

Professional/Specialty Information <i>-continued</i>		
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		
ADDITIONAL 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		
PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)		
Work History - Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.		
CURRENT PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY. Gap Dates: _____ Explanation: _____ Gap Dates: _____ Explanation: _____		