Volunteer Physician Information

FAX to: 262-5609

Name: ____ **Specialty:** ______________________________

Practice or Group Name: ____

Address: ____

Phone: ______________________ FAX: ____________ **Email**: ____________________________

Nurse/PA: ____________________________________ **Phone**: (direct line) __________________________

Business Mgr. or Claims Coordinator: ______________________________ **Phone:** _________________

Number of charity patients you are willing to see per year: # _______ **or** ____**Existing patients only**

Type of conditions you are not willing to treat: ____

Type of procedures/surgeries not willing to perform: ____

Hospital Privileges (where?): Active ____

Courtesy: ____

Other facilities where you perform procedures: ____

Laboratories used: ____

Medical License Number: ___________________ _____

_____ **Private Practice** _____**Employed Physician** _____**Retired** _____ **Other**

Foreign Languages spoken in your office: ____

Additional comments: ____

Before referring patients, we need to provide your staff with a brief orientation to Project Health. Would you like:

_____ **A personal visit to your office by a Project Health staff member**, or

_____ **An orientation packet mailed to your office**

For more information about Project Health go to www.imsonline.org . Please mail or fax this form to:

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Phone: 262-5625; Fax: *262-5609*