

AVLS PRO 2.0 VENOUS REGISTRY

PROVIDER APPLICATION

First:	MI:	Last:				
Designation (MD, DO, RP	hS, CLT-LANA, etc.):					
Mailing Address:						
City:		State: Zip:				
Email:	Phone:	Fax:				
Practice Name:						
Practice Contact:						
Email:	Phone:	Fax:				
Which EMR/EHR does yo	our practice currently use	(if any)?				
Primary Specialty:		Secondary Specialty:				
License #:	NPI #:	AMA #:				
IAC Vein Treatment Center Accredited?		Vascular Lab Accredited?				
ABVLM Board Certified?		Year Started in Phlebology:				
REGISTRATION FEE - \$1,500						
☐ Check made payable☐ Credit Card	to American Vein & Lymp	phatic Society				
Card Type	□ MasterCard □	I VISA □ American Express □ Discover				
		I VISA □ American Express □ Discover				
Name on Card:		·				
Name on Card: Credit Card Number:		· 				
Name on Card: Credit Card Number: Security Code:	Expiration Da					
Name on Card: Credit Card Number: Security Code:	Submit your applica L PROVIDERS AT	Billing Zip Code: Date: Billing Zip Code:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First:	Submit your applica L PROVIDERS AT	PRACTICE (MORE SPACE ON BACK) Last:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First: Designation (MD, DO, RP)	Expiration Da Submit your applica L PROVIDERS AT MI: hS, CLT-LANA, etc.):	PRACTICE (MORE SPACE ON BACK) Last:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First: Designation (MD, DO, RP Mailing Address:	Submit your applica L PROVIDERS AT MI: hS, CLT-LANA, etc.):	pate: Billing Zip Code: Stion to registry@myavls.org. PRACTICE (MORE SPACE ON BACK) Last:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First: Designation (MD, DO, RP Mailing Address: City:	Submit your applica L PROVIDERS AT MI: hS, CLT-LANA, etc.):	PRACTICE (MORE SPACE ON BACK) Last:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First: Designation (MD, DO, RP Mailing Address: City: Email:	Expiration Da Submit your applica L PROVIDERS AT MI: hS, CLT-LANA, etc.):	PRACTICE (MORE SPACE ON BACK) Last: State: Fax:				
Name on Card: Credit Card Number: Security Code: ADDITIONA First: Designation (MD, DO, RP Mailing Address: City: Email: Primary Specialty:	Submit your applica L PROVIDERS AT MI: hS, CLT-LANA, etc.): Phone:	Billing Zip Code: ate: Billing Zip Code: attion to registry@myavls.org. PRACTICE (MORE SPACE ON BACK) Last: State: Zip:				



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PROVIDER APPLICATION

ADDITIONAL PROVIDERS AT PRACTICE

First:		MI:	Last:	
			State:	
			Fax:	
			_ Secondary Specialty:	
License #:	NPI #: _		AMA #:	
ABVLM Board Certified?			_ Year Started in Phlebology:	
First:		MI:	Last:	
Designation (MD, DO, RPhS, Cl	LT-LANA, etc.):			
Mailing Address:				
			State:	
Email:	Phone: _		Fax:	
Primary Specialty:			_ Secondary Specialty:	
License #:	NPI #: _		AMA #:	
ABVLM Board Certified?			_ Year Started in Phlebology:	
First:		MI:	Last:	
Designation (MD, DO, RPhS, Cl	LT-LANA, etc.):			
Mailing Address:				
City:			State:	Zip:
Email:	Phone: _		Fax:	
Primary Specialty:			_ Secondary Specialty:	
License #:	NPI #: _		AMA #:	
ABVLM Board Certified?			_ Year Started in Phlebology:	
First:		MI:	Last:	
Designation (MD, DO, RPhS, CI	LT-LANA, etc.):			
Mailing Address:				
			State:	Zip:
Email:	Phone: _		Fax:	
Primary Specialty:			_ Secondary Specialty:	
License #:	NPI #: _		AMA #:	
ABVLM Board Certified?			_ Year Started in Phlebology:	