



STFREE CERTIFICATIONS CLINIC VERIFICATION FORM
 RETURN THIS FORM TO: STFREE MEMBER SERVICES, #46011 P.O. Box 4668, New York, NY 10163-4668

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)

STFree Certifications inc. uses this Verification Form to confirm member testing information. Part B of this form must be completed by the testing facility which administers the member’s examination. This form **MUST** be endorsed below with the testing facilities stamp in order to be deemed valid. The testing facility must complete all required information below and return this form to member. **TESTING FACILITY MUST NOT MAIL THIS FORM OR RESULTS DIRECTLY TO STFREE.** If you require assistance completing this form or need additional information regarding our services, please contact us at 1-(888)-277-4898 or visit us online at www.stfree.com.

HAVE YOU VERIFIED THE ABOVE MENTIONED MEMBERS INDENTITY?

YES NO

Facility Name: _____ Facility Contact Number: _____

Facility Address _____

ADMINISTOR NAME (Print) _____

ADMINISTOR SIGNITURE: _____ DATE: _____

TESTIND DATE: (mm/dd/yyyy); _____

TYPE OF TEST ADMINISTERED: _____

PART C – MEMBERS INSTRUCTIONS

Member must mail this completed form with a copy of their original testing results provided to the member by the above mentioned testing facility to:

STFree Certifications Inc
#46011
PO Box 4668
New York, NEW YORK 10163-4668

_____ Dated

_____ Member Sign

Member#

PLACE CLINIC STAMP HERE