



# KIDSNET PHYSICIAN REGISTRATION FORM

Please Type or Print Legibly

Original  
 Change of Information

Date: \_\_\_\_\_

Practice Name	FQHC (yes or no)
Street	Apt. /Suite
City/Town	State Zip code
Mailing Address (if different)	
Office Contact	
Phone	Phone 2
E-Mail Address	Fax

**Type of Practice: (Check One)**

- \_01 Pediatrician                      \_02 Family Practitioner                      \_03 Community Health Center  
\_04 Hospital Outpatient Clinic                      \_05 School Based Clinic                      \_06 Emergency Room  
\_07 Walk in/Urgent Care Clinic                      \_08 Free Immunization Clinic                      \_09 Newborn Nursery  
\_10 NICU                      \_11 Other Physician/Specialty/Clinic                      \_12 Inpatient Unit  
\_99 Other: Specify

**Days/Hours of Operation:**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

Practice Closed  
 Date: \_\_\_\_\_

Reminders:  
 Yes\_\_\_ No\_\_\_

**Participating Physicians and Other Authorized Users:**

Last	First	MI	License# -if MD or Nurse or Position Title

Return to: Rhode Island Department of Health – KIDSNET  
 3 Capitol Hill, Room 302  
 Providence, RI 02908-5097  
 Help Desk 401-222-4220  
 Fax 401-222-1442

**TTY 711**