COMANAGEMENT PARTICIPATION FORM

MEDICAL EYE CENTER

Fax completed form to our Comanagement Director: 541-210-8290

DOCTOR NAME _____ OD MD DO

ADDRESS _____

PHONE_____ FAX_____

EMAIL _____

TAX ID# OR SSN_____

COLLEGE / UNIVERSITY DEGREES HELD _____

OTHER TRAINING, CERTIFICATIONS_____

I AM LICENSED TO PRACTICE IN THE FOLLOWING STATES (PROVIDE YOUR LICENSE#)_____

SPECIAL REQUESTS OR PREFERENCES_____

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In signing this form I certify that I am competent to perform the postoperative care of the patients undergoing the procedures I have undertaken to comanage. I realize that all comanaging physicians are required to submit necessary clinical data and follow the management guidelines outlined by Medical Eye Center. I will notify Medical Eye Center of any changes in my status regarding the above. All information provided is correct.

SIGNATURE_____ DATE_____