

Please complete and return.
Fax: 312.377.9035 (No cover sheet required.)



We would like to be included as a healthcare provider in the resource directory for patients who may be at risk of or infected by (please check all that apply):

hepatitis A hepatitis B hepatitis C

Name of Practice: _____

Address: _____

Suite/Bldg/Unit: _____

City/State/Zip: _____

Office Phone Number: _____

Office Hours: _____

Web Site (if available): _____

Bilingual-please identify languages: _____

Name of treating physicians: _____

Name of treating physicians: _____

Hepatitis A (please check all that apply)

- Immunization We currently immunize patients against hepatitis A.
- Test We currently test patients for hepatitis A.
- Treatment We currently treat patients infected with hepatitis A.

Hepatitis B (please check all that apply)

- Immunization We currently immunize patients against hepatitis B.
- Test We currently test patients for hepatitis B.
- Treatment We currently treat patients infected with hepatitis B.

Hepatitis C (please check all that apply)

- Test We currently test patients for hepatitis C.
- Treatment We currently treat patients infected with hepatitis C.

Our patients may use the following insurances:

HMO PPO Medicare Medicaid Public Aid Self-pay Uninsured

FOR OFFICE USE ONLY – NOT FOR PUBLICATION:

This form was completed by _____ Phone: _____

e-mail address: _____

Comments: _____

