Healthcare Provider Certification Form

Name

First Name

Last Name

Middle Initials

Info

DOB

NPI

Email

Contact

Address

Address

City

State

Zip

I agree to be enrolled in and acknowledge that I have been trained on and will comply with the terms and Medicare mandated requirements of the ProMark Prostate Cancer Assay Certification and Training Registry (ProMark CTR) Program, including the items set forth below:

- ☐ Program Guide
- ☐ Training Package
- ☐ Healthcare Provider Certification Form
- ☐ Adverse Event Report Form
- ☐ Patient Guide

Physician Signature

Submitted Date