# My Healthcare Providers

| My Primary Care Team | |
|---|---|
| Provider Name(s) | |
| Clinic Address | |
| Phone Number | |
| Fax | |
| Email | |

| My Specialty Care Team | | |
|---|---|---|
| Provider Name(s) | Specialty | Phone Number |
| | | |
| | | |
| | | |
| | | |
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# My Healthcare Providers (Page 2)

| My Private Duty Nursing Team | |
|---|---|
| Company | |
| Phone Number | |
| Nurse(s) | |
| Company | |
| Phone Number | |
| Nurse(s) | |

| My Outpatient Therapy | |
|---|---|
| Company | |
| Address | |
| Phone Number | |
| Fax | |

| My Therapy Team | |
|---|---|
| Physical Therapist | |
| Occupational Therapist | |
| Speech Therapist | |
| ABA Therapy | |
| Behavioral Therapist | |