



Physician Specialty

1. _____ Certified: Y N 2. _____ Certified: Y N
Below identify age grouping, type of service as applicable

Are you willing to serve as an Interpreter for a language other than English? Y N

If yes, what other language(s) _____

Residency _____

Medical School _____

Medical License# _____

Tax ID# _____

SSN# _____ **DEA#** _____

List Actively Admitting Hospital Privileges

Malpractice Limits: Single Occurrence \$ _____ Aggregate \$ _____

Mental Health Counselors License / Certification

1. _____ 2. _____
Below identify age grouping, type of service as applicable (i.e., eating disorder, etc)

Skilled Nursing Facility (SNF)

Medical Director's Name

Below list types of service and number of specialty beds (i.e., bariatric, etc)

ADDITIONAL REQUIREMENTS FOR CONSIDERATION

- 1. **Mental Health** or **Physician** fax with Provider Data Info and **Curriculum Vitae/Resume**
- 2. Sign and date **SWHP Guidelines for Selection and Continued Affiliation of Practitioners**

Questions: Contact **SWHP Provider Relations** at: **254-298-3064 ph**

Fax: 254-298-3044

Email address: SWHPPROVIDERRELATIONSDEPARTMENT@swmail.sw.org

Visit our **website** at: www.swhp.org

SWHP Provider Relations

Start Date _____ Panel _____ SWHP _____ Sr. Care only _____ PCP _____ Y/N

Gray shaded areas will be filled out by SWHP Provider Relations.