Chapter 3 Homework: Healthcare Team

Provider Name:	
Business Name:	
Address:	
City:	State:Zip Code:
Phone: (Fax: ()
Services Provided:	
Treating Diagnosis:	
Medications Prescribed:	
Provider Name:	Credentials:
Business Name:	
Address:	
City:	State:Zip Code:
Phone: (Fax: ()
Services Provided:	
Treating Diagnosis:	
Medications Prescribed:	

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State:Zip Code:
Fax: ()
Credentials:
State:Zip Code:
Fax: ()

Credentials:
State:Zip Code:
Fax: ()
Credentials:
State:Zip Code:
Fax: ()