PROVIDER KEY CONTACTS

LOUISIANA HIGH SCHOOL ATHLETIC ASSOCIATION HEALTHCARE PROVIDER

ORGANIZATION: _____

PROPOSAL PREPARER (PRIMARY)

Name: _____ Title: _____
Organization: _____
Mailing Address: _____
Email Address: _____
Phone: _____ Cell: _____

HEAD PHYSICIAN

Name: _____ Title: _____
Organization: _____
Mailing Address: _____
Email Address: _____
Phone: _____ Cell: _____

HEAD ATHLETIC TRAINER

Name: _____ Title: _____
Organization: _____
Mailing Address: _____
Email Address: _____
Phone: _____ Cell: _____