Oregon
Eye Specialists, P.C.

Co-management Participation Form

Doctor Name:_____ ☐ OD ☐ MD ☐ DO

Address:_____ City/State:_____

Phone:_____ Fax: _____ Email:_____

Tax ID# or SSN_____

College Degree / University Degrees held:_____

Other training or certifications: _____

License #:_____ State: _____ Additional license #/State:_____

Special requests or preferences: _____

_____

In signing this form I certify that I am competent to perform the postoperative care of the patients undergoing the procedures I have undertaken to co-manage. I realize that all co-managing physicians are required to submit necessary clinical data and follow the management guidelines outlined by Oregon Eye Specialists, PC. I will notify Oregon Eye Specialists, PC of any changes in my status regarding the above. All information provided is correct.

Signature_____ Date_____

FAX COMPLETED FORM & CERTIFICATE OF INSURANCE TO OUR SURGERY COORDINATOR:

Select Clinic