

# MEDICAL EDUCATION SPEAKERS NETWORK

ESTD **96** DATE

## FACULTY INFORMATION FORM

General Information (Please print or type)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Academic or Professional Title

\_\_\_\_\_  
Organization

\_\_\_\_\_  
Office /Mailing Address

\_\_\_\_\_  
Email Address:

\_\_\_\_\_  
NPI#

\_\_\_\_\_  
Provider License #

\_\_\_\_\_  
Office Telephone Number

\_\_\_\_\_  
Cellular Telephone Number

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Patient Referral #

A. Minimum Honorarium: \$ \_\_\_\_\_ any amount  I will consider all requests

B. Please list lectures you would like to be considered for (e-mail or attach a complete list if more space is needed):

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

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Faculty Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Please send your completed form along with a copy of your CV and Bio/Introduction to:  
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