**Please Complete & Mail the following to Request Membership to the BHP Provider Network**

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| --- |
| **Membership Request Application** |
| ***PERSONAL INFORMATION:***  |
| **Provider Name:**       **Degree:**       **Home Phone:**       **Cell Phone:**       **Email Address:**       **Provider Specialty(s):**       **Number of Years in Practice:**       **Electronic Medical Record :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***CLINICAL PRACTICE INFORMATION:*** |
| **Primary Practice Location:**       **Primary Practice Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(2) Practice Location:**       **Practice Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(3) Practice Location:**       **Practice Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**        |
| ***HOSPITAL/MEDICAL CENTER AFFILIATIONS:*** |
| **Institution:**       **Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **Services Provided:**       **Status:** **[ ]** Active**[ ]** Courtesy**[ ]** Consulting**[ ]** Inactive**[ ]** Honorary [ ]  **Appointment Date:**       **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Institution:**       **Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **Services Provided:** **Status: [ ]** Active **[ ]** Courtesy **[ ]** Consulting **[ ]** Inactive **[ ]** Honorary [ ]  **Appointment Date:**  |
| ***HOSPITAL/MEDICAL CENTER AFFILIATIONS (cont.):*** |
| **Institution:**       **Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **Services Provided:**       **Status: [ ]** Active **[ ]** Courtesy **[ ]** Consulting **[ ]** Inactive **[ ]** Honorary [ ]  **Appointment Date:**       **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Institution:**       **Address:**        (street address, city, state, zip code)**Phone:**       **Fax:**       **Services Provided:**       **Status: [ ]** Active **[ ]** Courtesy **[ ]** Consulting **[ ]** Inactive **[ ]** Honorary [ ]  **Appointment Date:**       *\*\* If additional affiliations, please indicate on a separate piece of paper.* |
| ***REFERENCES:*** |
| **(1) Name of Reference:** **Title:** **Email Address:** **Phone:** **Fax:** **Address, City/State/Zip:** **(2) Name of Reference:** **Title:** **Email Address:** **Phone:** **Fax:** **Address, City/State/Zip:** **(3) Name of Reference:** **Title:** **Email Address:** **Phone:** **Fax:** **Address, City/State/Zip:**  |
| ***WHY DO YOU WANT TO JOIN BELLIN HEALTH PARTNERS?:*** |
| **Signature:**  **Date:**   |
| **FOR OFFICE USE ONLY** |
| **Membership Request Received:** **Date Taken to Board:** **Approved for Membership:** **YES** [ ]  **NO** [ ]   |