Medina Community Clinic
www.medinahealthcare.org

Panel Provider Intake Form

Legal Name: _____

Designation (Degree): _____

Specialty: _____

Hospital Affiliations (*please list all*): _____

_____

Personal Contact Information:

Phone: _____ Email: _____

Primary Office Information:

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Office Manager Name: _____

Manager Work Email: _____

Primary Contact For Medina Related Services:

___ Myself (Provider) ____ Office Manager ____ Other: _____

Check all that apply:

____ I would like to offer my pro bono medical services by allowing Medina Clinic patients to be seen in my private outpatient practice location indicated above.

____ I would like to offer my pro bono medical consultation services to Medina Clinic patients via e-consultation, with appropriate patient clinical information through email and fax coordination.

_____ _____

Provider Signature Date