DOCTORS CARE®
Accessible Care for the Underserved

Provider Information Form

Please fill out one form per provider, including mid-levels.

Date: _____

Name and credentials: _____

☐ Female ☐ Male

Practice Name: _____

Office Locations where you practice: _____

Email: _____

Cell (***NOT*** for patients): (___) _____

Direct line (***NOT*** for patients): (___) _____

Website: _____

Specialties offered, including any sub-specialties (if offered):

_____

_____

Do you speak any languages besides English? ☐ Yes ☐ No

If yes, please list: _____

Hospital Privileges:

☐ Swedish Medical Center ☐ Parker Adventist Hospital

☐ Porter Adventist Hospital ☐ Sky Ridge Medical Center

☐ Littleton Adventist Hospital ☐ Other: _____

I will manage _____ active patients at a time.

(Please enter number of patients you are willing to manage. This can be changed at any time.)

Special Instructions: _____

_____

_____

Signature of person completing form: _____ Date: _____

609 West Littleton Boulevard, Suite 100, Littleton, Colorado 80120 Phone 303-730-1313 Fax 720-458-6206
www.DoctorsCare.org