ALLEN MEDICAL INTERNATIONAL

Please provide information about your facility/clinic and/or hospital.

Medical Facility International Network Enrollment Form

Please return this form with your fee schedule/rates to one of the options below:

E-mail: info@allenmedicalinternational.com /**Fax:** +1-818-698-8434 /
Postal at: Allen Medical International - 13106 Riverside Drive, Sherman Oaks, California 91423, USA

PROVIDER INFORMATION

Facility Name:

Provider Name:

Physical Address:

P.O. Box

City

Postal Code

COUNTRY

Web URL

Additional Locations? ◯ YES ◯ NO

If "YES" please provide contact details below.
You may attach a separate sheet if necessary.

Name		Name	
Address		Address	
City		City	
COUNTRY		**COUNTRY**	
Phone		Phone	
Fax:		Fax:	

KEY CONTACTS

International Patient Coordinator		**Medical Director**	
Name:		Name:	
Phone:		Phone:	
Fax:		Fax:	
E-mail:		E-mail:	

Admissions Department		**Accident & Emergency Department**	
Name:		Name:	

Phone: Phone:

Fax: Fax:

E-mail E-mail

Payments Accounts & Credit **Agreements**

Name: Name:

Phone: Phone:

Fax: Fax:

E-mail: E-mail:

FACILITY STATISTICS

Total number of beds: International Patient Centre on-site? ◯ YES ◯ NO

Number of Private Rooms: Number of Semi-Private Rooms:

Number of Shared Wards: Number of Intensive Care Beds:

Average Doctor to Patient Ratio: Average Nurse to Patient Ratio:

Number of International Patients Per year: Number of Admissions Per Year:

Number of A&E Visits Per Year: Number of Day Cases Per Year:

Complication Rate: Morality Rate: Infection Rate:

24/7 Accident & Emergency Department? ◯ YES ◯ NO

24/7 On-Site Doctor Led Resuscitation? ◯ YES ◯ NO

English Spoken Medical Staff? ◯ YES ◯ NO

English Spoken Administrative Staff? ◯ YES ◯ NO

OTHER INFORMATION

What is the legal entity of your facility? ◯ PRIVATE ◯ GOVERNMENT ◯ OTHER

If "OTHER", please specify:

Languages spoken by staff:

Has your facility been accredited by a national/ international accreditation body?	◯ YES ◯ NO	If "YES", please specify accreditation(s) & date(s) received:	
Does your facility have affiliations/ training arrangements with any hospitals/ universities?	◯ YES ◯ NO	If "YES", please specify:	
Does your facility have affiliations with other hospitals on a national or international basis?	◯ YES ◯ NO	If "YES", please specify:	
Does your facility have agreements with international insurance companies?	◯ YES ◯ NO	If "YES", please specify:	
Is your facility considered as a centre of excellence for specific diagnosis or treatments:	◯ YES ◯ NO	If "YES", please specify:	
Have you and/ or any of your medical staff trained in the U.S.?	◯ YES ◯ NO	If "YES", please list names & specialties:	
Status doctors: *(Pease send us a list of the doctors working at your facility)*	☐ INDEPENDENT ☐ PAYROLL		

FACILITY LIST OF SPECIALTIES *(Please check all that apply)*

ALLERGOLOGY	☐	INFECTIOUS	☐	PHSIOTHERAPY	☐
ANESTHESIOLOGY	☐	INTERNSIVE/ CRITICAL	☐	PLASTIC SURGERY	☐

BLOOD BANK ☐	INTERNAL MEDICINE ☐	PNEUMOLOGY ☐
BURN CENTRE ☐	LABORATORY ☐	PODIATRY ☐
CARDIAC SURGERY ☐	MAXILLOFACIAL ☐	PREVENTATIVE MEDICINE ☐
CARDIOLOGY ☐	NEONTOLOGY ☐	PSYCHIATRY ☐
DENTAL SURGERY ☐	NEPHROLOGY ☐	PSYCHOLOGY ☐
DENTISTRY ☐	NEUROLOGY ☐	RADIOLOGY ☐
DERMATOLOGY ☐	NEUROSURGERY ☐	RADIATION THERAPY ☐
DIALYSIS-OUTPATIENT ☐	NUCLEAR MEDICINE ☐	REHABILITATION ☐
DIALYSIS-INPATIENT ☐	OBSTETRICS ☐	REPRODUCTIVE MEDICINE ☐
EMERGENCY MEDICINE ☐	OCCUPATIONAL ☐	RHEUMATOLOGY ☐
ENDOCRINOLOGY ☐	ONCOLOGY ☐	SPORTS MEDICINE ☐
GASTRO-ENTEROLOGY ☐	OPHTALMOLOGY ☐	STOMATOLOGY ☐
GENERAL SURGERY ☐	ORGAN TRANSPLANT ☐	SUBSTANCE ABUSE ☐
GERIATRIC MEDICINE ☐	ORTHOPAEDICS ☐	THORACIC SURGERY ☐
GYNECOLOGY ☐	OTOLARYNGOLOGY ☐	TRAUMATIC SURGERY ☐
HEMATOLOGY ☐	PATHOLOGY ☐	TROPICAL DISEASE ☐
HOUSE CALLS ☐	PEDIATRICS ☐	UROLOGY ☐
IMAGING ☐	PHARMACY ☐	VASCULAR SURGERY ☐
IMMUNOLOGY ☐	OTHERS (please list):	

Please provide details of ancillary services your facility offers. You may attach a separate sheet if necessary:

Laboratory:

Imaging & Radiology:

Pharmacy:

Transport (Ambulance; Helicopter; etc.):

Printed Name: Title:

Signature: Date:

Please send a list of your procedures and fees for each along with this form.

SAVE

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