TGH EpicLink New Office Request Form

Form provided by: Sheryl Smith

Date: _____

Office Information

Name: _____
Address: _____
_____
City: _____ State: _____ Zip: _____
Phone: (___) _____ Fax: _____
Practice NPI: _____

Site Admin Info

First Name: _____ Last Name: _____ Middle Initial: _____
SSN (last 4 digits): _____ DOB: _____
JobTitle: _____ Birth City: _____ Birth State: _____
Primary Phone: (___) _____ Primary Email: _____

Provider Info

First Name: _____ Last Name: _____ Middle Initial: _____
Provider NPI: _____ Specialty: _____
License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Provider NPI: _____ Specialty: _____
License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Provider NPI: _____ Specialty: _____
License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Provider NPI: _____ Specialty: _____
License Number: _____

First Name: _____ Last Name: _____ Middle Initial: _____
Provider NPI: _____ Specialty: _____
License Number: _____

By clicking "submit," Adobe will attempt to open your email client and send the completed form to the TGH EpicLink email address. If this doesn't work, please click the "save" button to save a copy of the form.

Email a typed form to **PhysicianRelations@tgh.org**.

Submit