Project TCMS

Tulsa Charitable Medical Services

Yes, sign me up! I support the success of PROJECT TCMS.

(PLEASE PRINT)

GROUP NAME _____

PHYSICIAN NAME (S) _____ _____

_____ _____

_____ _____

_____ _____

SPECIALTY _____

OFFICE MANAGER/ADMINISTRATOR _____

PRACTICE ADDRESS _____

PLEASE CHECK YOUR PREFERRED METHOD OF COMMUNICATION:

PHONE _____ FAX _____

EMAIL _____

PRIMARY HOSPITAL AFFILIATION _____

( ) I (We) pledge to accept ____ referrals per year into my (our) office.
We suggest a minimum of 12 = 1 per month.

( ) I (We) pledge to volunteer ____ hours per year at an area free clinic.
We suggest 24 hours = 3 hour clinic X's 8 per physician.

( ) Please contact me with more information.

( ) I am not interested in volunteering at this time.

SIGNATURE _____ **DATE** _____

********** Return by fax; (918) 743-0336**********