

PHYSICAL MEDICINE AND REHABILITATION

(Addendum To Application for Physicians and Surgeons)

1. Do you perform any of the following injections?

- | | | | | | |
|----|--|--------------------------|-----|--------------------------|----|
| a. | Epidural-Caudal, Translumbar and Selective | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| b. | Facet-Cervical and Lumbar | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| c. | Sacroiliac Joint and Gleno-humeral Joint | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| d. | Hip Joint | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

If Yes, explain _____

Signature

Please Print Name