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 PROVIDER MEMBERSHIP APPLICATION REQUEST FORM

Thank you for your interest in becoming a part of Chinese Community Health Care Association's (CCHCA) network. Please complete this form to request an application and contract. Once completed, please include a LETTER OF INTENT and a copy of the applying physician's CURRICULUM VITAE (CV) with this form and mail to CCHCA at:

Chinese Community Health Care Association (CCHCA)
Attn: Provider Relations Department
827 Pacific Avenue
San Francisco, CA 94133

Applicant Name _____

Specialty _____

Current Practice Address _____

_____

Contact Phone # _____ Fax # _____

Email Address _____

Requested status:

Primary Care: ❒ Specialty: _____

Specialist: ❒ Specialty: _____

1. I have a current license to practice medicine in the State of California. Yes ❒ No ❒

2. I have a current federal DEA registration. Yes ❒ No ❒

3. I have been granted hospital privileges at (List ALL Hospitals, Staff Category & dated granted):

_____

_____

4. I have professional medical liability coverage as an independent provider, at least in the amount of $1 million per claim/ $3 million annual aggregate. Yes ❒ No ❒

5. How did you hear about CCHCA? _____

Applicant Signature _____ Date _____