



Allen County Patient Safety Ordinance (Title 10, Article 10) ITINERANT MEDICAL PROVIDER SUBMISSION FORM

*Please make checks payable to and submit applications to:
Fort Wayne-Alten County Department of Health, 1 E. Main St., 5th Floor, Fort Wayne, IN 46802*

Date Application is being submitted: _____

Name of Person Completing Submission Form: _____

Facility: _____ Position: _____

.....
(Please complete a separate form for each Itinerant Medical Provider even with same facility)

Itinerant Medical Provider Name: _____ Medical License #: _____

Facility Name: _____

Business Address: _____
(street) (city) (state) (zip)

Phone Number: () _____ (for 24 hr/7day/week contact)
.....

Physician Designee: _____
("Physician Designee" means a physician who is willing to be designated and who is not an Itinerant Medical Provider. ACC 10-10-1.)

Medical License #: _____

Phone Number: () _____ (for 24 hr/7day/week contact)
.....

.....
Verification Information and Attestation:

I, _____, understand that as an Itinerant Medical Provider in Allen County, Indiana, I must provide emergency contact information to those persons and entities set forth in Allen County Code, Title 10, Article 10 ("Patient Safety Ordinance") in the manner provided therein. I attest that all information provided above regarding my emergency contact information and that of my Physician Designee is accurate. I understand that if this information changes at any time, I must resubmit this information to the Fort Wayne-Alten County Department of Health and all other parties as delineated in the Patient Safety Ordinance.

Signature (of Itinerant Medical Provider)

Date

.....
For Office Use Only Below this Line.....

Date Received: _____ By: _____

\$250 Fee Received: Cash Check (Check #: _____) Money Order Receipt #: _____

Administrative Authorization to Issue Certificate of Compliance given by: _____ Date: _____

Certificate of Compliance Packet mailed on: _____ by: _____