OFFICE INFORMATION:

Office Name		Address	
Order Facilitator Group Name		City	
Phone		State	
FAX		Zip	
Group NPI		Group Tax ID	
Who should SCI Contact when Completed?	Name:	Phone (Include Area Code):	

DOCTOR INFORMATION:

Name (Last, First) **Print Clearly**	Specialty (Required)
Provider NPI:	

DOCTOR USER INFORMATION:

Doctor User Request	Name (Last, First) Print Clearly	Requested Username (Optional)	DOB	Email	Phone (Include area code)
Add Doctor as User **IMPORTANT - See Instructions**					

In an electronic environment the same legal weight associated with an original signature on a paper document can be associated with an electronic signature. Physicians are not required to be employees of the participating hospitals and thus agree to allow the use of his/her signature only for the purpose of ordering procedures at the hospitals and sending referrals to other medical providers.

I certify that the identifiers assigned to me for the purpose of this attestation process will be kept confidential, will not be disclosed to others and will be used appropriately.

I also understand that I am ultimately responsible for any orders transmitted using Order Facilitator on my behalf by my office staff.

Furthermore, I understand that the privilege to use the Order Facilitator system may be revoked if it is not used appropriately.

Print Name: _____ **Date: _____**

***** DO NOT CROSS OVER ANY LINES OF THE BOX BELOW WHEN SIGNING OR YOU WILL BE REQUIRED TO COMPLETE THIS AGAIN*****

Authenticated By:

***** SIGNATURE MUST BE *COMPLETELY INSIDE* THE BOX *****