

Kern Augustine Conroy & Schoppmann, P.C.  
1120 Route 22 East  
Bridgewater, NJ 08807

**Podiatric Physician Defense Program<sup>SM</sup>**  
**APPLICATION**

Name: \_\_\_\_\_

Name of Practice \_\_\_\_\_

Address of Practice: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Program Membership Price: \$425**

NOTE: If you have received your NJ Podiatry License within the last 12 months, you are entitled to a one time 50% discount off your first years' membership fee in the Podiatric Physician Defense Program<sup>TM</sup>. If you believe that you qualify for this discount, please fill your license number and licensure date below.

License Number: \_\_\_\_\_ Licensure Date: \_\_\_\_\_

*I have read the Program Description and Agree to its terms. Please enroll my in the Podiatric Physician Defense Program<sup>SM</sup>.*

Enclosed is my check for \$425

Please charge my credit card:

Credit Card: Visa \_\_\_ MasterCard \_\_\_ American Express \_\_\_ Security Code \_\_\_\_\_

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Authorized Amount \$ \_\_\_\_\_

By signing this application I hereby authorize Kern Augustine Conroy & Schoppmann, P.C. to charge my credit card for the authorized amount stated above. I understand that the charge will appear on my credit card statement as "Kern Augustine"