

Business card order form

PHYSICIAN

Note: Cards are ordered in batches on the 15th of every month but may be delayed until the order is of sufficient size to be cost effective.

☐ **Appointment cards**

 Name Credentials Job title Pronouns: name@clinicname.com	Your physician is a member of the Calgary West Central Primary Care Network cwcpn.com	Your next appointment: Date: _____ Time: _____	Clinic name Address Calgary, AB Postal Code p: 403.555.4567 f: 403.555.4568 clinicwebsite.com
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Only completed fields will appear on your cards.

Physician name: _____ **Credentials:** _____

Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: _____

☐ **Do not** include Pronouns on my cards

Title: _____ **Email:** _____

Clinic name: _____ **Clinic website:** _____

If a clinic name is provided, we will include the address.

Clinic phone number: _____ **Clinic fax number:** _____

Quantity: ☐ 100 ☐ 500

Please email the completed form to: memberservices@cwcpn.com.