

FAMILY HEALTH PARTNERSHIP CLINIC DATA SHEET – PROVIDERS

Name _____

Office Address _____

Office Phone _____

E-Mail _____ Pager _____

Mobile _____

May we call you the day before you are scheduled to be here? _____

Phone number you would like us to call _____

Home Address _____

Home Phone _____

Specialty _____

Affiliated Hospital _____

Days and Times Available *First Choice* _____

Second Choice _____

Third Choice _____

Please mail back to: 05/11/2011:

Family Health Partnership Clinic

Kathy Rauch

13707 W. Jackson Street

Woodstock, IL 60098

(815) 334-8987 Ext. 18

Please include:

Copy of License

DEA Certificate

Letter of good standing from hospital (Physician/Nurse Practitioner)

Copy of Insurance Coverage (Physician/Nurse Practitioner)

Copy of Collaborative Agreement (if an NP)

