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FOR LICENSEE

By _____
(signature of authorized representative)

Typed Name _____

Title _____

Date _____

FOR JOHNS HOPKINS UNIVERSITY

By _____
(signature of authorized representative)

Typed Name: _____

Title: _____

Date _____

Reminder: Payment should accompany signed Agreement and be made to "Johns Hopkins University", c/o Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, Suite W1100, Baltimore, Maryland 21205-1996, Attention: D. Alper. Email: LipitzCenter@jhsph.edu. Phone: 410-955-6546.

12/10/04