



Organization Information:							
Name:Address:					Phone: Org. NPI:		
Required User Information:			D : 1 ND!"	- " •			
First, Middle, Last Name	Credentials	Job Title/Role	Provider NPI#	Email Ad	laress	Please Indicate: Add, Delete or Change (State the change)	
Does your organization need hb/m I hereby request and approve acce Agreement. My organization accep any of the named individuals, my o Upon completion, please email to	ess to The Health ots responsibility organization is res	Collaborative for for the actions of sponsible for prom	the following individual each user while using optly notifying The He	g The Health Collaborative's alth Collaborative. For ques	s systems. Upon term stions call (513) 469-72	ination or resignation of 222.	
inbox via email address provided			ers will then receive	s a username and tempor	ary password to acc	ess the organization s	
Organization Administrator In	nformation (Or	g. Administrato	r cannot be applic	ant)			
Printed Name			Signature		Date	Date	
The Health Collaborative Representative Printed Name		ame Si	Signature		 Date	Date	