W e s t c h e s t e r R E M A C

On-Line Medical Control Physician – Info Change

(Address or Hospital Affiliation)

Please Type or Print Legibly. Indicate which information has changed

Last Name _____ **First Name** _____ **M.I.** _____

☐ **ADDRESS CHANGE**

Address _____

City _____ **State** _____ **Zip** _____ **Email** _____

Home Phone ( ) _____ **Work Phone** ( ) _____

☐ **HOSPITAL AFFILIATION CHANGE**

(Also have bottom section completed by the Emergency Department Director or his or her designee)

Primary Hospital* _____ **Hospital ID** _____

Other Hospital _____ **Hospital ID** _____

(* Note: Westchester Regional Medical Control or Special Resource Hospital)

THIS SECTION TO BE COMPLETED BY THE MEDICAL CONTROL OR SPECIAL RESOURCE HOSPITAL

As Emergency Department Director (or his or her designee) of _____

(a Westchester Regional Medical Control or Special Resource Hospital), I will ensure that this Medical Control Physician is updated as required by the Westchester REMAC.

ED Director or designee (Print) _____

Signature _____ **Date** ____ / ____ / _____

This completed form must be <u>MAILED</u> to:

Westchester REMAC
4 Dana Rd.
Valhalla, NY 10595
ATTN: Physician Credentialing

4 Dana Rd. Valhalla, NY 10595 **P** (914) 231-1616 **F** (914) 813-4161 www.wremsco.org