Access 2 Health Care - Provider Profile

Provider Name:

NPI:		**TIN: 03-0466803**
Cred. Date (Initial):	**Recred Date Cycle 1**	**Recred Date Cycle 2**
Medical License:		**DEA:**

Education/Personal Information:

Medical Education: (School Name, Yrs Attended, Degree Earned)					
Internship: (Facility, Specialty, From/To)					
Residency(ies) (Facility, Specialty, From/To)					
Fellowship(s)					
SSN:		**DOB:**		**Ethnic Origin**	
Gender		**Provider Languages:**			

Provider Information:

PCP or Specialist:		**Primary Specialty:**		**Secondary Specialty:**	
Board Certified:		**Certified in: (list effective dates)**			
Covering Physicians:					
Hospital Affiliations: (list effective dates)					

Practice Information:

Location 1: Phone/Fax:					
Office Hours	**M:**	**Tu:**	**W:**	**Th:**	**Fr:**
Billing Information:	**5350 SPRING HILL DRIVE, SPRING HILL, FLORIDA 34606**				
	352-688-8116		**352-686-9477**		
Location 2: Phone/Fax:					
Office Hours	**M:**	**Tu:**	**W:**	**Th:**	**Fr:**
Billing information:					