



12. MEDICAL SCHOOL(S)	CITY	STATE	YEARS	DEGREE	GRAD DATE
13. GRADUATE EDUCATION	CITY	STATE	YEARS	DEGREE	GRAD DATE
14. COLLEGE (S)	CITY	STATE	YEARS	DEGREE	GRAD DATE

**15. RESEARCH EXPERIENCE/PUBLICATIONS**

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**16. References**

A. (Name) (Title) Program Director (Institution)

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(Address)

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B. (Name) (Title) (Institution)

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(Address)

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C. (Name) (Title) (Institution)

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(Address)

**CHECK ONE**

- I hereby waive access to the above letters and will so inform the authors.
- I desire access to the above letters and will so inform the authors.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Note: The Signature and Date on this statement Must be Original

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Send application to: **Krista L. Kaups, M.D.**  
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**Community Regional Medical Center**  
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