FAMILY HEALTH PARTNERSHIP CLINIC
DATA SHEET – PROVIDERS

Name _____

Office Address _____

Office Phone _____
E-Mail_____ Pager_____
Mobile_____ Birthdate:_____

May we call you the day before you are scheduled to be here? _____
Phone number you would like us to call_____

Home Address _____
This is for invitations to volunteer events/functions only.

Home Phone _____

Specialty _____

Affiliated Hospital _____

Days and Times Available *First Choice*_____
Second Choice_____
Third Choice_____

Please mail back to: 08/04/12:
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 affiliated hospital (Physician/Nurse Practitioner)
Copy of Insurance Coverage (Physician/Nurse Practitioner)
Copy of Collaborative Agreement (if an NP)