NEWBORN FRENULECTOMY TRAINING

This statement affirms that I have completed and understand the Newborn Frenulectomy training received on _____.
(Date of Training)

Signature_____ Date_____

Print Name_____

Please sign and submit this form using one of the following:

Mail: OU Medical System
Medical Staff/Credentialing Services Department
1200 Everett Drive, #2315
Oklahoma City, Oklahoma 73104

Fax: 405-271-3602

Email: OUMCcredentialing@hcahealthcare.com

If you have any questions or concerns, please contact the Medical Staff/Credentialing Services Department at (405) 271-3741.