



Nevada State Health Division
Physician Health Emergency Communication



Physician Enrollment Form

First Name:	<input type="text"/>	City:	<input type="text"/>
Last Name:	<input type="text"/>	Zip:	<input type="text"/>

Work Location

The following information will be used to establish groups of medical professionals. The groups selected for a particular communication will depend on the nature of the health emergency.

Specialty:	Family Practice	<input type="checkbox"/>	Ob/Gyn	<input type="checkbox"/>
	Internal Medicine	<input type="checkbox"/>	Pediatrics	<input type="checkbox"/>
	Hospitalist	<input type="checkbox"/>	Check here for nurse	<input type="checkbox"/>

The following information will be used to contact you in case of health emergencies. Please include all the various forms as it will ensure that we can reach you even if some of the communication infrastructure in the State is compromised.

Work Phone	<input type="text"/>	Fax	<input type="text"/>
Cell Phone	<input type="text"/>	Email	<input type="text"/>

Primary Contact Name	<input type="text"/>
Contact Information	<input type="text"/>

Reason given for not participating: