



# APPLICATION

## PLEASE ENROLL ME IN THE PHYSICIAN ADVOCACY PROGRAM®

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Address

\_\_\_\_\_/\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Facsimile Number

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Signature \*

**Kern Augustine Conroy  
& Schoppmann, P.C.**  
"Attorneys to Health Professionals"

STATE BOARDS OF MEDICINE AND  
OSTEOPATHIC MEDICINE DEFENSE PROGRAM \$110.00

TOTAL ENCLOSED \$ \_\_\_\_\_

- OR -

COMPREHENSIVE DEFENSE PROGRAM - includes:

- State Boards of Medicine and Osteopathic Medicine
- Medicare Fraud Defense Program
- Medicare Quality Improvement Organization
- Occupational Safety and Health Administration

Special Price for PaPRI Insureds \$455.00

TOTAL ENCLOSED \$ \_\_\_\_\_



**PLEASE MAKE CHECK PAYABLE AND MAIL TO:**  
KERN AUGUSTINE CONROY & SCHOPPMANN, P.C.  
1500 Market Street, 12th Fl  
PHILADELPHIA, PA 19102  
(215) 665-5790

\* I hereby acknowledge receipt of and agree to be bound by the terms  
of the Physician Retainer Agreement