

## Telehealth Service Notification Form

Date:

Submitted By:

Department: \_\_\_\_\_ Program or Division: \_\_\_\_\_

Please provide a brief description of the clinical telehealth services that you are planning to provide or receive.

UNM HSC physicians/providers delivering or receiving telehealth services:

Name: \_\_\_\_\_ Phone No. \_\_\_\_\_ Email: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone No. \_\_\_\_\_ Email: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone No. \_\_\_\_\_ Email: \_\_\_\_\_

Please provide the following information for each remote site (use additional form if necessary):

*Name of Organization:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Clinical Contact Name:* \_\_\_\_\_ *Phone No.* \_\_\_\_\_ *Email* \_\_\_\_\_

*Technical Contact Name:* \_\_\_\_\_ *Phone No.* \_\_\_\_\_ *Email* \_\_\_\_\_

*Admin. Contact Name:* \_\_\_\_\_ *Phone No.* \_\_\_\_\_ *Email* \_\_\_\_\_

*Location of videoconferencing facility* \_\_\_\_\_

Telehealth service start date: \_\_\_\_\_ Telehealth service end date: \_\_\_\_\_

Who is responsible for the cost of clinical services? \_\_\_\_\_

Grant number, if applicable \_\_\_\_\_

Who is responsible for connectivity charges? \_\_\_\_\_

PR number for connectivity charges, if applicable \_\_\_\_\_

Division Chief Approval \_\_\_\_\_ (Signature)

Department Chair Approval \_\_\_\_\_ (Signature)

*Please submit completed form to: Telehealth Services Manager, UNM Center for Telehealth,  
MSC 11 6090, 1 University of New Mexico, Albuquerque, NM 87131-0001*