



COMMUNITYHEALTH
CONNECT

2008 Provider Information
Please complete and fax to (801) 818-1003

Provider Name	Office Name	Name of Office Contact
Fax Number	Office phone number	Phone number/extension of office contact
Address	City, State, Zip	Discipline
Email (if used for contact)	License number	Licensing State

I, _____ (please print) have adequate liability insurance to cover patients referred to me by Community Health Connect.*
First Name Last Name Title

Signature Date

*Utah Law does not hold health care professionals liable in charity care (except in cases of gross negligence). However, this law has never been challenged in court. As a precautionary measure, we want to be sure everyone is covered. We need to have proof that the physicians participating in our program are legally permitted to practice.

Please indicate preferences:

- I would like to see:
 - One patient per month
 - Other (please specify: _____)
- Do you need interpretation?
 - Yes, please send an interpreter with non-English-speaking patients
 - No, we do not need an interpreter
- Are there any limitations to the services you can donate?
 - No, there are no specific limitations
 - Yes, unfortunately I cannot donate the following services: _____
- Would you be interested if CHC were to offer you an opportunity to offer your services in another setting?
 - Yes, I would be interested in a future option of providing charity care in another office
 - No, I prefer to see patients in my own office

We would like to extend this volunteer opportunity to as many providers as possible. Please list the names of any providers you feel would be interested in participating with Community Health Connect:

THANK YOU!