



In Town Doctors, inc.

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Dear Practice Manager,

To ensure the information contained in our database at www.InTownDoctors.com is correct about your physician(s) and /or physician group(s), please take a second to complete the following:

Practice Name: _____

Address: _____

Phone: (____) _____ Fax # (____) _____

E-Mail: _____

Website: _____

Specialization: _____

Hospital Affiliation _____

Health Insurance Accepted: _____

Office Hours: _____

Are you willing to accept patients with personal injuries and industrial or workmen compensation claims?

☐

Yes

☐

No

Thank you for your prompt reply.

Respectfully, InTownDoctors.com