

UROLOGY

(Addendum To Application for Physicians and Surgeons)

1. Is your practice strictly office based? YES NO

2. Do you perform prosthetic implants? YES NO

If yes, which type _____

3. Do you perform organ transplants? YES NO

4. Do you perform sex change surgery? YES NO

If yes, explain: _____

5. Do you perform IVPs? If yes, where? _____

6. Do you perform phalloplasty? YES NO

If yes:

a. Number per month _____

b. Do you perform this procedure for: Cosmetic Purposes Other Purposes

If other, explain _____

c. Submit proof of training.

Signature

Please Print Name