the May 1997 issue of *Health Data Management* magazine (Chicago, Illinois). The National Network of Children's Advocacy Centers made an educational film in spring 1997 that documented the program at Ft. Duchesne (the only rural program so documented) along with the programs at Baltimore, Maryland, and at the University of Southern California in Los Angeles. Janet Reno did the introduction, and the film will be distributed to all members of the National Network of Children's Advocacy Centers. This program at Ft. Duchesne was also presented at the Indian Health Service *Information Technology Conference 1997* in Albuquerque and at the *Tribal Telemedicine 2000 Conference* in San Diego, California.

A few problems still remain to be solved, however. Because this program is the only one of its kind in northeastern Utah and has the only specially trained personnel, the surrounding communities in a broad geographic area are looking to this program to provide services as the “expert” in this area of health care. A new Children’s Justice Center is under construction in Roosevelt, Utah (Duchesne County) to help remedy this, but more providers need appropriate training to be able to perform these delicate and technical examinations for victims in need.

This effort is just one example of how a child sexual abuse program in a community of any size, regardless of geographical constraints, can meet the special needs of victims of child sexual abuse at the local level at a reasonable cost. Since October 1996 the Ft. Duchesne Indian Health Center has realized a savings of \$20,250 (the average cost for a consultant exam was \$450/exam x 45 exams). This figure does not include mileage and per diem costs for the trips required in the

past or the lost provider productivity, and clearly shows that the program has saved more money than the total cost of the program itself.

The program also sends a clear message that efforts to combat this growing social problem are sincere and determined, and that the community as a whole will no longer stand for such crimes. The other added advantage of a program such as this is that these very sensitive examinations can be done locally where matters such as culture, religion, family, and friends could be considered in the patient’s individual care plan. It also allows these exams to be conducted in a timely manner so as to best preserve forensic evidence. Your community could have a program like this, too.

For further information, contact CDR P. Jane Powers at the Ft. Duchesne Indian Health Center, P. O. Box 160, Ft. Duchesne, Utah, 84026. Phone (800) 635-3324, Facsimile (435) 722-9137. □

Lessons Learned from a Camp for Adults with Type 2 Diabetes

Sara J. Boskovich, RN, DNSc, Director of Community Health Prevention, American Indian Health Service, Inc., and Department of Community Health Nursing, Rush University College of Nursing, Chicago, Illinois

Abstract

This quasi-experimental study examines intervention outcomes in two groups of urban Native Americans with Type 2 diabetes mellitus. The volunteer sample for both groups came from an ongoing Diabetes Surveillance Project at an urban primary care clinic. The intervention group (n = 10) attended a week long Diabetes Camp emphasizing nutrition, complications, blood sugar measurement, and treatment modalities. The control group (n = 10) received usual diabetic care. Data were collected at three points; pre-camp, immediately post-camp, and three months post-camp. Variables included (1) demographic data, diabetic history, home glucose monitoring (HGM); (2) physiological parameters: glycosylated hemoglobin (HbA_{1c}) and fasting blood sugars (FBS); and (3) the Diabetes Knowledge Survey for Native Americans (DKSNA), version 1. Daily FBS results for the intervention group showed improvement during the five-day period in camp. Pearson’s correlation coefficient revealed significant knowledge improvements pre- and post-camp (p=.001) in the camp group. There

was no significant difference between pre- and three months post-camp HbA_{1c}, as measured by the two factor repeated measures ANOVA. This culturally specific intervention was well accepted by the community.

Introduction

The idea for a summer camp for Native Americans with Type 2 diabetes mellitus and their families came from a survey conducted of patients with diabetes at an urban primary care clinic. Many patients, when questioned about their diabetes, stated “I wish you could just put me in the hospital, like the old days, where I could have regular meals and get back on track.” These statements and an article by Newman¹ in *The IHS Provider* gave us the idea to develop a week long residential camp. As an evaluation of the camp we developed a quasi-experimental study design to examine both knowledge and physiological variables before and after participation. While planning the knowledge evaluation component, it was found that no instruments existed to measure the general diabetes knowledge in this population. A short, readable, culturally appropriate instrument, the Diabetes Knowledge Survey for Native Americans (DKSNA), was designed and piloted during the program (Figure 1).

Figure 1. Diabetes Knowledge Survey for Native Americans, Version 1

Please circle the correct responses. Thank you for your participation. Date: _____

1. In uncontrolled diabetes the blood sugar is:
 - a. normal
 - b. increased
 - c. decreased
 - d. I don't know
2. Which of the following is true?
 - a. it does not matter if your diabetes is fully controlled so long as you feel all right
 - b. it is best to have a blood sugar greater than 160
 - c. poor control of diabetes could result in a greater chance of complications later
 - d. I don't know
3. The normal range for a fasting blood sugar is:
 - a. 80-120
 - b. 140-180
 - c. 180-220
 - d. 60-90.
 - e. I don't know
4. Butter is mainly:
 - a. protein
 - b. carbohydrate
 - c. fat
 - d. mineral and vitamin
 - e. I don't know
5. Rice is mainly:
 - a. protein
 - b. carbohydrate
 - c. fat
 - d. mineral and vitamin
 - e. I don't know
6. Which of these complications is usually not associated with diabetes?
 - a. changes in vision
 - b. changes in the kidney
 - c. changes in the lung
 - d. I don't know
7. Diabetics should see an eye doctor:
 - a. once a year
 - b. every five years
 - c. when needed
 - d. I don't know
8. The usual symptoms of low blood sugar include all of the following except:
 - a. abdominal pain
 - b. restlessness
 - c. feeling sweaty
 - d. shakiness
 - e. I don't know
9. You can eat as much as you like of which one of the following foods?
 - a. apples
 - b. celery
 - c. meat
 - d. honey
 - e. I don't know
10. A low blood sugar reaction is caused by:
 - a. too much insulin
 - b. too little exercise
 - c. weight loss
 - d. I don't know
11. The signs and symptoms of high blood sugar include all of the following except:
 - a. decreased thirst
 - b. increased urination
 - c. increased hunger
 - d. weight loss
 - e. I don't know
12. One of the following substitutions is wrong. Which one is it?
 - a. 1 portion (1 oz.) bread = 1/2 cup cooked rice
 - b. 1 egg = 1 small lean hamburger
 - c. 5 oz. milk = 5 oz. orange juice
 - d. 3/4 cup cornflakes = 3/4 cup cooked porridge
 - e. I don't know
13. Daily foot care includes:
 - a. checking for cuts and sores
 - b. wash and dry feet thoroughly
 - c. not going barefoot
 - d. all of the above
 - e. I don't know

Significance

Type 2 diabetes mellitus, previously referred to as non-insulin dependent (NIDDM) or adult onset diabetes mellitus, has become a health problem of catastrophic proportions in the Native American population. What was once described as a benign disease is now a leading cause of morbidity and mortality in this population.^{2,3,4} Knowledge, attitudes, and beliefs all impact the self-management of diabetes in Native Americans.^{5,6,7} If an assessment of clients' knowledge of diabetes mellitus could be made accurately and early, practitioners working with Native Americans would be able to help patients self-manage and control their disease better. Early intervention can enable patients to recognize the symptoms of poor control and forestall and even prevent morbidity, mortality, and other complications.⁸

Intervention

The intervention consisted of a week-long residential camp. The daily schedule included a fasting morning blood sugar followed by morning prayer; portion and calorie controlled meals and snacks (1400 calories per day); scheduled exercise (boating, swimming, walking); quiet time; and learning modules such as "Complications" and "Spirituality and Traditional Healing." Staff included a community health nurse, a community health worker, a spiritual advisor, and a variety of invited speakers.

Methods

The research questions for this study were: (1) did the camp group experience significant changes in fasting blood sugar during camp week? (2) were there significant changes in knowledge about diabetes between the camp and the control group, pre- and post-camp? and (3) were there significant changes in glycosylated hemoglobin (HbA_{1c}) over time, between the camp and the control groups?

The setting for this study was a YMCA camp. The study was open to clients enrolled in the Diabetes Registry (n = 82) at the clinic. Participation in both the camp and the control group was voluntary, and informed written consent was obtained. The timetable included the administration of the DKSNA and the collection of a blood sample for a HbA_{1c} during the week prior to camp in both the camp and the control group. Three months after the intervention, the DKSNA was repeated in the camp group, and HbA_{1c}s were drawn from all participants. The post-test was not repeated in the control group because of difficulty in tracking them.

Results

A convenience sample (n = 20) of adult urban Native Americans with Type 2 diabetes participated in the study. In the camp group there were 7 females, and in the control group there were 9. In the camp group 60% were receiving oral hypoglycemics, while in the control group 50% had been so treated. Seven tribes were represented in the combined sample; 70% had completed high school and 80% had an income less than \$10,000. Using the independent samples t test, there were no significant differences between the groups in the variables examined in Table 1.

Table 1. Sample characteristics

	Camp group (n=10)	Control group (n=10)	p
Age	53.5 ± 13.8 years	51.8 ± 7.9 years	0.069
Age at diagnosis	45.2 ± 12.6 years	38.8 ± 8.0 years	0.519
Duration of diagnosis	8.3 ± 7.0 years	8.8 ± 5.6 years	0.751
HbA _{1c} pretest	8.53 ± 1.7%	9.86 ± 2.3 %	0.451
DKSNA pre-test score	8.70 ± 2.31	9.0 ± 1.94	0.767

During the five day camp, mean fasting glucose levels fell from 175 to 128 mg/dl, as seen in Table 2. To examine differences in daily blood glucose by participant, a statistical test, the one factor repeated measure ANOVA was used. The results suggested that the differences in daily blood sugars by camper did not occur by chance (p < 0.001).

Table 2. Individual campers' fasting blood sugars

CAMPER	MON	TUE	WED	THU	FRI
CS	217	216	209	196	175
DN	179	130	133	140	126
EA	190	183	171	151	153
MR	51	90	91	80	80
GS	183	215	186	155	109
WN	145	174	160	149	142
RL	206	258	248	192	146
WF	128	87	126	87	77
JS	138	107	119	120	99
LM	315	257	199	188	176
Mean	175	172	164	146	128

As anticipated there was no significant difference (p = .757) between camp and control groups in the diabetes knowledge pre-test; however in the camp group there was a significant difference (p= .001) in knowledge scores, comparing pre- to post-camp, as examined using Pearson's correlation coefficient. In both groups, post-camp HbA_{1c} results were elevated: the control group HbA_{1c} was 9.03 ± 2.11, and the camp group HbA_{1c} was 9.34 ± 1.95. T tests for paired samples revealed no difference between groups.

Discussion

Limitations of this study included the small sample size and the effect of history. There were several valuable lessons learned, including a better understanding by the community health staff of the importance of teaching portion control, pre-camp nutrition education, and the need for participant evaluation.

The clients were very enthusiastic about the camp and attended all work sessions. An unexpected finding during the study was the disregard for portion control. Although individual servings of the main dish were served, the salad bar was open, and campers filled their plates with everything on the salad bar. This was explained by one participant who said "we have a history of [being hungry]; when this much food is available . . . we take advantage of it." Participants told stories of deprivation and the forced use of commodity items. That diabetes imposes a further deprivation, in a cultural sense, was not recognized by this clinician. Portion control was seen by the participants as an imposition. The children who joined their parents were encouraged by the participants to eat as much as they wanted (they were not considered by the participants to be a part of the "diabetes camp"). The necessity for camp-specific nutrition education before camp had not been recognized. For example, we could have discussed together the menus and made choices before camp, and we should also have reviewed portion control. People in the community still tell stories about how small the hamburgers were!

Conclusions

In conclusion, the residential camp was a great success.

There were new opportunities for exercise; participants saw the results of the nutrition intervention every morning when their blood sugar was tested; improved knowledge scores supported the participants' comments about learning a lot; and there was a chance for all to be spiritually reawakened. □

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MEETINGS OF INTEREST □

Fetal Alcohol Syndrome

Two identical sessions: May 27-29, 1998, and June 10-12, 1998 Seattle, Washington

This conference is cosponsored by the University of Washington Fetal Alcohol and Drug Unit, the University of Washington FAS Diagnostic and Prevention Network, and the Indian Health Service. Native Americans or those working with Native Americans are eligible, including professionals (physicians, psychiatrists, psychologists, social workers, nurses, teachers, CHNs, chemical dependency counselors, lawyers, judges, etc.) as well as advocates and parent activists. Six trainees will be selected for each session by the IHS Alcohol and Substance Abuse Program, HQW. Costs for lodging and most meals will be paid for by the UW Fetal Alcohol and Drug Unit. Costs for travel to and from Seattle, airport transfers, and some meals are the responsibility of the attendees or their organizations.

The curriculum includes 1) preventing and overcoming secondary disabilities in people with FAS and FAE across the lifespan (1 day); 2) preventing FAS with the Birth to Three Advocacy Model for working with very high-risk mothers and their families (1 day); and 3) demonstration of a multidisciplinary FAS Diagnostic Clinic and its relevance for community inter-

ventions, parent advocacy, and prevention (1 day).

The faculty includes Ann Streissguth, PhD; Sterling Clarren, MD; Robin LaDue, PhD; Therese Grant, PhD; and others from the Fetal Alcohol and Drug Unit and the FAS Diagnostic and Prevention Network. To apply, provide a description of past experience related to FAS and plans for the utilization of this training in Indian communities. Send your application to Timothy Taylor, PhD, Health Researcher, Alcoholism and Substance Abuse Program, IHS Headquarters West, 5300 Homestead Road, NE, Albuquerque, NM 87110. For more information, please contact Timothy Taylor at (505) 248-4125; fax (505) 248-4129; or e-mail iltaylor@smtp.ih.gov.

Mid-Level Primary Care Providers

June 2-5, 1998 Phoenix, Arizona

This conference for mid-level providers (physician assistants, nurse practitioners, and pharmacist practitioners) employed by the Indian Health Service or Indian health programs will offer 20 hours of continuing education designed to meet the needs of those providing primary care to American Indians and Alaska Natives. There will be a registration fee of \$150 of those employed by compacting tribes or those in the private sector. For additional information, contact the IHS Clinical



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