



***Bay Area Biomedical Consultants Network
Request for Information Form***

Name: _____

Degree(s): _____

Certification(s):

Area(s) of Biomedical Consulting Expertise:

How long have you worked as an employee in the biomedical industry? _____

How long have you been an independent biomedical consultant? _____

Business Name: _____

Address: _____

Telephone: _____

Cell Phone: _____

Email: _____

Website or LinkedIn profile: _____

How did you hear of BABCN? _____

Please provide the name of up to 4 BABCN members you know or the name and email address of 2 other professional references below:

By submitting this form, I certify that all of the information that I have provided on this form is true and correct. I have never been debarred or the subject of any disciplinary action that resulted, or may result, in the suspension or loss of any license or certification held, or prohibits or prohibited any business activity. I further understand that the use of false or misleading information as well as inappropriate use of the BABCN name, website Directory or Members-only content, membership list, or any other function or activity of the BABCN may result in my ineligibility for membership in, or expulsion from, the Bay Area Biomedical Consultants Network.

Date: _____ (Month/Day/Year)

Please submit Completed Information Request Form to: admin@BABCN.net