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) ____________________

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____________________ 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 AFFLIATED CLINIC? ☐ Yes ☐ NO

ADMINISTRATOR NAME (PRINT):

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ADMINISTRATOR SIGNATURE/DATE:

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PLACE CLINIC STAMP HERE