

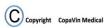
Sclerotherapy Certification Application Form Please fill-in and submit the following application for Crown Medical Sclerotherapy Certification to the address of reference.

To determine the extent of exam you can also download Topics for the Sclerotherapy Examination.

1. Contact Information:								
Professional Title: MD	DO DD	S □DMD	□DPMS	□ARNP	□NP	□RN	□Other	
First Name: Last Name								
Address								
City	ity		State/Country			Zip Code		
Home Phone Email			ne A	Iternate Ph	Fa	ax Num	ber	
2. Work Information:								
Work Place:					_			
Position:								
Address								
City		State/C	ountry		Z	ip Code	<u> </u>	
Number of Years in Practice	eF	lospital Privil	eges					
Member of Professional Ass	ociation							
Country/State License Locat Country/State License Locat	ion							
3. Education Information:								
Medical Degree		Number of Years in Practice						



University of	Graduation Year
4. – Institute where you obtained your formal Scler	otherapy Training?
Advanced Sclerotherapy Training of Crown Medical	Yes No No
If you have not been trained by Crown Medical please By whom did you receive Sclerotherapy Training?	explain the following:
Dates of Training:	
How many hours of training did you receive:	
Please describe the Bibliographical Reference/	•
— What other Sclerotherapy Manual have you use	ed, read, or consulted.
- Have you performed Sclerotherapy before, if sclerotherapy have you treated	so please briefly state how many patients of
Please explain any other training / experience you may	y have in performing sclerotherapy:
5. Certification and Database Registration	
This is an application for Certification; I am Of the corresponding documentation, need Copy of Medical Degree	attaching copies, (no originals accepted) ed to be verified. Photo ID, Copy of License,



	Please reserve my seat at the next examination for Sclerotherapy Certification Date of Exam requested:								
	I am also Appling to be register in the Professionals of Sclerotherapy Data Base								
	Application is for Sclerotherapy Certification for Doctors								
	Application is for Sclerotherapy Certification for Nurses								
	Application is for Sclerotherapy Certification for International Doctors								
6- Type of F	Payment ————————————————————————————————————								
Please check off your form of Payment, Please state Check type and Exam Dated									
Fees are									
	Application Fees								
	Total Fees275.00 US								
□ <u>Check/Mo</u>	Payable to Crown Medical, ATTN: Registrar Office 6785 SW 40st, Miami, Fl. 33155								
□ Credit Card Charge to the following account □ VISA □ MASTERCARD □ AMERICAN EXPRESS □ DISCOVER									
Billing Address of Credit Card Billing Address									
Address									
City	State/Country Zip Code								
Credit Card 3 4 Digit Se	Number: Expiration Date: curity Code, on Back of Credit Card								
For security purpose, we will only ship Manual and other Materials to billing address of the credit card.									



	e charged See Course Sched	ule for fees:(Not	valid without signature)					
7. Methods of Registration for Direct line call 786 597 3202								
Submit Payment and Complete Registration form via 1 of 4 methods								
Mail ATTN: Registrar Office 6785 sw 40st	Fax ATTN: Registrar Office 305-662-7140	Email Sales@copavin.com	Online www.copavin.com					
Miami , Fl. 33155 Check, Money Order, Credit Card	Credit Card Only	Credit Card Only	Credit Card Only					
8. Terms and Conditions: By signing you hereby confirm you have read, and accepted the full "Terms and Conditions" of COPVIN, under which the Sclerotherapy Certification is given.								
☐ I have read and ful	ly understand terms and cond	ditions for this Course, Manua	I and/or Certification.					
Signature:	Signature: (Not valid without signature)							
□ <u>Americans with Disability Act</u> All of our courses intend to fully comply with the ADA. If you need any special assistance please contact an event staff specialist at 305-740-4444 at least 3 weeks prior to activity.								

