



T-BONES Membership Registration

Name and Title:			
Practice Name:			
Mailing Address:			
Phone Number:		Fax:	
Work e-mail:			
# of Physicians:			
Certifications:		# of Locations:	
Practice Type:	<input type="checkbox"/> Private <input type="checkbox"/> University Affiliated <input type="checkbox"/> Solo	<input type="checkbox"/> Multi-Specialty <input type="checkbox"/> Hospital Based/Owned <input type="checkbox"/> Clinical	
Does the Practice Employ:	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> MA <input type="checkbox"/> PA <input type="checkbox"/> Ortho Tech <input type="checkbox"/> Radiology Tech <input type="checkbox"/> Other:	<input type="checkbox"/> Occupational Therapist <input type="checkbox"/> NP <input type="checkbox"/> Surgical Asst <input type="checkbox"/> Hand Therapist <input type="checkbox"/> PT	
Does Office Have:	<input type="checkbox"/> X-Ray <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Ambulatory Surgery Center <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> Occupational Therapy		
Charts:	<input type="checkbox"/> Electronic <input type="checkbox"/> Paper	EMR/EHR Name:	
PMS Name:			

Send to: Hilary Marshall
 9737 Great Hills Trail #240 | Austin, TX | 78759
 Phone: 512.708.8834 | Fax: 512.708.8131

