



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

**EARLY INTERVENTION PROGRAM PROVIDER AGREEMENT
APPENDIX B**

Please complete for all additional service locations

ADDITIONAL CLINIC					
Facility Name:					
Physical Address:					
City:		State:		Zip:	
Appointment Number:		Fax Number:			
BUSINESS INFORMATION					
Appointment phone number:		Fax Number:			
Location address:					
City:		State:		Zip:	
CONTACT INFORMATION					
Office Manager/Admin:		Phone Number:			
Email address:					

ADDITIONAL CLINIC					
Facility Name:					
Physical Address:					
City:		State:		Zip:	
Appointment Number:		Fax Number:			
BUSINESS INFORMATION					
Appointment phone number:		Fax Number:			
Location address:					
City:		State:		Zip:	
CONTACT INFORMATION					
Office Manager/Admin:		Phone Number:			
Email address:					

PLEASE USE ADDITIONAL FORMS AS NEEDED