AMERICAN VEIN & LYMPHATIC SOCIETY

AVLS PRO 2.0 VENOUS REGISTRY

PROVIDER APPLICATION

First: _____ MI: _____ Last: _____

Designation (MD, DO, RPhS, CLT-LANA, etc.): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Fax: _____

Practice Name: _____

Practice Contact: _____

Email: _____ Phone: _____ Fax: _____

Which EMR/EHR does your 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 to American Vein & Lymphatic Society

☐ Credit Card

Card Type ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

Name on Card: _____

Credit Card Number: _____

Security Code: _____ Expiration Date: _____ Billing Zip Code: _____

Submit your application to registry@myavls.org.

ADDITIONAL PROVIDERS AT PRACTICE *(MORE SPACE ON BACK)*

First: _____ MI: _____ Last: _____

Designation (MD, DO, RPhS, CLT-LANA, etc.): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Fax: _____

Primary Specialty: _____ Secondary Specialty: _____

License #: _____ NPI #: _____ AMA #: _____

ABVLM Board Certified? _____ Year Started in Phlebology: _____

434 W. Ontario St. Suite 200, Chicago, IL 60654 ▪ p: 510-346-6800 ▪ f: 510-346-6808
www.veinandlymph.org ▪ registry@myavls.org

AMERICAN VEIN & LYMPHATIC SOCIETY

AVLS PRO 2.0 VENOUS REGISTRY

PROVIDER APPLICATION

ADDITIONAL PROVIDERS AT PRACTICE

First: ______________________ MI: __________ Last: ______________________

Designation (MD, DO, RPhS, CLT-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, CLT-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, CLT-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, CLT-LANA, etc.): ______________________

Mailing Address: ______________________

City: ______________________ State: __________ Zip: __________

Email: ______________________ Phone: ______________________ Fax: ______________________

Primary Specialty: ______________________ Secondary Specialty: ______________________

License #: ______________________ NPI #: ______________________ AMA #: ______________________

ABVLM Board Certified? ______________________ Year Started in Phlebology: ______________________