PROVIDER NOMINATION FORM

I am Nominating:

- ❑ An individual practitioner, such as a doctor or other healthcare professional
- ❑ A group of practitioners
- ❑ A facility such as a hospital or lab

Provider Information:

Provider Specialty: _____

Provider's First Name:_____ Provider's Last Name:_____

Provider's Gender: ❑ Male ❑ Female

Provider's Email: _____

Provider's Phone: _____

Provider Office Address:

Practice Name:_____ Attention:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Your Information:

First Name:_____ Last Name:_____

Company Name:_____ Member ID:_____

Email Address:_____

City:_____ State:_____

Submit your nomination(s) to:

Mail:

Attn: AMPS America, 35 Technology Parkway South, Suite 100, Peachtree Corners, GA 30092

Fax: 866-861-9227

Email: nominate@ampsamerica.com

You can also visit ampsamerica.com to nominate a provider online.