



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*******