

PART I – TO BE COMPLETED BY THE BORROWER (COMPLETE IN INK)

Name	Social Security #	ECSI Account # (if available)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

HEALTH CARE RELATED PROFESSION (NON-NURSING) SERVICE CANCELLATION

BEGINNING (mm/dd/yyyy)	ENDING (mm/dd/yyyy)
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(Altered dates will not be accepted)

THIS IS TO CERTIFY THAT I WAS A **FULL-TIME** LICENSED HEALTH CARE PROFESSIONAL (NON-NURSING) PRACTICING IN A BOARD-APPROVED DISCIPLINE AT:

Clinic/Hospital		Clinic/Hospital Street Address	
City, State, Zip	Telephone #	County	Type of Service (board-approved options listed below)

THIS FORM IS INVALID WITHOUT BORROWER’S SIGNATURE, SOCIAL SECURITY NUMBER, BEGINNING AND ENDING DATES, AND PART II CERTIFICATION.

<p>MD’s Only: Circle practice type</p> <p>Family Medicine Internal Medicine OB/GYN Pediatric</p>

I HEREBY CLAIM THAT THE ABOVE INFORMATION IS TRUE.

X _____
Borrower’s Signature Date

PART II – TO BE COMPLETED BY HUMAN RESOURCE DEPARTMENT

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X _____
Signature of Authorizing Official Date

Printed Name, Title, and Address of Official		Official Stamp or Seal If no stamp or seal is available, please provide letterhead certification in addition to this form.
Telephone #		
Dates Employed Full-time (mm/dd/yyyy)	From:	To:
Dates Employed Part-time (mm/dd/yyyy)	From:	To:

RETURN FORM TO:
Mississippi Institutions of Higher Learning (MIHL)
C/O ECSI, Inc.
181 Montour Run Rd.
Coraopolis, PA 15108

Questions:
Email: webcservice@ecsi.net
Phone: (888) 549-3274