Print Form

CERTIFICATE OF EMPLOYMENT FOR INSTITUTIONAL LICENSE

Please enter required information, sign and date at the bottom of the page. Mail or fax form.

I, _____, Director of
Director's Name

_____
Name of Hospital, Institution or Medical Care Facility

located at _____
Address City State Zip

certifies that _____ , MD
Name of Doctor

license number. _____ is currently employed at said facility and is
Doctor's Institutional License No.

under contract from _____ through _____
Start date Ending Date

Additional Comments: _____

_____

_____ _____
Director's Signature Date

Print Form

revised 1-25-11, kl

800 SW Jackson, Lower Level-Suite A., TOPEKA KS 66612
Voice: 785-296-7413 Toll Free: 1-888-886-7205 Fax: 785-296-0852 Website: www.ksbha.org