Health Care Provider Information	Team # (Trip Date)
Name (Last, First, Middle)	Primary Phone Number
Profession	Specialty
Are you Board Certified? Y / N Board Eligible? Y / N Board Certification Date:	

States in which you hold valid registration or licenses:

State	License Number	Expiration Date
State	License Number	Expiration Date
State	License Number	Expiration Date

1. Have you ever had a professional license revoked or suspended?	Yes	No
2. Has your employment or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, limited, or not renewed at any health care facility?	Yes	No

If you answered yes to either question, please explain:

Professional References

1. Name	Title
Institution	
Phone Number	
2. Name	Title
Institution	
Phone Number	

Please email or fax a copy of your current license.
Please email or fax a copy of your diploma if you will be involved with surgery.

I certify the above information is true and complete and that the accompanying document(s) are valid.

Signature: **Date:**