

KAN Non-Clinician Member Registration Form

Thank you for your interest in the Kentucky Ambulatory Network (KAN). To join, please complete the registration form. The information will help us to communicate with you and to describe KAN membership. Membership is free.

DATE: _____

*please check preferred contact mode

1. Name: _____ 2. Phone: _____

3. Place of Employment: _____ 4. Fax: _____

5. Work Address: _____ 6. Pager: _____

7. Email: _____

8. What is your professional position, rank and/or title?

9. Education.

Please list professional degrees, universities/institutions from where the degrees were received and dates completed.

▪ Degree _____ Institution _____
Date Completed _____

▪ Degree _____ Institution _____
Date Completed _____

▪ Degree _____ Institution _____
Date Completed _____

10.

Male Female

11. Please briefly summarize your research activities or interest:

12. Do you have Broadband internet access from your office computer?

Yes No Unsure

