



Application of Payor Advisory/ Practice Staff

Please print or type.

Name: _____ Degree(s): _____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: (____) _____ Fax: (____) _____

Employed by: _____

Office Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Office Phone: (____) _____ Fax: (____) _____

Other Current Professional organization memberships: _____

List any practice(s), clinic(s), hospital(s), or surgical/treatment center with which you are affiliated:

1. _____
2. _____
3. _____

Please briefly describe the nature of your position: _____

Are you currently a member of OSCO's Payor Advisory Committee? Yes _____ No _____

If not, would you like to participate in the monthly meetings either in person or via teleconference?
_____ in person (Tulsa) _____ by teleconference

Signature: _____ Date: _____

Questions:

Call: 918-274-8374

Fax: 918-274-8354

Email: MaryJo@oscook.org

Mail: OSCO

8805 N 145th E Ave, Ste 203

Owasso, OK 74055

PLEASE FAX THIS FORM TO 918-274-8354