

South Carolina Department of Social Services
**PHYSICIAN OR CURRENT HEALTH SERVICE PROVIDER(S)
AND TELEPHONE NUMBERS**

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____

Name: _____ Telephone: _____

Address: _____

Medical Dentist Specialist Type: _____

Therapist Other: _____