American College of PHLEBOLOGY
advancing vein care

ACP PRO VENOUS REGISTRY
Provider Application

Provider Information
Please type of print clearly.

NPI Number: _____ First and Last Name: _____

Year Began Treating Veins: _____ ABVLM Certification: ☐ Yes ☐ No

Primary Specialty: ☐ Phlebology ☐ Emergency Medicine ☐ Vascular Medicine ☐ Internal Medicine ☐ Vascular Surgery ☐ General Surgery ☐ Dermatology ☐ Interventional Radiology ☐ Other: _____

Vascular Lab Accreditation: ☐ Yes ☐ No IAC Vein Treatment Facility Accreditation: ☐ Yes ☐ No

Practice Information

Practice Name: _____

Street Address: _____ City : _____ State: _____ Zip: _____

Practice Contact (First & Last Name): _____

Email (Required): _____ Phone: _____ Fax: _____

Does your practice currently use an EMR/EHR: ☐ Yes ☐ No If "Yes", which one: _____

Additional NPI Information
If additional physicians within the practice will be contributing data, please add them here.

NPI Number: _____ First and Last Name: _____

Year Began Treating Veins: _____ ABVLM Certification: ☐ Yes ☐ No

Primary Specialty: ☐ Phlebology ☐ Emergency Medicine ☐ Vascular Medicine ☐ Internal Medicine ☐ Vascular Surgery ☐ General Surgery ☐ Dermatology ☐ Interventional Radiology ☐ Other: _____

Vascular Lab Accreditation: ☐ Yes ☐ No IAC Vein Treatment Facility Accreditation: ☐ Yes ☐ No

NPI Number: _____ First and Last Name: _____

Year Began Treating Veins: _____ ABVLM Certification: ☐ Yes ☐ No

Primary Specialty: ☐ Phlebology ☐ Emergency Medicine ☐ Vascular Medicine ☐ Internal Medicine ☐ Vascular Surgery ☐ General Surgery ☐ Dermatology ☐ Interventional Radiology ☐ Other: _____

Vascular Lab Accreditation: ☐ Yes ☐ No IAC Vein Treatment Facility Accreditation: ☐ Yes ☐ No

Registration Fee: $1,500 (per login) *Make checks payable to **American College of Phlebology***

Credit Card Information

Card Number: _____ Expiration Date: _____ Security Code: _____

Cardholder's Name: _____

Billing Address: _____ City : _____ State: _____ Zip : _____

Cardholder's Signature: _____ Date: _____