COUNTY MEDICAL LIEN

FOLLOW INSTRUCTIONS

Instructions:

1. Please type and sign this form in black.
2. File only the original. Make copies for your file. The original will be returned as your acknowledgment.
3. Enter only one debtor's name or assumed name per debtor block exactly as it is to be indexed. If more than four names, use an attached sheet.
4. When the obligation has been satisfied, complete the Termination Statement and return the original to the filing officer.

Mail to: Secretary of State
UCC Division
450 N 4th Street
PO Box 83720
Boise ID 83720-0080

Telephone: 208-334-3191

Name or business name of each debtor against whom the lien is claimed, and the address of each.

1 Organization or Indiv. Last Name	First Name	Middle Name		Suffix
Address	City	State	Zip	
2 Organization or Indiv. Last Name	First Name	Middle Name		Suffix
Address	City	State	Zip	
3 Organization or Indiv. Last Name	First Name	Middle Name		Suffix
Address	City	State	Zip	
4 Organization or Indiv. Last Name	First Name	Middle Name		Suffix
Address	City	State	Zip	

Secured Party Name and Address

Organization or Indiv. Last Name	First Name	Middle Name	
Address	City	State	Zip

Assignee Name and Address

Organization or Indiv. Last Name	First Name	Middle Name	
Address	City	State	Zip

Acknowledgment Name and Address, if not Secured Party

Organization or Indiv. Last Name	First Name	Middle Name	
Address	City	State	Zip

This financing statement covers the following types or items of property:

Signature of Secured Party:

TERMINATION STATEMENT

The Secured Party no longer claims a security interest under the financing statement.

Signature of Secured Party / Assignee of Record

Date