

WEB MD MEDICAL FORM

Please do your best to fill out this form as accurately as possible.
We will notify when the announcement is posted. Please make sure
you check your spelling.

In completing this web md medical form please fill out complete names
In Address and locations, please give city state and zip.

Date you want web md medical to come out_____

web md medical will not be published until receive a date.

If partners are available please list full names of all partners involved

Full names and address of web md medical _____

Partners (include address) _____

other partners (include address)_____

Are the web md medical partners on the Internet? Yes____ No____

If no list the relationship of the web md medical _____

Company been in business for how long?_____

Partner employed by_____

NAME AND DAYTIME NUMBER (WITH AREA CODE) OF A PERSON AVAILABLE TO ANSWER QUESTIONS

I certify to the best of my knowledge my information is true.

(Name) _____ (Signature) _____

mail completed forms to:
WEB MD MEDICAL DEPT
web md medical times
po box 391
midland tx 79701