APPENDIX F2

National Association of Pediatric Nurse Practitioners℠

40 Exchange Place, Ste. 1902
New York, NY 10005
Ph: 917-746-8300
www.napnap.org

Faculty Qualification Record

Title of Presentation_____

Name of Presenter_____

Address_____

City_____State_____Zip_____

Telephone (_____)_____ FAX (_____)_____

EMAIL_____

Credentials (list all degrees and certifications earned)_____

Field of Specialization_____

_____

Current Position and Title_____

_____

Place of Employment_____

_____

Qualification for presenting session content, including publications or previous seminars conducted, if pertinent.

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Your cooperation in complying with these guidelines is appreciated. Please return this form by _____ (due date) to_____(name and contact info).