



**MANAGEMENT / PERSONNEL**

Owner                       Physician                       Other

Full Name: \_\_\_\_\_  
*Last*    *First*    *M.I.*

Occupation: \_\_\_\_\_ Verifiable hours worked per week at clinic: \_\_\_\_\_

Medical License # (if applicable): \_\_\_\_\_ DEA # (if applicable): \_\_\_\_\_

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