Anderson Healthcare

PROVIDER SIGNATURE FORM

Dear Provider:

Please sign the bottom **exactly** as you sign your medical records. As well, please initial **exactly** as you initial progress notes, etc. This signature form is kept on file for reference purposes.

Please return the signed and initialed form with your credentialing packet.

Thank you for your cooperation in this matter!

PLEASE DO NOT USE TYPED TEXT OR DOCUSIGN.
MUST BE IN BLUE OR BLACK INK.

PROVIDER SIGNATURE

Printed Name:_____ Date: _____

Sign your **full name** as it would be documented in the Medical Record:

_____

Sign your **initials** as it would be documented in the Medical Record:

_____