



<u>For Office Use Only</u>	
Date recv'd: _____	Ck# _____
All licenses/certs? Y N	Charge _____
Approved by: _____	last 4 digits: _____
Date: _____	_____
Therapist Training Codes: _____	

NLN Affiliate Physician Application

Today's Date: _____

Physician's Name: _____

Professional License Type & State: _____ License Number: _____ Exp: _____

Physician's Business Address: _____

City, State, Zip Code: _____

Telephone: (____) _____ FAX: (____) _____ Email: _____

Please indicate how you would like your renewed listing to appear:

Physician's Name: _____

Affiliation, if any: _____

City/State: _____ **Telephone:** _____

Please provide a brief description of your background and experience in the field of lymphology:

Number of years in practice: _____ Specialty: _____

Please attach a copy of your vitae.

In your practice, do you:

Use pumps? Yes No If yes, what type(s): _____

Sell pumps? Yes No If yes, what type(s): _____

Perform diagnostic studies? Yes No If yes, what type(s): _____

(Continued next page)

