



## PHYSICIAN NOMINATION FORM for MD's and DO's

\_\_\_\_\_ Date

Physician Name including Degree: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State Zip Code: \_\_\_\_\_

Phone Number (including Area code): \_\_\_\_\_

Specialty: \_\_\_\_\_

### **BELOW TO BE COMPLETED BY AETNA PERSONNEL:**

Request Completed By: \_\_\_\_\_

Aetna Representative: \_\_\_\_\_

**Please forward this form to City of Scottsdale Human Resources (HR 101) for transmittal to Aetna. Thank you.**