Interventional Radiology Practice Attestation

TYPE OR PRINT (IN INK) ALL INFORMATION

1. Applicant Information:

_____

Last Name First Name Middle Name

Date of Birth: _____
MM-DD-YYYY

2. Applicant's IR Practice Attestation (to be completed by current department chair or section chief):

Current Practice Name	Practice Location *(City, State)*	Hours Per Week Applicant Practices IR

I verify that the applicant named above is practicing interventional radiology the amount of time indicated above.

_____
Printed Name of Department Chair/Section Chief

_____ _____
Signature of Department Chair/Section Chief Date

Department Chair/Section Chief Contact Information:

Phone Number: _____ Email Address: _____