

<b>Education - continued</b>		
<b>POST-GRADUATE EDUCATION</b> <input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<input type="checkbox"/> Please check this box and complete and submit Attachment B if you received additional postgraduate training.		
<b>OTHER GRADUATE-LEVEL EDUCATION</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
<b>Licenses and Certificates</b> - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.		
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<input type="checkbox"/> DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<b>OTHER CDS</b> (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)	
ARE YOU A PARTICIPATING MEDICARE PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Provider Number:		ARE YOU A PARTICIPATING MEDICAID PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid Provider Number:
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No ECFMG Number:		ECFMG ISSUE DATE (MM/DD/YYYY)
<b>Professional/Specialty Information</b>		
PRIMARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY. <input type="checkbox"/> I have taken exam, results pending for Board. <input type="checkbox"/> I have taken Part I and am eligible for Part II of the Exam. <input type="checkbox"/> I am intending to sit for the Boards on (date) <input type="checkbox"/> I am not planning to take Boards.		
DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: <input type="checkbox"/> Yes <input type="checkbox"/> No PPO: <input type="checkbox"/> Yes <input type="checkbox"/> No POS: <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECONDARY SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)