



# 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  
vvalencia@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:  
Vanessa Valencia at (877) 228-7321 ext. 242, or email at [vvalencia@alpha1.org](mailto:vvalencia@alpha1.org)**