Clinical Resource Center Application

3300 Ponce De Leon Blvd.
Coral Gables, FL 33134
(877) 228-7321
Fax: (305) 567-1317
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? Please select a

   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? Please selec

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 ☐
Adult ☐
Pediatric ☐

Pulmonologists ☐
Adult ☐
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? Please selec

11. Facility Name: Location:

12. Are you affiliated with a liver transplant facility? Please selec

13. Facility Name: Location:

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

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

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