Legacy Health Partners

MEMBERSHIP APPLICATION

Name:	
Phone Number:	
NPI:	
Practice Name:	
Practice Address:	
Primary office Phone & Fax:	
Practicing Specialty:	
Provider Email Address:	
Office Manager Name:	
Office Manager Email:	
Type of Medical Record Keeping: (e.g., electronic, paper)	
Type of EMR / Year of installation, if applicable:	
EMR platform contact in office, if applicable:	
Member of a Legacy medical staff? Please specify which hospital(s):	