Provider Resources, LLC

Physicians Wishing to Purchase Practices

Please fax completed application to 480-563-7939

Last Name Middle Name or Initial First Name

Address City State Zip

Home Phone Cell Phone Email

Do you hold licenses in any States? ______________________________

Board Certifications, if any ______________________________

Total Years Licensed ______________________________

State(s) seeking to purchase practice in ______________________________

What is your time frame? ______________________________

Please attach CV