Your Community Physicians
Chinese Community Health Care Association
827 Pacific Ave., San Francisco, CA 94133
Tel: (415) 216 - 0088 Fax: (415) 216 - 0081
www.cchca.com

CCHCA PHYSICIAN RESIGNATION NOTIFICATION FORM

This form is used to notify CCHCA of a physician's decision to terminate/resign from CCHCA. **YOU MUST PROVIDE A HUNDRED AND TWENTY (120) DAYS ADVANCED NOTICE FOR ANY CHANGE IN STATUS.**

Please fill in the appropriate responses below.

1) I WISH TO TERMINATE/RESIGN MY PRACTICE FROM CCHCA TO BE EFFECTIVE ON: _____
(Providers who wish to terminate/resign from CCHCA must also include a written notice on office letterhead with this form).

2) REASON FOR TERMINATION/RESIGNATION:

_____

_____

_____

3) PLEASE TRANSFER MY PATIENTS TO THE CARE OF:
(If applicable, indicate the physician(s) you have made arrangements with to take care of your patients. Must be a CCHCA)

_____

_____

_____

Physician Name (Please print): _____

Physician Signature: _____ Date: _____

PLEASE RETURN COMPLETED FORM BY ANY OF THE FOLLOWING METHODS:

Fax to: 415-216-0081
Email to: Provider.Relations@cchca.com
Mail to: CCHCA, 827 Pacific Avenue, San Francisco, CA 94133

This section to be completed by CCHCA

Acceptance by CCHCA: CCHCA Approval

By: _____ Effective Date: _____