Practice/Team Volunteers Survey

* Is your group practice or Tele-ICU team is willing to partner with one of the NETCCN Teams to deliver tele-critical care services using the NETCCN application assigned?

* Please provide your Point of Contact Information in the input fields below:

* First Name: * Last Name:

* Practice Name:

* Email Address: * Best Contact Phone Number:

What are the provider types and numbers that your practice/group/team can provide?

	Specialty	Quantity
MD		
Critical Care Physician		
Critical Care Nurse		
RN		
Respiratory Therapist		
Social Worker		
Critical Care Pharmacist		
Palliative Care		
Clergy		
Other:		

* What is your practice/group/team's availability to provide telemedicine services? Please annotate by checking the boxes below.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
24 Hours	☐	☐	☐	☐	☐	☐	☐
Night Shift Coverage	☐	☐	☐	☐	☐	☐	☐
Day Shift Coverage	☐	☐	☐	☐	☐	☐	☐
Weekends Only	☐	☐	☐	☐	☐	☐	☐
Other: Please define	☐	☐	☐	☐	☐	☐	☐

* Do all the providers that will be providing support have appropriate licenses?

Save the form then e-mail completed form to:
usarmy.detrick.medcom-usamrmc.mesg.netccn-operations-officer@mail.mil

Save