CareNet Physician Response Form

Please return this form to indicate your interest in participating in Toledo/Lucas County CareNet.

Physician Name: _____

Practice Area: _____

Hospital Affiliation(s)/ Privilege(s): _____

_____

_____

License Number: _____

Office Contact Person: _____

Phone Number: _____Fax Number_____

Number of CareNet Referrals I will accept per year _____

Please indicate general diagnosis/symptoms you treat:

_____

_____

Thank you for your interest and participation in CareNet! If you have any questions, contact the CareNet office at 419-842-0800. Please complete and return this form by fax to (888)- 393-9235 or mail to:

Toledo/Lucas County CareNet
3550 Executive Parkway, #7105
Toledo, Ohio 43606

Updated 2.5.2024