



***Center of Occupational Health & Education (COHE) Program
Attending Provider in the Program (APP) - Notice of Program Disenrollment***

Provider Name	L&I Provider Number(s)
Name of Clinic/Group, if applicable	Group Number(s), if applicable
Name of person making disenrollment request from the clinic/group:	Date

Please select reason for APP disenrollment:

- Left group/clinic/facility Moved No longer practicing (retired, etc.)
- Still practicing, but electing disenrollment. List reason (optional): _____
- Other _____

Last day of COHE participation: _____
(MM/DD/YY)

This notification is for COHE Program disenrollment only.

If provider has separated employment from your organization, and you would like his/her L&I Provider Account Inactivated, please select box below.

- Provider above has *completely separated* from employment with this organization. Please inactivate his/her L&I Provider account effective the same date provider is disenrolled from the COHE Program.

COHE representative submitting request to L&I: _____

**When complete, send by fax to 360-902-4249, L&I COHE Program, Attention: Kim Arakawa;
Or complete and send via email to: Kim.Arakawa@LNI.WA.GOV**