



W e s t c h e s t e r R E M A C
On-Line Medical Control Physician – Info Change
 (Address or Hospital Affiliation)

Please Type or Print Legibly. Indicate which information has changed

Last Name _____ First Name _____ M.I. _____

ADDRESS CHANGE

Address _____

City _____ State _____ Zip _____ Email _____

Home Phone () _____ Work Phone () _____

HOSPITAL AFFILIATION CHANGE

(Also have bottom section completed by the Emergency Department Director or his or her designee)

Primary Hospital* _____ Hospital ID _____

Other Hospital _____ Hospital ID _____

(* Note: Westchester Regional Medical Control or Special Resource Hospital)

THIS SECTION TO BE COMPLETED BY THE MEDICAL CONTROL OR SPECIAL RESOURCE HOSPITAL

As Emergency Department Director (or his or her designee) of _____
 (a Westchester Regional Medical Control or Special Resource Hospital), I will ensure that this Medical Control
 Physician is updated as required by the Westchester REMAC.

ED Director or
 designee (Print) _____

Signature _____

Date ____ / ____ / ____

This completed form must be **MAILED** to:

Westchester REMAC
4 Dana Rd.
Valhalla, NY 10595
ATTN: Physician Credentialing