

**Signature Card: Physicians, Podiatrists, and Dentists**

Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

DEA# \_\_\_\_\_ Phone # \_\_\_\_\_

Signature: \_\_\_\_\_

Practicing Location: VA Medical Center, 1201 NW 16<sup>th</sup> St. Miami, FL 33125

VA Form 10114e Medical Facility

Please complete all four of these.

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