EXHIBIT B

ACKNOWLEDGEMENT OF PROFESSIONAL QUALIFICATIONS

APPLICANT NAME: _____
(Last) (First) (Middle)

BIRTH DATE: _____ GENDER: MALE: ☐ FEMALE: ☐

MAILING ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

EMAIL: _____

GRADUATE EDUCATION:

MD: _____
(Name of College) (Year of Degree)

POST GRADUATE SCHOOL TRAINING (Internship, residency, fellowship, etc.):

NAME OF INSTITUTION: _____

TYPE OF TRAINING: _____

YEAR OF TRAINING: _____

LICENSE NUMBER: _____ STATE: _____

EXPIRATION DATE: _____ TAX ID #: _____

NATIONAL BOARD: YES ☐ NO ☐ YEAR: _____

BOARD CERTIFIED: YES ☐ NO ☐ YEAR: _____ BOARD ELIGIBLE: YES ☐ NO ☐ YEAR: _____

AREA(S) OF MEDICAL EXPERTISE: _____
_____

_____ _____
Applicant Signature Date