

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

Podiatric Physician Defense Program™
APPLICATION

Name: _____

Name of Practice _____

Address of Practice: _____

Telephone: _____ Fax: _____

E-Mail: _____ Group Provider #: _____

Program Membership Price: \$425
(Discount Price for PICA Insureds) \$390

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™. 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™.

Enclosed is my check for \$ _____

Please charge my credit card

Credit Card: Visa ___ MasterCard ___ American Express ___

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"

New Jersey Supreme Court Reg. No.: NJ-2000-09-229