Provider Commitment Form

We ask that each individual provider (i.e., prescriber) at participating facilities complete a commitment form. Fill out and submit the form in the enclosed postage paid envelope along with your completed baseline survey. All forms can also be emailed to Antibiotic.Stewardship@Hektoen.org.

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1. To confirm your participation in the **Precious Drugs & Scary Bugs Campaign**, please provide your information below.

   First name _____

   Last name _____

   E-mail address _____

2. What is your title? Select all that apply.

   Title (Select all that apply)

   ☐ Midwife
   ☐ Nurse Practitioner
   ☐ Physician
   ☐ Physician Assistant
   ☐ Other (please specify) _____

3. What is the name of your primary care facility? *If you practice at more than one facility, please list the facility that is participating in the campaign. If more than one of your facilities are participating in the campaign, please list the facility where you practice more than 50% of your time.*

   Facility Name _____

   Street Address _____

   City _____

   Zip code _____

I understand the importance of antibiotic stewardship and am committed to promoting judicious antibiotic use. Your signature below confirms your commitment to participate in the campaign.

_____ _____

Signature Date

Thank you for taking part in preventing antibiotic resistance. Your participation is greatly appreciated.