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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please Include the Additional Practitioner List with the ATC Form | | | | | | | | | | |  | | | Phone Number: | |  | |
| Legal Entity Name: | | | | | | | | | | |  | | | Date Submitted: | |  | |
| Federal Tax ID: | | | | | | | | | | | | | | | | | Internal Use ONLY |
|  | SSN | NPI | Practitioner’s Name | Gender | Title or Degree | Date of Birth | License Number | License State | DEA Number | DEA State | | Accepting New Patients? | Directory Suppress? | | Practice Type | | Cred Validation |
| 1 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
| 2 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
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| 9 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
| 10 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
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| 24 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
|  | **SSN** | **NPI** | **Practitioner’s Name** | **Gender** | **Title or Degree** | **Date of Birth** | **License Number** | **License State** | **DEA Number** | DEA State | | Accepting New Patients? | Directory Suppress? | | **Practice Type** | | **Cred Validation** |
| 25 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
| 26 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
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| 46 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
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| 49 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |
| 50 |  |  |  |  |  |  |  |  |  |  | | Select One | Select One | | Select One | |  |

E-mail the completed form, along with the ATC form to [MedicaDemoFormSubmis@medica.com](mailto:MedicaDemoFormSubmission@medica.com).