



Nassau Physicians Foundation

A Not-for-Profit Organization providing Health Education for the Community & sponsoring Fundraising Events for Medical Research

PHYSICIAN INFORMATION

Please return information form & Affiliation Contribution (\$250) to:
NPF
P.O. Box 756
Manhasset, New York 11030

First name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Medical specialty: _____

Home address

Street: _____

City: _____ State: _____ Zip: _____

Office address

Name of practice: _____ Position: _____

Street: _____

City: _____ State: _____ Zip: _____

Practice Type:

Private solo Private group Academia Administration Research Other _____

***Contact Name of Office Manager/Personal Assistant: _____

Preferred Mailing Address: Home Office

Telephone: Home: _____ Office: _____

Fax: _____ Cell: _____

*E-mail: _____ *Please note that mailings will be sent to your e-mail address.

EDUCATIONAL BACKGROUND

Undergraduate School: _____ Year graduated: _____

Medical School: _____ Year graduated: _____

Internship: _____ Specialty: _____ Date: _____

Residency: _____ Specialty: _____ Dates: _____

Fellowship: _____ Specialty: _____ Dates: _____

License State(s): _____ Specialty: _____

Please check applicable category: Board Eligible Board Certified

Professional organizations: _____

Personal Interests: _____

I would be interested in working on the following committees:

Programming Special community service projects Fundraising Recruitment Newsletter contributor

Signature _____

Date _____

Please print your name on the above line.