NEW INDEPENDENT PROVIDER REQUEST

Name of Independent Provider:

Name and Date of Request:

Description of Request (Certification fees, Background check)

Total dollar amount of request: $

Name of Requester (please print):

Signature of Requester:

Contact Phone or Email:

Address to send the check:

Please return this completed form to Amy Lash at alash@clearwatercog.org
Questions? Amy can be reached at 567-262-3153

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Approval/Denial: ☐ Approved ☐ Denied

Clearwater COG Staff: ______________________________

MISSION
The Clearwater Council of Governments is committed to collaborating with our partners to enhance people's lives one system, one community and one person at a time.