

**2. Practitioner Identification**

This section is to be completed with information about yourself; where Medicare can contact you directly; whether you are rendering services in a health care facility as a resident or an intern; and whether you have established your practice as a separate business entity. You must also designate your medical specialty.

**A. Personal Information** ☐ **Change** **Effective Date:** \_\_\_\_\_

1. Name	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
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2. Other Name (including Maiden)	First	Middle	Last	Jr., Sr., etc.	M.D., D.O., etc.
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3. Date of Birth (MM/DD/YYYY)	State of Birth	Country of Birth
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4. Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female
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5. Medical School/Training Institution	Year of Graduation (YYYY)
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**B. Correspondence Address** ☐ **Change** **Effective Date:** \_\_\_\_\_

**You must furnish an address and telephone number where Medicare can contact you directly.**

Mailing Address Line 1 (Street Name and Number)

Mailing Address Line 2 (Suite, Room, etc.)

City	State	ZIP Code + 4
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Telephone Number ( ) ( )	(Ext.) ( )	Fax Number (if applicable) ( )	E-mail Address (if applicable)
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**C. Residency Status** ☐ **Change** **Effective Date:** \_\_\_\_\_

1. Are you currently:	a resident?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	an intern?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	in a fellowship program?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**IF YES** to any of the above questions, provide the name of the facility where you are a resident, intern, or fellow on the line below:

\_\_\_\_\_

**IF NO**, skip to Section 2D (Business Information) below.

2. Are the services that you render at the facility shown in Question 1 part of your requirements for graduation from a formal residency program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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3. Do you also render services at other facilities or practice locations?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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**IF YES**, you must report these practice locations in Section 4 (Practice Location).

4. Are the services that you render in any of the practice locations you will be reporting in Section 4 (Practice Location) part of your requirements for graduation from a formal residency program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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**IF YES**, has the teaching hospital reported in Question 1 above agreed to incur all or substantially all of the costs of training in the non-hospital facility or location?

☐ YES ☐ NO

**D. Business Information (if applicable)** ☐ **Change** **Effective Date:** \_\_\_\_\_

1. Check here ☐ if this section does not apply to you and skip to Section 2E. Otherwise, furnish the following information if you operate your practice as a business under a name other than your own name.

2. Legal Business Name as Reported to the IRS	Tax Identification Number
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