



NEW JERSEY PHYSICIAN ADVOCACY PROGRAM® APPLICATION

Name (Please Print)

Practice Name

Address City State Zip

Phone Number Facsimile Number E-Mail Address

Signature *

Programs Available:

Individual Membership:

Please check one:

- Basic Program \$175.00
Comprehensive Program \$525.00

Comprehensive Group Rate:

Please check one:

- 3 Physician Group \$1,450.00
4 or more Physicians
Number of Physicians at \$195.00 each
Plus Group Rate of \$1,000.00

Names of Physicians and other Health Care Providers (Attach additional sheet if required):

Blank lines for listing names of physicians and health care providers.

I have read the Program Description and agree to its terms.

To apply by check:

Enclosed is my check for \$

PLEASE MAKE CHECK PAYABLE AND MAIL TO: KERN AUGUSTINE CONROY & SCHOPPMANN, P.C. 1120 ROUTE 22 EAST, BRIDGEWATER, NJ 08807 (800) 445-0954

To apply by credit card:

Card type: Visa MasterCard American Express

Card Number

Expiration Date

Security Code

Authorized Amount

Print Name

Signature

By signing this application I hereby authorize Kern Augustine Conroy & Shoppmann, P.C. to charge my credit card for the authorized amount stated above.