HOSPITAL-BASED OUTPATIENT CLINICS UPDATE PROJECT

Hospital Name: _____ **License No.** _____

Address: _____ **City/State/ZipCode:** _____

Contact Person Completing Form (*please print*): _____

Phone Number: _____ **E-mail Address:** _____

Pursuant to Health and Safety Code, Section 1253.5, please provide the required information listed below for each hospital-based outpatient clinic providing primary care services to include Family Practice, Pediatric, Primary Care and Rural Health. List the contact person at each outpatient clinic if the Department has any questions.
Also copy this form if additional entries are needed.

Outpatient Clinic Name:_____ **Type:**_____

Physical Address of the Clinic: _____

City/State/Zip Code: _____

Contact Person (*please print*): _____ **Phone #:** _____

E-mail Address: _____

Outpatient Clinic Name:_____ **Type:**_____

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