Physician Partners, LTD

♦ PO Box 1683, Green Bay, WI 54305-1683 ♦ Tel. 920-436-8693 ♦ Fax 920-436-8699

Please Complete & Mail the following to Request Membership to the PPL Provider Network

Membership Request Application

PERSONAL INFORMATION:

Provider Name:________________________________ **Degree:**________________________

Home Phone:______________________________ **Cell Phone:**__________________________

Email Address:____

Provider Specialty(s):____

Number of Years in Practice:__________________

CLINICAL PRACTICE INFORMATION:

Primary Practice Location:____

Primary Practice Address:____
(street address, city, state, zip code)

Phone:________________________ **Fax:**__________________________

____

(2) Practice Location:____

Practice Address:____
(street address, city, state, zip code)

Phone:________________________ **Fax:**__________________________

____

(3) Practice Location:____

Practice Address:____
(street address, city, state, zip code)

Phone:________________________ **Fax:**__________________________

HOSPITAL/MEDICAL CENTER AFFILIATIONS:

Institution:____

Address:____
(street address, city, state, zip code)

Phone:________________________ **Fax:**__________________________

Services Provided:____

Status: ☐ Active ☐ Courtesy ☐ Consulting ☐ Inactive ☐ Honorary ☐ ____________________

Appointment Date:__________________________

____

Institution:____

Address:____
(street address, city, state, zip code)

Phone:________________________ **Fax:**__________________________

Services Provided:____

Status: ☐ Active ☐ Courtesy ☐ Consulting ☐ Inactive ☐ Honorary ☐ ____________________

Appointment Date:__________________________

HOSPITAL/MEDICAL CENTER AFFILIATIONS (cont.):

Institution:____

Address:____
(street address, city, state, zip code)

Phone:____________________ **Fax:**____________________

Services Provided:______________________________________

Status: ☐ Active ☐ Courtesy ☐ Consulting ☐ Inactive ☐ Honorary ☐ ______________

Appointment Date:__________________

Institution:____

Address:____
(street address, city, state, zip code)

Phone:____________________ **Fax:**____________________

Services Provided:______________________________________

Status: ☐ Active ☐ Courtesy ☐ Consulting ☐ Inactive ☐ Honorary ☐ ______________

Appointment Date:__________________

*** If additional affiliations, please indicate on a separate piece of paper.*

REFERENCES:

(1) Name of Reference:__________________________ **Title:**______________

Email Address:______________________________

Phone:________________________ **Fax:**____________________

Address, City/State/Zip:____

(2) Name of Reference:__________________________ **Title:**______________

Email Address:______________________________

Phone:________________________ **Fax:**____________________

Address, City/State/Zip:____

(3) Name of Reference:__________________________ **Title:**______________

Email Address:______________________________

Phone:________________________ **Fax:**____________________

Address, City/State/Zip:____

WHY DO YOU WANT TO JOIN PHYSICIAN PARTNERS, LTD?:

Signature:______________________________ **Date:**__________________

FOR OFFICE USE ONLY

Membership Request Received:__________________

Date Taken to Board:____________________ **Approved for Membership: YES** ☐ **NO** ☐