



Clinical Resource Center Application

3300 Ponce De Leon Blvd.
Coral Gables, FL 33134
(877) 228-7321
www.alpha1.org

Please return the completed application via E-mail to
dfernandez@alpha1.org

Date of Application

Name of Facility

Address

Telephone Number

Fax Number

Email address

WEBSITE LISTING: For the **ONE** designated physician per specialty to be listed on the website please provide:

Physician Name

Title

Specialty/Division

Facility Name

Facility Address

Facility Phone

Contact Person

Contact Person's Phone

Contact Person's Fax

Contact Person's Email

1. How many patients have been tested for Alpha-1 at your facility in the past year?
2. How many new Alpha-1 patients have been seen in the past year at your facility?
3. How many Alpha-1 patients in total are currently followed at your facility?
4. Is there a local support group located at or organized by your facility for individuals with Alpha-1?

If yes, how many members are part of the support group?

What support group activities have you participated in?

5. Does your facility have a Nurse or Respiratory Therapist with special interest in

Alpha-1?

6. Please list the contact person or Nurse Coordinator for Alpha-1 patients at your facility:

Name: _____ Email: _____

7. Is your facility located or affiliated with:

University Solo Practice
Hospital Physician Group Other (please list)

8. Please indicate the specialties available to Alpha-1 patients (in your practice or nearby):

Gastroenterologists/Hepatologists	Pulmonologists
Adult	Adult
Pediatric	Pediatric
Allergist Immunologist	Pediatricians
Critical Care Physicians	Psychologists/Social Workers
Internal Medicine Physicians	Respiratory Therapists
Genetic Counselors	Transplant Surgeons
Nutritionists	Other

9. Do you participate in:

Basic Research Clinical Research Alpha-1 Research

10. Are you affiliated with a lung transplant facility?

11. Facility Name: _____ Location: _____

12. Are you affiliated with a liver transplant facility?

13. Facility Name: _____ Location: _____

12. Do your Alpha-1 patients have access to a Pulmonary Rehabilitation facility?

13. Would you be willing to give scientific or educational presentations about Alpha-1?

14. What program(s) do you use for Electronic Health Records (EHR)?

CHECKLIST PRIOR TO SENDING APPLICATION

**THIS COMPLETED APPLICATION
SIGNED AGREEMENT
CV/RESUME OF DESIGNATED PHYSICIAN
CV/RESUME OF NURSE COORDINATOR**

**IF YOU HAVE ANY QUESTIONS REGARDING THIS APPLICATION, PLEASE CONTACT:
David Fernandez at (877) 228-7321 ext. 242, or email at dfernandez@alpha1.org**