SCMS HealthAccess

Physician Volunteer Form

Name: _____Date:_____

Practice: _____Specialty:_____

Address: _____

Telephone: _____

Fax: _____

E-mail: _____

Yes! I'll do my part to make SCMS HealthAccess a success. Here's my

Commitment:

During the next year, I will:

___ Accept **SCMS HealthAccess** referrals for ongoing or short term care needs.

___ Please contact me. I have additional questions regarding my volunteer role in ***SCMS HealthAccess***.

Please fax this form to 235-2385 or mail to PO Box 615, Topeka, KS 66601