

Provider Contact Information

If you are interested in receiving important information about narcotic treatment program services, across the state and nationally, please complete the following information:

Are you a COMP Member (circle one) Yes No

Provider Name: _____

Principal: _____ Title: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

Alternate Contact (optional): _____

Address: _____

Telephone: _____ Fax: _____

Email: _____