Gateway to CARE Provider Health Network

GATEWAY TO CARE
PROVIDER HEALTH NETWORK
PLEDGE CARD

□ Yes, I wish to volunteer for the PHN and pledge the following:

Every twelve* months, I will:

□ Accept ____ (minimum of 2) PHN referrals for ongoing or short term care needs (We suggest 10 for primary care or 20 for specialists.)

□ Volunteer at an area clinic (We suggest 8 times.)
*You may modify your commitment or leave the program at any time.

□ Please contact me. I have additional questions regarding the Provider Health Network (PHN).

□ I am unable to volunteer for the PHN at this time, but I would like to make a contribution to the PHN Project. Checks should be made out to: Gateway to Care – PHN Project and mailed to: 3611 Ennis, Houston, Texas 77004.
All donations are tax deductible to the extent allowed by law.

Name: _____Signature_____
(Please print)

Address: _____

City: _____ Zip: _____

Specialty: _____

Contact Information:

Office phone:_____ Cell:_____ E-mail:_____

Preferred method of contact: (1) _____
(2) _____

Date: _____

Upon Completion, please fax to: Lyn Widlaski, 713.785.3077
Lyn Widlaski, Development and Provider Relations, 713.783.4616 (Ext. 222)
E-mail: lyn.widlaski@gatewaytocare.org

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