

STFREE CERTIFICATIONS CLINIC VERIFICATION FORM
RETURN THIS FORM TO: STFREE MEMBER SERVICES, 369 BAINBRIDGE, BROOKLYN, NEW YORK, 11233

PART A – MEMBER INFORMATION (MUST BE COMPLETED BY MEMBER)

FIRST NAME: _____ ADDRESS 1: _____

LAST NAME: _____ ADDRESS 2: _____

MEMBER#: _____ CITY: _____

CONTACT#: _____ STATE: _____ ZIP: _____

EMAIL: _____

PART B – CLINIC INFORMATION (FOR CLINIC USE ONLY)

In order to complete the member verification process, the testing clinic must complete Part B of this verification form. Testing clinic must verify member's identity. This form must be endorsed with the testing clinic's stamp in order to be processed. After completion, testing clinic must place the original testing results along with this form in a sealed envelope that has the clinic address printed on it. The envelope must be given to the member **ONLY** for mailing. **CLINIC MUST NOT MAIL THIS FORM OR RESULTS TO STFREE.** If you require assistance or need additional information regarding our service, please contact us as 888-210-1105 or visit us online at www.stfree.com. If you are not an affiliate an STFree associate may contact you for further verification of this form. We ask that you please keep a copy of this form for your records.

CLINIC NAME: _____ CLINIC CONTACT NUMBER: _____
(Optional)

CLINIC ADDRESS: _____ CLINIC EMAIL ADDRESS: _____
(Optional)

CLINIC WEB SITE: _____
(Optional)

HAVE YOU VERIFIED THE ABOVE MENTIONED MEMBER'S IDENTITY Yes NO

DO YOU VERIFY THAT THE ABOVE MENTIONED MEMBER HAS BEEN LEGALLY TESTED FOR HIV AT THE ABOVE MENTIONED CLINIC? Yes NO

TESTING DATE (MM/DD/YYYY): _____

ARE YOU AN STFREE AFFILIATED CLINIC? Yes NO

ADMINISTRATOR NAME (PRINT):

PLACE CLINIC STAMP HERE

ADMINISTRATOR SIGNATURE/DATE:
