



## PHYSICIAN/ HEALTH CARE PROVIDER PARTICIPATION FORM

**INSTRUCTIONS:** Form to be completed by health care provider and faxed to Anchorage Project Access.  
**Fax to (907) 339-8710.**

NAME OF PROVIDER: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

SCOPE OF PRACTICE: \_\_\_\_\_

CONTACT PERSON (MANAGER): \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

### **YES, I'll do my part to make Anchorage Project Access a success.**

Here's my participation pledge:

\_\_\_\_\_ I will accept \_\_\_\_\_ Anchorage Project Access referrals.

We suggest per year

- 1 patient per month for Primary Care
- 2 patients per month for Specialty Care

\_\_\_\_\_ Please contact me. I have additional questions regarding my role in Anchorage Project Access.

\_\_\_\_\_ I am not interested in volunteering in Anchorage Project Access at this time.

\_\_\_\_\_  
Print Provider's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Office Use Only DB Entered _____ Lic Verified _____
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