

**PATHS PROVIDER ENROLLMENT**

*Please provide the following information regarding your medical practice and all enrolling providers.*

**Date of Enrollment Request:** Click or tap to enter a date.

**Medical Practice Name:** Click or tap here to enter text.

**Street Address:** Click or tap here to enter text.

**City / State / Zip:** Click or tap here to enter text.

**Mailing Address (if different):** Click or tap here to enter text.

**Manager / Administrator Name:** Click or tap here to enter text.

**Manager / Administrator Email:** Click or tap here to enter text.

**Phone Number with area code:** Click or tap here to enter text.

**Please list all enrolling providers with credentials:** Click or tap here to enter text.

**Please list email addresses of all enrolling providers:** Click or tap here to enter text.

**If more than one practice location, list additional locations here:** Click or tap here to enter text.

**How did you hear about PATHS?** [ ]  **Website**

[ ]  **Colleague told me about it**

[ ]  **Presentation by PATHS staff**

[ ]  **Conference**

[ ]  **Other (specify):** Click or tap here to enter text.

**Please list any child/adolescent mental health topics you would be interested in learning more about:** Click or tap here to enter text.

   

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