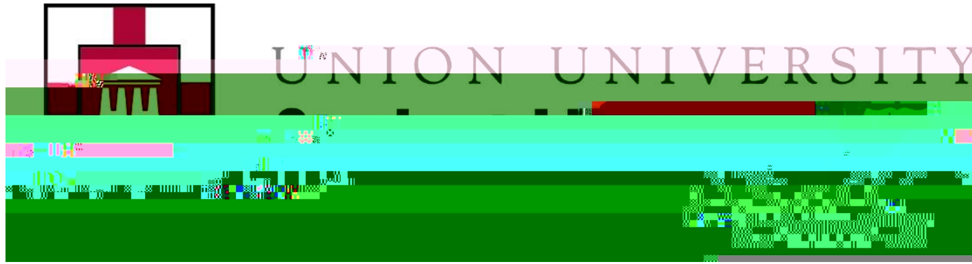

Licensed Provider Recommendation for Medical Withdrawal

Part I: Provider information: *All areas required*

Provider Name: ____________________________________ Office Phone: (_____) _____-____________

Office Address: ____

____

Provider Credentials: MD/DO NP/PA Mental Health Other NPI #:_______________ P 2 (o)]TJ

Specialty: __________________________ License #: ________________ State of Issue: