COMMUNITY HEALTH CENTER NETWORK

DEA Arrangement

I _____, agree to prescribe on the behalf of

Select One

_____

_____ _____

Signature of Prescribing Provider **Date**

_____

Print Name of Prescribing Provider

_____

DEA Number

Working relationship with practitioner I agree to cover: _____

Practice Location(s):

_____

_____

_____

_____

_____

_____