DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville, MD 20857

NOTICE OF INITIATION OF DISQUALIFICATION PROCEEDINGS AND OPPORTUNITY TO EXPLAIN (NIDPOE)

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Manuel Macapinlac, MD
65-47 110th Street, 1st Floor
Forest Hills, NY 11375

Dear Dr. Macapinlac:

Between September 24, 2007 and October 24, 2007, CAPT Robert Steyert and Mr. Thomas Hanson, representing the Food and Drug Administration (FDA), conducted an investigation and met with you to review your conduct of the following clinical investigations:

Protocol (b) (4) entitled "A Phase II, Prospective, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Multicenter Study of (b) (4) Therapy for (b) (4) of the investigational drug, (b) (4), performed for (b) (4).

Protocol (b) (4) entitled "A Phase II, Multi-Center, Open-label Study of (b) (4) in Subjects with (b) (4) Cancer (b) (4) Previously Treated with At Least One Prior Chemotherapy Regimen" of the investigational drug, (b) (4), performed for (b) (4).

Protocol (b) (4) entitled "An Open Label, Repeat Dose, Randomized, Two Period Crossover Study to Investigate the Potential Pharmacokinetic Interactions Between Oral (b) (4) and Intravenous (b) (4) in Cancer Patients" of the investigational drug (b) (4), performed for (b) (4).

This inspection is a part of the FDA's Bioresearch Monitoring Program, which includes inspections designed to evaluate the conduct of research and to ensure that the rights, safety, and welfare of the human subjects of those studies have been protected.

At the conclusion of the inspection, FDA investigators presented and discussed with you the items listed on Form FDA 483, Inspectional Observations. We have reviewed the inspection report and the documents submitted with that report.

Based on our evaluation of information obtained by the Agency, we believe that you have repeatedly or deliberately submitted false information to the sponsor and/or FDA in required reports and repeatedly or deliberately violated regulations governing the proper conduct of clinical studies involving investigational products under 21 CFR Part 312.

This letter provides you with written notice of the matters under complaint, and initiates an administrative proceeding, described below, to determine whether you should be disqualified from receiving investigational products as set forth under 21 CFR 312.70.

A listing of the violations follows. The applicable provisions of the CFR are cited for each violation.

1. **You repeatedly or deliberately submitted false information to the sponsor in a required report [21 CFR 312.70(a)].**

   Protocol (b) (4) specified that subjects were to be distributed patient daily diary cards every 4 weeks, beginning with Week 0, and ending on Week 53. Per the protocol, patients should only have received one set of diary cards for each four-week period. However, during its inspection, FDA discovered that your records contained multiple diary entries for the same subjects on the same dates. Furthermore, the information you reported to the CRF excluded some of the data from one or more sets of patient diaries. This is a violation of 21 CFR 312.70.

   Protocol (b) (4) specified that the study coordinator was to review the patient diary cards with the patient during each scheduled visit and, if possible, query the patient to obtain any missing information at the scheduled visit. Thus, patient diaries should have only contained dated entries for dates that occurred between two scheduled visits.

   The daily diary cards included information concerning whether the subject took the doses of medication in the morning and the evening (diary question #1), whether any concomitant medications were taken (diary question #2), the name of the concomitant medication taken (diary question #3), usual daily activity interruptions due to (b) (4) pain (diary question #4), whether any medical facility was visited due to (b) (4) pain (diary question #5), the name of the medical facility visited (diary question #6), and the daily pain level experienced on a scale of 0 to 10 (diary question #7). Per the protocol, information in patient diary cards was to be recorded onto the appropriate case report form (CRF).

   FDA's audit identified that 2 of 12 subjects enrolled in the study, Subjects #003 and #010, had two sets of patient diaries which contained different information for the same dates. From our review of the two sets of patient diaries, we were unable to determine which diary provided the correct information. In addition, we note that the information reported to the CRF was either (1) obtained from one diary but not the other, or (2) could not be verified in our review of either version of the duplicate

diaries' entries for specified dates. The discrepancies we observed included, but were not limited to, the following:

a. For Subject #003, source records indicated that his/her Week 4 visit (i.e. visit 3) occurred on July 22, 2005, and his/her Week 8 visit (i.e. visit 4) occurred on August 12, 2005. Thus, patient diaries that covered the time period between these two visits would have been collected on August 12, 2005, during the Week 8 visit. FDA's investigation found that there were two different diaries that contained different information for the dated entries that occurred between July 22, 2005 and July 28, 2005. We were unable to confirm how you determined which diary contained the correct information, and/or where you derived the information that was reported to the CRF.

One patient diary listed the start date as July 22, 2005 and the stop date as August 5, 2005. The first page of this diary stated that the diary was to be brought back to your site on August 19, 2005. Information in the diary for the dates of July 22, 2005 through July 28, 2005 only showed a checkmark in response to question #1, noting that the subject took medication in the morning. There were no other answers provided within the diary for any other remaining diary questions. These included, but were not limited to, diary question #4, which asked whether the subject's daily activity was interrupted due to (b) (4) pain, or diary question #7, concerning the level of pain experienced.

The second patient diary for this same time period listed the start date as July 15, 2005 and the stop date as July 28, 2005. Per the first page of this diary, the diary was to be brought back to your site on July 22, 2005, which would have been prior to the stop date noted on the diary card. Information in the diary for the dates of July 22 through July 28, 2005 showed checkmark responses for diary question #1, noting that the subject took medication in the morning. There were also checkmark responses to diary questions #2, #4 and #5. There was no written documentation within the diary card on these dates that answered diary question #7, concerning the level of pain experienced.

The CRF for the Week 8 visit noted that during this covered time period, the number of days the subject's daily activity was interrupted due to (b) (4) pain since the last visit was 00 (i.e. diary question #4) and the subject had experienced 21 days of 00 pain on the pain scale (i.e. diary question #7). The patient diary provided the sole source documentation for this information, so it is unclear from where the CRF information was derived. FDA was unable to determine where you obtained the information documented in the CRF, or how you reconciled the conflicting data contained in the two patient diaries.

b. For Subject #010, we identified two different sets of patient diaries that covered the time period between the Week 16 visit (i.e. Visit 6) on January 3, 2007 and the Week 20 visit (i.e. Visit 7) on February 5, 2007. FDA's investigation identified two sets of diaries for the following dates: (1) January 3, 2007 to January 16, 2007; (2) January 17, 2007 to January 30, 2007; and (3) January 31, 2007 with no stop date. In FDA's comparison of the two sets of patient diaries, we noted numerous discrepancies where information placed in one patient diary was different than the information placed into the duplicate diary for the corresponding dates. We were unable to determine which, if either, of the two diaries contained the correct information. In addition, we note that in many cases, information reported to the CRF could be traced to (1) either one or the other diary or (2) to neither one of the diaries.

In both of these cases, the identification of two sets of patient diaries raises significant concerns regarding the study's conduct and the integrity of the data collected from your site.

2. You failed to personally conduct or supervise the clinical investigations [21 CFR 312.60].

When you signed the investigator statements (Form FDA 1572) for the above referenced clinical investigations, you agreed to take on the responsibilities of a clinical investigator at your site. Your general responsibilities (21 CFR 312.60) include ensuring that the investigation is conducted according to the signed investigator statement, the investigational plan, and applicable regulations; protecting the rights, safety and welfare of subjects under your care; and ensuring control of drugs under investigation. You specifically agreed to personally conduct the clinical studies or to supervise those aspects of the studies that you did not personally conduct. While you may delegate certain study tasks to individuals qualified to perform them, as clinical investigator, you may not delegate your general responsibilities. Our investigation indicates that your supervision of personnel to whom you delegated study tasks was not adequate to ensure that clinical trials were conducted according to the signed investigator statement, the investigational plan, and applicable regulations, and in a manner that protected the rights, safety, and welfare of human subjects.

We note that your failure to adequately supervise this study led to significant problems identified with the conduct of the studies. For example,

a. With respect to Protocol (b) (4), we noted the following:

i. Your initials were present on many source documents, including those documenting physical examinations conducted during study-related office visits. This created the appearance that you examined these subjects and/or personally performed these study-related procedures. For 5 of 12 subjects, however, FDA's investigation found that, in many instances, you were on

leave during the times of these visits, and thus could not have performed the evaluations. In addition, you informed FDA investigators that you did not authorize anyone else to initial these documents on your behalf. These examples include, but are not limited to, the following:

1. Subject #004 had his/her Week 8 visit on July 18, 2006. The progress note for this subject's visit was signed only by your study coordinator, (b) (6) . Your initials (i.e. MM) and the date "7/18/06" were found on other source records for this subject's visit. We note, however, that you were on leave during the time of this visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

2. The following observations were noted with respect to the records for Subject #005:

   a. Subject #005 had his/her Week 8 visit on July 19, 2006. The progress note for this subject's visit was signed only by your study coordinator, (b) (6) . Your initials (i.e. MM) and the date "10/10/06" were found next to the physical exam portion of other source records for this subject's visit. We note, however, that you could not have performed the physical exam on "10/10/06," as this subject's visit occurred on July 19, 2006. In addition, we note that you were on leave during the time of the Week 8 visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

   b. Subject #005 had his/her Week 24 visit on November 21, 2006, and his/her Week 28 visit on December 12, 2006. The progress notes for these visits were signed only by your study coordinator, (b) (6) . The initials (b) (6) appear next to the physical exam section of these source documents. Your initials ("MM"), however, are overwritten over someone else's initials in the line "Investigator Initials." We note, however, that you could not have attended the visits on November 21 and December 12, because you were on leave during the time of these visits.

   c. Subject #005 had his/her Week 36 visit on January 29, 2007. The progress note for this subject's visit was signed only by your study coordinator, (b) (6) . Your initials ("MM") were found on the source records for this subject's visit. We note, however, that you were on leave during the time of this visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

3. Subject #008 had his/her Week 28 visit on December 4, 2006. The progress note for this subject's visit was signed only by your study coordinator, (b) (6). Your initials ("MM") and the date "12/4/06" were found on the source records for this subject's visit. We note, however, that you were on leave during the time of this visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

4. Subject #009 had his/her Week 4 visit on August 1, 2006. The progress note for this subject's visit was signed only by your study coordinator, (b) (6). Your initials ("MM") were found on the source records for this subject's visit. We note, however, that you were on leave during the time of this visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

5. Subject #012 had his/her Day 0 visit on November 15, 2006. The progress note for this visit was signed only by your study coordinator, (b) (6). Your initials ("MM") with the date of 11/15/06 were found on the source records for this subject's visit. We note, however, that you were on leave during the time of this visit. Thus, you could not have participated in the subject's examination nor initialed the documents at the time of the examination.

You informed FDA investigators that although you did not authorize anyone to initial any of the above-referenced documents on your behalf, you acknowledged that you observed that other individuals had signed your initials on numerous case records. You further acknowledged to FDA investigators that you failed to recognize this in a timely manner, and you also failed to report, correct and prevent the recurrence of this unauthorized use of your initials.

ii. FDA's review of the study's laboratory reports identified that, for 8 of 12 subjects, the reports: (1) were not documented as having been reviewed by anyone; (2) there were significant delays in review of the laboratory reports; and/or (3) there were discrepancies with the dates on the lab reports documenting when they were reviewed.

You informed FDA investigators that, during the dates when you were not at the hospital, you remotely accessed the subjects' electronic medical records in order to review their laboratory results. However, during FDA's review of the (b) (6) Medical Center's electronic records, which documents when an individual remotely accesses a subject's record, FDA was unable to confirm your assertion that you reviewed these subjects' records remotely on the dates noted on several laboratory reports. FDA further notes that some electronic

records indicated that no one at your investigative site reviewed these subjects' records on the dates documented on the laboratory reports.

For example,

1. The laboratory reports for visits that occurred on December 15, 2006 and January 3, 2007 for Subject #010 did not include any written documentation that they were reviewed by you or your sub-investigators.

2. The laboratory report for the visit that occurred on November 21, 2006 for Subject #005 was not documented as having been reviewed until February 6, 2007.

3. The laboratory report for a January 4, 2007 visit for Subject #004 shows a handwritten signature with the date of February 7, 2007, indicating an electronic review on January 4, 2007. However, FDA's review of the (b) (6) Medical Center's electronic records could not verify that any individual listed on your site's clinical site authorization list electronically reviewed this subject's record on January 4, 2007.

4. The laboratory report for an October 31, 2006 visit for Subject #006 shows what appears to be your handwritten signature with the date of November 15, 2006 and an evaluation of NCS (i.e. not clinically significant). However, in FDA's review of the (b) (6) Medical Center's electronic records, we note that no one listed on your site's clinical site authorization list electronically reviewed this subject's record on November 15, 2006. In addition, we note that documents provided to FDA during its inspection stated that you were on leave on the date documented on the laboratory report. Thus, you could not have reviewed the subject's records on that date.

Your lack of oversight over these studies, particularly with regard to conflicting documentation of laboratory reports, raises significant concerns regarding subject safety.

iii. According to the study's monitoring reports, the monitor repeatedly instructed you and your study coordinators to sign and date the progress reports of physical exams as verification that you personally conducted them, even if you dictated the progress reports to your study coordinators. However, FDA reviewed several of the progress reports written by your study coordinators, and there was no documentation regarding who had performed the subject's evaluation, including the physical exam, during study visits. Also, as noted in item 1.a.i. above, while your initials appeared on source documents for many of the study visits, we note that you were not present at the site during these visits, and thus could not have performed these physical examinations. The only individuals whose names appeared on these progress reports were your

study coordinators; therefore, it appears that they conducted the study evaluations. We note that your study coordinators were not certified or licensed within the U.S. to conduct study-related evaluations, and per the clinical site authorization, they were not authorized to perform these evaluations.

b. You informed FDA investigators that you personally examined and evaluated study subjects and verified their eligibility for the study. We were unable to validate your assertion, because your initials and/or signature were found on many source documents during times when you were on official leave from the site. In addition, there was a lack of written documentation indicating that you reviewed certain study reports. Examples include, but are not limited to, the following observations regarding Protocol (b) (4) :

   i. For Subject #111, source documents for a screening visit that occurred on July 25, 2006 appear to have been signed by you, and were dated "7/25/06." We note, however, that you were on leave on the date of this visit.

   ii. For Subject #107, there was no written documentation on the laboratory report for the visit that occurred on March 24, 2006 that indicated that you reviewed the results of this report.

You acknowledged to FDA investigators that you had lost control over the studies and were unable to effectively manage them. You further informed FDA investigators that you were unaware of the status of the studies during your absence. We wish to emphasize again that, as the clinical investigator, it was your ultimate responsibility to ensure that the studies were conducted properly and in compliance with FDA regulations, in order to protect the rights, safety and welfare of study subjects. In our review of the inspectional report and the documents submitted with that report, we note that you failed to have such adequate involvement and oversight over the studies. Your failure to adequately supervise the studies resulted in the submission of false information to FDA and/or the sponsor in required reports, in violation of 312.70(a).

3. You failed to conduct the studies, or ensure they were conducted, according to the investigational plan [21 CFR 312.60].

a. The following violations were noted with respect to Protocol (b) (4) :

   i. The protocol specified that, in order to be included in the study, a subject was to have had at least two episodes of painful crises within 12 months of the screening visit. Subject #006 was enrolled into the study on April 14, 2006. A source document dated after the subject's enrollment into the study noted that the subject had not had any crises since the subject moved to the United States in 2002.

   ii. The protocol specified that subjects were to be distributed patient daily diary cards every 4 weeks, beginning with Week 0 and ending on Week 53. The diaries should have been exchanged at your site every 4 weeks. Thus,

patient diaries should only have contained four weeks of dated entries that covered the time period between the subjects' visits. However, when FDA reviewed the diaries for Subject #003, it found several patient diaries with dated entries that spanned the time period before and after the date of an office visit. For example:

1. Subject #003's Week 4 visit (i.e. Visit 3) occurred on July 22, 2005, and his/her Week 8 visit (i.e. Visit 4) occurred on August 12, 2005. As noted previously, there were two patient diaries that contained duplicate dated entries with different responses for several dates within these two diaries. It was noted that one of the patient diaries, which listed the start date as 7/15/05 and stop date as 7/28/05, had dated entries that covered the time period both before and after the Week 4 visit.

2. Subject #003 had his/her week 36 visit (i.e. visit 11) on March 3, 2006. In the patient diary which listed the start date as February 20, 2006 and the stop date as March 5, 2006, there were dated entries and responses to the diary questions that covered the time period before and after the week 36 visit. We further note that the responses for the dates of March 4 and March 5 were subsequently crossed out with the notation "cancelled." FDA's investigation found that, in a different diary, the dates of March 4 and March 5 were repeated, and the subject's responses for the concomitant medications taken on these two dates differed between the diaries.

b. The following violations were noted in reference to protocol (b) (4):

i. The protocol specified that, at the baseline visit, subjects were to be re-evaluated to assess eligibility to remain in the study. Among other inclusion criteria, a subject's eligibility into the study required that the subject's serum (b) (4) level be < 50 ng/dL. We note that the laboratory report for the sample collected on April 20, 2006 showed that Subject #1546001's total (b) (4) was 409 ng/dL. We note that this subject was subsequently treated with study drug on April 26, 2006.

ii. The protocol specified that the screening period was to be completed within 28 days prior to the administration of (b) (4) in Cycle 1, and that after obtaining informed consent, the subject was to undergo assessments which included a bone scan. There was no documentation that a bone scan was performed on Subject #1546001 until May 15, 2006, which was after the time in which the subject had already received the first dose of study medication (i.e. April 26, 2006).

c. In reference to protocol (b) (4), the protocol specified that, in order to be included in the study, the subject was to have adequate haematologic and other physiological organ function as evidenced by several factors, including AST and ALT levels less than two times the upper limit of the reference range (i.e. 1- 40 U/L). We note that Subject # 108's lab report for the screening visit on May 22, 2006 showed that the subject's AST (i.e. 83 U/L) and ALT (i.e. 94 U/L) levels were two times greater than the upper limit of the reference range. We note, however, that this subject was enrolled into the study.

4. You failed to maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual [21 CFR 312.62(b)].

a. The following violations were noted in reference to Protocol (b) (4) for 4 of 12 subjects enrolled:

i. The following were noted in the review of records for Subject #001:

1. There were 4 versions of the CRF for the General Medical History for Visit 1 (Week 4) for Subject #001, with each version adding a new disease or condition. Source documents could not validate where the added diseases or conditions came from.

2. Two different versions of page 2 of the Visit 1 source documents were found for Subject #001. Each version contained slightly different information.

ii. Per the patient enrollment log, Subject #007 was screened for enrollment into the study on May 4, 2006. FDA's audit of this study found no records for Subject #007.

iii. The CRF and the enrollment log noted that Subject #008 had his/her Week 0 visit on May 19, 2006. The patient diary for this subject, however, included responses that started on May 14, 2006, which was 5 days before the date of Week 0 visit (i.e. May 19, 2006). This is the date when the diary would have been initially distributed to the subject.

iv. It was noted that Subject #009 had labs drawn on November 27, 2006. However, the corresponding lab report was dated November 23, 2006, prior to the subject's labs being drawn. We were unable to determine who signed this lab report, as the signature did not match any of your investigative staff's signatures, per the clinical site authorization list for this study.

b. With respect to Protocol (b) (4), FDA found discrepancies regarding the date when Subject #111 enrolled into the study. Source documents noted that the subject signed the informed consent document to be enrolled into the study on July 25, 2006, and at that time, laboratory samples were collected. The enrollment

log initially showed that the subject was enrolled into the study on July 25, 2006. However, this was crossed out, and the date of August 2006 was entered as the date enrolled. The enrollment log also reported that the subject was screened on August 2, 2006.

5. You failed to maintain adequate investigational drug disposition records with respect to quantity and use by subjects [21 CFR § 312.62(a)].

The following was noted for Protocol (b) (4):

a. There were several dispensation logs for Subject #001 containing different information for the same date. Specifically, one log noted that on September 27, 2005, the subject was dispensed 200 packets of investigational drug. On two other logs, it was noted that on September 27, 2005, the subject was dispensed 220 packets of investigational drug.

b. For many entries in the investigational drug disposition records for Subject #110, the amount of investigational drug returned to the site did not equal the amount that was dispensed. There was no indication on the log as to why there was a discrepancy. For example,

   i. On October 11, 2006, the subject was dispensed 150 packets of investigational drug. On November 7, 2006, the subject returned 124 packets of investigational drug. There were 26 packets of investigational drug that were not accounted for on the investigational product accountability form.

   ii. On March 20, 2007, the subject was dispensed 150 packets of investigational drug. On April 17, 2007, the subject returned 140 packets of investigational drug. There were 10 packets of investigational drug that were not accounted for on the investigational product accountability form.

This letter is not intended to be an all-inclusive list of deficiencies with your clinical studies of investigational products. It is your responsibility to ensure adherence to each requirement of the law and relevant regulations.

On the basis of the above listed violations, FDA asserts that you have failed to protect the rights, safety and welfare of subjects under your care, repeatedly or deliberately submitted false information to the sponsor in a required report, and repeatedly or deliberately failed to comply with the cited regulations, which placed unnecessary risks to human subjects and jeopardized the integrity of data. Therefore, the FDA proposes that you be disqualified as a clinical investigator. You may reply to the above stated issues, including an explanation of why you should remain eligible to receive investigational products and not be disqualified as a clinical investigator, in a written response or at an informal conference in my office. This procedure is provided for by regulation 21 CFR 312.70.

Within fifteen (15) days of receipt of this letter, write or call me at 301-796-3150 to arrange a conference time or to indicate your intent to respond in writing.

Should you choose to respond in writing, your written response must be forwarded within thirty (30) days of receipt of this letter.

Your reply should be sent to:

Leslie K. Ball, M.D.
Director
Division of Scientific Investigations
Office of Compliance
Center for Drug Evaluation and Research
Food and Drug Administration
Bldg. 51, Rm. 5342
10903 New Hampshire Avenue
Silver Spring, MD 20993-0002

Should you request an informal conference, we ask that you provide us with a full and complete explanation of the above listed violations. You should bring with you all pertinent documents, and a representative of your choice may accompany you. Although the conference is informal, a transcript of the conference will be prepared. If you choose to proceed in this manner, we plan to hold such a conference within 30 days of your request.

At any time during this administrative process, you may enter into a consent agreement with FDA regarding your future use of investigational products. Such an agreement would terminate this disqualification proceeding. Enclosed you will find a proposed agreement between you and FDA.

The FDA's Center for Drug Evaluation and Research (the Center) will carefully consider any oral or written response. If your explanation is accepted by the Center, the disqualification process will be terminated. If your written or oral responses to our allegations are unsatisfactory, or we cannot come to terms on a consent agreement, or you do not respond to this notice, you will be offered a regulatory hearing before FDA, pursuant to 21 CFR 16 (enclosed) and 21 CFR 312.70. Before such a hearing, FDA will provide you notice of the matters to be considered, including a comprehensive statement of the basis for the decision or action taken or proposed, and a general summary of the information that will be presented by FDA in support of the decision or action. A presiding officer who is free from bias or prejudice and who has not participated in this matter will conduct the hearing. Such a hearing will determine whether or not you will remain entitled to receive investigational products.

You should be aware that neither entry into a consent agreement nor pursuit of a hearing precludes the possibility of a corollary judicial proceeding or administrative remedy concerning these violations.

At any time during this administrative process, you may enter into a consent agreement with FDA regarding your future use of investigational products. Such an agreement

would terminate this disqualification proceeding. Enclosed you will find a proposed agreement between you and FDA. To enter into this agreement, you must:

(1) initial and date each page of this Agreement,
(2) sign and date the last page of this Agreement, and
(3) return this Agreement initialed, signed and dated to the signature below.

A copy of the fully executed Agreement will be mailed to you.

Sincerely yours,

{See appended electronic signature page}

Leslie K. Ball, M.D.
Director
Division of Scientific Investigations
Office of Compliance
Center for Drug Evaluation and Research
Food and Drug Administration

Enclosures:
#1 - Consent Agreement
#2 - 21 CFR 16
#3 - 21 CFR 312.60
#4 - 21 CFR 312.70

This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.

/s/

LESLIE K BALL
02/23/2009