

MedLink Neurology — Trainee Discount Form

Please complete this form – then sign and email (service@medlink.com) or fax (619-640-4664) the form to MedLink Subscriber Services along **with a photocopy of your identification badge.**

Subscriber Information (*required info):

*First Name:		*Last Name:	
*Username:			
Address:			
Address:			
City:	State:	Postal Code:	
Country:			
*Phone:		Fax:	
*Email:			

Supervisor (*required info):

*First Name:		*Last Name:	
*Institution:			
*Title/Position:			
City:	State:	Postal Code:	
Country:			
*Phone:		Fax:	
*Email:			

CERTIFICATION OF MEDICAL ELIGIBILITY

****The information below is required; discount will not be awarded if any information is missing****

I certify that the abovementioned individual is a medical student, resident, or fellow at this institution.

_____ through ____/____/____ (dd/mm/yyyy).
(Signature of Authorized Official) (End Date)

Print or type the name of signing official, title, department, and institution:

(Printed Name)

(Title)

(Department)

(Institution)

Payment Method Authorization

Visa MasterCard American Express

Credit Card Number

Signature of Cardholder

Expiration Date on Card (mm/yy)

Printed Name as it Appears on Card

Reference/Security Number
