Registration Form for www.coxdocs.com

This form is for physicians, physician assistants, nurse practitioners, nurses and all appropriate clinic staff. Please complete the information below to secure your registration and access privileges for the Physician on Line web site at www.coxdocs.com:

Please print legibly (**Indicates a required field)

Full name** _____

Clinic Name _____

Clinic Address _____

_____

City/Town _____ State _____ Zip _____

Home phone _____ Work phone _____

Fax number _____ Pager _____

Wireless phone _____

Check one:

☐ Male

☐ Female

Date of Birth _____ Social Security Number _____

User name (i.e. wgerech or your 7 character user name for accessing the health system network)**

_____ **E-mail** _____

Specialty ** _____

Title (i.e. MD, DO, RN, office manager, etc.)** _____

Work Title (i.e. Section Chief of Pediatrics) _____

Please fax, 269-7729 or mail this form to: Springfield Inpatient Physicians, Attn: Tresa Seibert, 3801 S. National Ave., 5th floor; Spfld, MO 65807.