

**Provider Referral Participation Form for  
Allina Physician Referral and Allina.com Find a Doctor**



As a health care provider affiliated with Allina Hospitals & Clinics, you have the opportunity to be included in the Allina Physician Referral telephone service and the Find a Doctor feature of Allina.com. Both services refer consumers and patients to health care providers 365 days a year.

Please complete this form and **fax** it to **Allina Physician Referral at 612-262-4133** or send it via **e-mail** to [medicalexchange@allina.com](mailto:medicalexchange@allina.com). Once submitted and approved, your information will be available to current and potential patients who call Allina Physician Referral at 612-262-3333 or 1-800-877-7878, or visit [www.allina.com/doctors](http://www.allina.com/doctors).

If you would like to personalize your Web site profile with your photograph, please send it via e-mail to [medicalexchange@allina.com](mailto:medicalexchange@allina.com). Photos should be a headshot of professional nature no larger than 155 pixels wide and 220 pixels high and no smaller than 140 pixels wide and 200 pixels high. Please include your first and last name in the name of the file, for example, lastname\_firstname.jpg.

**Provider name:** \_\_\_\_\_

**Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Year entered practice:** \_\_\_\_\_

**Languages spoken other than English:** \_\_\_\_\_

**How should this form be processed?**

- Add me to the Allina Physician Referral and Allina.com Find a Doctor directory.
- Update my information as noted.
- Remove my information; I am no longer affiliated with Allina Hospitals & Clinics.

	<b>Title of specialty</b>	<b>Board certified</b>	<b>Date of certification</b>
<b>Specialty #1</b>		<input type="radio"/> Yes <input type="radio"/> Eligible <input type="radio"/> No	
<b>Specialty #2</b>		<input type="radio"/> Yes <input type="radio"/> Eligible <input type="radio"/> No	

**Education** (G=Graduate school, M=Medical school, I=Internship, R=Residency, F=Fellowship)

<b>Institution</b>	<b>City/state</b>	<b>Year graduated</b>	<b>Program (G, M, I, R, F)</b>

**Professional activities**

**Special interests:** \_\_\_\_\_

**Associations/memberships:** \_\_\_\_\_

**Allina hospital affiliation/s**

- Abbott Northwestern Hospital
- Buffalo Hospital
- Cambridge Medical Center
- Mercy Hospital
- New Ulm Medical Center
- Owatonna Hospital
- Phillips Eye Institute
- River Falls Area Hospital
- St. Francis Regional Medical Center
- United Hospital
- Unity Hospital

**Primary clinic:** \_\_\_\_\_

**Primary clinic address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone number:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Clinic manager:** \_\_\_\_\_ **Manager's e-mail:** \_\_\_\_\_

\_\_\_\_ **Initial here if you are not accepting new patients.** (Please notify us when you would like to begin receiving patient referrals.)

<b>Secondary clinic information</b>	
<b>Clinic/group name:</b>	
<b>Primary clinic address:</b> (including city, state, zip)	
<b>Telephone number:</b>	
<b>Fax number:</b>	

<b>Third clinic information</b>	
<b>Clinic/group name:</b>	
<b>Primary clinic address:</b> (including city, state, zip)	
<b>Telephone number:</b>	
<b>Fax number:</b>	

<b>Fourth clinic information</b>	
<b>Clinic/group name:</b>	
<b>Primary clinic address:</b> (including city, state, zip)	
<b>Telephone number:</b>	
<b>Fax number:</b>	

Please fax your completed form to Allina Physician Referral at 612-262-4133 or e-mail it to [medicalexchange@allina.com](mailto:medicalexchange@allina.com). Thank you for providing complete and accurate information so that we may represent you well to our callers and Web site visitors.