Care Physicians
Risk Purchasing Group, LLC

Application for RPG Membership

General Information

Name (first, middle, last) ______ ☐ MD ☐ DO (check one)

Date of birth ______ ☐ Male ☐ Female

Address ______

City ______ State ______ Zip ______

Telephone ______ Fax ______

Email ______

Indicate which hospital you are credentialed at by checking the box from the list below:

☐ Lenox Hill Hospital ☐ Manhattan Eye Ear and Throat Hospital ☐ Phelps Memorial Hospital

☐ John T. Mather Memorial Hospital

Coverage Information

New York Medical License Number ______ ☐ Permanent ☐ Temporary

Specialty ______ MLMIC policy Number ______

I herby consent to join the Care Physicians Risk Purchasing Group, LLC ("Care Physicians RPG") and I agree to the following:

- I certify I am credentialed to practice at the hospital that I have checked off in the above section, and will notify the Care Physicians RPG in writing immediately in the event that my credentialing status changes.

Name of physician ______ Date ______

Physician signature ______

(For RPG use only)

Approved by ______ Title ______

Authorized signature ______ Date of signature ______