



**Central Texas Primary Care Research Network**

**Attn: Marcine Chambers**

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**Membership Form**

NAME: \_\_\_\_\_

SPECIALITY: \_\_\_\_\_ DEGREE(S): \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (        ) \_\_\_\_\_ EXT: \_\_\_\_\_

FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

What method of communication is most preferable?

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_ US Mail \_\_\_\_\_

Are you currently a member of the AAFP? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently Board certified? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, what Specialty/Year? \_\_\_\_\_

Are you willing to serve as the Clinical Champion Physician at your location?

Yes \_\_\_\_\_ No \_\_\_\_\_

If not, will you please recommend a physician who might be interested in serving as the Clinical Champion Physician at your location?

Name: \_\_\_\_\_

Have you ever participated in any research project? Yes \_\_\_\_\_ No \_\_\_\_\_

Research interests: \_\_\_\_\_

\_\_\_\_\_

**Thank you for your interest in and cooperation with CentTexNet.**

**Please return completed form to address above or fax to number listed.**