

MAILING ADDRESS FILE
BY
PHYSICIAN'S PRIMARY SPECIALTY

Your Department Name _____

Brief description of what you are mailing with these labels _____

Name of your contact person regarding this request _____

Phone _____ FAX _____ Campus Address _____

Date Ordered _____ **Date Needed** _____

STEP 1. Please check geographical areas you want your mailing sent to:

| | |
|--|--|
| Check your choices here <input checked="" type="checkbox"/> | |
| | All University of Utah Medical Faculty |
| | Wasatch Front physicians – Salt Lake, Davis, Utah, Weber Counties (specify specialty in <i>Part 2</i>) (labels will include Univ. Medical Faculty) |
| | Utah (specify specialty in <i>Part 2</i>) (labels will include Univ. Medical Faculty) |
| | Nevada (specify specialty in <i>Part 2</i>) |
| | Idaho (specify specialty in <i>Part 2</i>) |
| | Wyoming (specify specialty in <i>Part 2</i>) |
| | Montana (specify specialty in <i>Part 2</i>) |
| | Western Colorado (specify specialty in <i>Part 2</i>) |
| | Other: Please specify – such as a specific city, county or zip code: _____ _____ |

STEP 2. Please check specialties you want to receive your mailing:

| <u>CODE</u> | Check your choices here <input checked="" type="checkbox"/> | <u>Specialty Name</u> |
|--------------------|--|---|
| 0 | | All specialties (codes 3 through 35 listed below) |
| 3 | | Allergy |
| 4 | | Anatomy |
| 5 | | Anesthesiology |
| 6 | | Biochemistry |
| 7 | | Cardiology |
| 8 | | Cardiovascular Disease |
| | | (continued on next page ...) |

| <u>CODE</u> | Check your choices here  | <u>Specialty Name</u> |
|--------------------|---|-------------------------------------|
| 9 | | Cardiovascular Surgery |
| 12 | | Cellular, Viral & Molecular Biology |
| 10 | | Child Psychiatry |
| 11 | | Colon/Rectal Surgery |
| 13 | | Dentists |
| 14 | | Dermatology |
| 15 | | Diagnostic Radiology |
| 16 | | Emergency Medicine |
| 17 | | Endocrinology |
| 18 | | Family Medicine |
| 19 | | Gastroenterology |
| 20 | | General Practice |
| 21 | | General Surgery |
| 22 | | Genetics |
| 23 | | Geriatric Medicine |
| 24 | | Gynecology |
| 25 | | Hematology |
| 26 | | Infectious Disease |
| 27 | | Informatics |
| 28 | | Internal Medicine |
| 29 | | Medical Education |
| 30 | | Neonatology |
| 31 | | Nephrology |
| 33 | | Neurology |
| 34 | | Neurosurgery |
| 32 | | Nuclear Medicine |
| 36 | | Obstetrics |
| 37 | | Obstetrics/Gynecology |
| 38 | | Occupational Medicine |
| 39 | | Oncology |
| 40 | | Ophthalmology |
| 41 | | Orthopedic Surgery |
| 42 | | Osteopaths |
| 43 | | Otolaryngology |
| 44 | | Pathology |
| 45 | | Pediatrics |
| 46 | | Pharmacology |
| 47 | | Physical Medicine/Rehabilitation |
| 48 | | Physiology |
| 49 | | Plastic Surgery |
| 50 | | Preventive Medicine |
| 51 | | Psychiatry |
| 52 | | Public Health |
| 53 | | Pulmonary Disease |
| | | (continued on next page ...) |

| <u>CODE</u> | Check your choices here <input checked="" type="checkbox"/> | <u>Specialty Name</u> |
|-------------|--|---|
| 54 | | Radiation Oncology |
| 55 | | Radiology |
| 57 | | Rheumatology |
| 58 | | Therapeutic Radiology |
| 59 | | Thoracic Surgery |
| 60 | | Urology |
| 62 | | Vascular Surgery |
| 63 | | Legal Medicine |
| 35 | | Unspecified Specialty |
| xx | | Doctors licensed in 6-state region but living elsewhere |

| Check your choices here <input checked="" type="checkbox"/> | <u>ALSO AVAILABLE</u> | |
|--|--------------------------------|-----|
| | UTAH CHIROPRACTORS | 363 |
| | UTAH PODIATRISTS | 125 |
| | INTERMOUNTAIN REGION HOSPITALS | 277 |
| | UTAH NURSING HOMES | 109 |
| | UTAH HOME HEALTH AGENCIES | 96 |
| | UTAH INSURANCE COMPANIES | 33 |

STEP 3. Please FAX or Email all three pages of this completed form to:

Brian Gresh
OFFICE OF PLANNING & MARKETING
 Fax – 715-8157
brian.gresh@hsc.utah.edu

please return all three pages even if you did not order on each page, so we know we received the entire order. Thanks!