



PRACTITIONER APPLICATION
Network Enrollment and Credentialing
Complete as a new employee or when re-credentialing.

Section I. Practitioner Profile

(To be completed by applicant)

Name of Practitioner Seeking Privileges: _____

Former Last Name (if applicable): _____

Date of Birth: _____

Title within the Organization you work for: _____

Name of Organization you work for: _____

Address of Organization you work for: _____

Organization Phone Number: _____

Supervisor Name: _____

Email Address: _____

Date of Hire: _____

Degree: _____

NPI Number: _____

Licensure: _____

License Number: _____

Exp. Date: _____

Certification: _____

Exp. Date: _____

Certification: _____

Exp. Date: _____

Current Credentialing Status: Provisional Probationary Full N/A Current Term Dates: _____

Applying for: Provisional Full Re-Credentialing *(Term shall be determined by Credentialing Committee)*

Target Populations you are seeking privileges to serve within the Region 10 PIHP Provider Network

- Children (0-3 years)
- Children w/Intellectual/Developmental Disabilities (4-17 years)
- Children w/ Serious Emotional Disturbance (4-17 years)
- Children with Substance Use Disorder
- Adults w/ Intellectual / Developmental Disabilities
- Adults with Mental Illness
- Adults with Substance Use Disorder
- Co-occurring Disorders (MH/SUD)
- ABA

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Cultural Competencies and Linguistic Capabilities

Do you speak a language other than English that can assist non-English speaking individuals within the agency you are providing services? YES NO

If you answered 'YES', please identify the language(s): _____

Do you have any cultural or ethnic specialties you would like identified? YES NO

If you answered 'YES', please list them here and identify your specialty qualifications.

**Additional specialties may be identified on Attachment B of this application*

Section II. Privileges Requested

(To be completed by applicant)

I am seeking privileges to perform services as (check all that apply):

<input type="checkbox"/>	Psychiatrist	<input type="checkbox"/> MD <input type="checkbox"/> DO
<input type="checkbox"/>	Physician, Non-Psychiatrist	<input type="checkbox"/> MD <input type="checkbox"/> DO
<input type="checkbox"/>	Psychologist	<input type="checkbox"/> LP
<input type="checkbox"/>	Physician Assistant	<input type="checkbox"/> PA-C
<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/> APRN-BC ANP <input type="checkbox"/> FNP <input type="checkbox"/> PedNP <input type="checkbox"/> APRN-BE NHNP <input type="checkbox"/> PsychNP
<input type="checkbox"/>	Therapist/Clinician, Psychologist Limited License	<input type="checkbox"/> LMSW <input type="checkbox"/> LLMSW* <input type="checkbox"/> LLP <input type="checkbox"/> TLLP* <input type="checkbox"/> LPC <input type="checkbox"/> LLPC* <input type="checkbox"/> LLMFT* <input type="checkbox"/> LMFT <small>*May only provide services under the supervision of LMSW, LLP, LPC or LLMFT</small>
<input type="checkbox"/>	Supports Coordinator/ Case Manager	<input type="checkbox"/> LBSW <input type="checkbox"/> LLBSW* <input type="checkbox"/> SST <small>*May only provide services under the supervision of LMSW</small>
<input type="checkbox"/>	Psychiatric Nurse	<input type="checkbox"/> MA <input type="checkbox"/> MSN in Psych <input type="checkbox"/> RN
<input type="checkbox"/>	Registered Nurse, BSN	<input type="checkbox"/> BSN <input type="checkbox"/> RN <input type="checkbox"/> LPN
<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/> OTR
<input type="checkbox"/>	Occupational Therapy Assistant	<input type="checkbox"/> COTA

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<input type="checkbox"/>	Physical Therapist	<input type="checkbox"/> PTR
<input type="checkbox"/>	Physical Therapy Assistant	<input type="checkbox"/> PTA
<input type="checkbox"/>	Speech Pathologist or Audiologist	<input type="checkbox"/> SLP
<input type="checkbox"/>	Registered Dietician	<input type="checkbox"/> RD

Other Certifications

<input type="checkbox"/>	Substance Abuse Treatment Specialist	<input type="checkbox"/> CADC <input type="checkbox"/> CADC-M <input type="checkbox"/> CAADC <input type="checkbox"/> CCS <input type="checkbox"/> CCS-M <input type="checkbox"/> CCJP <input type="checkbox"/> CCDP <input type="checkbox"/> CCDP-D <input type="checkbox"/> Development Plan
<input type="checkbox"/>	Non-Credentialed Staff	
<input type="checkbox"/>	Qualified Behavioral Health Professional (QBHP)	
<input type="checkbox"/>	Qualified Mental Health Professional (QMHP)	
<input type="checkbox"/>	Qualified Intellectual Disability Professional (QIDP)	
<input type="checkbox"/>	Certified Peer Support Specialist (PSS)	
<input type="checkbox"/>	Children's Mental Health Professional (CMHP)	
<input type="checkbox"/>	Family Psychoeducation	<input type="checkbox"/> Successful completion of Certified Training
<input type="checkbox"/>	Peer Recovery Coach (SUD)**	<input type="checkbox"/> CPRM <input type="checkbox"/> Certified Recovery Coach (CRC) <input type="checkbox"/> MDHHS Certification <input type="checkbox"/> CCAR Completion
<input type="checkbox"/>	Certified in SUD Prevention	<input type="checkbox"/> CPC-R <input type="checkbox"/> CPC-M <input type="checkbox"/> CPS-R <input type="checkbox"/> Development Plan <input type="checkbox"/> CHES
<input type="checkbox"/>	Gender Competent	
<input type="checkbox"/>	Communicable Disease Trainer	<input type="checkbox"/> HAPIS

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<input type="checkbox"/>	Parent Management Training – Oregon Model	<input type="checkbox"/> PMTO
<input type="checkbox"/>	Infant Mental Health Certification	<input type="checkbox"/> IMH
<input type="checkbox"/>	Trauma Focused CBT	<input type="checkbox"/> TFCBT
<input type="checkbox"/>	Board Certified Behavioral Analyst (BCBA)	
<input type="checkbox"/>	Board Certified Aide Behavioral Analyst (BCaBA)	

****Peer Recovery Coach Practitioner Attestation:** This is to be completed when applying for peer recovery coach privileges

- I am in peer recovery
- I have a High School Diploma or equivalent
- I am in stable recovery
- I am actively working in a recovery program E.g.) Twelve-step, church/spiritual, other recovery support group
- I have completed the Connecticut Community for Addiction Recovery (CCAR) training, MDHHS Recovery Coach training, or a MCBAP Certification for Certified Peer Recovery Mentor.

Section III. Privileging Questionnaire

(To be completed by applicant)

1. Are you now, or have you ever been, involved in any malpractice suit, including arbitration?
 Yes No
2. Has any malpractice claim settlement, without litigation or arbitration, ever been paid by you or on your behalf?
 Yes No
3. With regard to each of the following, have you ever been involuntarily denied, removed, suspended, penalized, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any of the items below in anticipation of any of these actions; or any adverse actions pending?
 - a. Clinical Privileges Yes No
 - b. State License Yes No
 - c. Specialty Board Certification Yes No
 - d. DEA Registration or other applicable narcotic regulation Yes No
 - e. Hospital staff membership or privileges Yes No
 - f. Other health care organization staff membership or privileges Yes No
 - g. Professional organization membership Yes No
 - h. Medicare, Medicaid or other government program participation Yes No
 - i. HMO, PPO, or other prepaid health plan participation Yes No
 - j. Professional liability insurance Yes No
4. Have you ever been discharged (terminated) from any position in a healthcare or substance use disorder organization (e.g. hospital, nursing home, CMH, Inpatient state facility, nonprofit agency, etc.)?
 Yes No

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- 5. Other than traffic violations, have you had a misdemeanor conviction in the last 5 years?
 Yes No
- 6. Have you ever had a felony conviction?
 Yes No
- 7. Have you ever been investigated, reprimanded, sanctioned, or fined by any state or local agency?
 Yes No
- 8. Are you an owner partner or investor; or do you have a business (financial) interest in a clinical laboratory, diagnostic or testing center; or do you have other involvement with the provision of health services or pharmaceuticals?
 Yes No
- 9. Do you currently have malpractice coverage either independently or through your agency that you are seeking privileges to provide services through?
 Yes No
 - a. What is the coverage amount? _____
 - b. Dates of coverage: _____
- 10. Are you currently able to perform all necessary functions of the position that is requested to be privileged and credentialed?
 Yes No
- 11. Do you attest that you have no present/current illegal drug or unprescribed medication use?
 Yes No
- 12. I attest that I have completed and attached the Region 10 PIHP Conflict of Interest form.
 Yes No

If no, please provide explanation: _____

**If you answered "Yes" to any question(s) # 1- # 8, please attach a signed and dated explanation for confidential review by the privileging entity.*

Section IV. Attestation

(To be completed by applicant and signed by applicant supervisor)

By signing below I attest that I understand that I am applying to be appointed to provide specialty services within **PIHP Provider Network** and that my clinical work may be subject to Federal, State, PIHP, and/or CMH performance and compliance reviews.

By signing below I attest that I have reviewed the **Mission and Values** statements and **Code of Conduct** as contained in the Corporate Compliance Program and/or Credentialing and Privileging Policy and agree to adhere to these ethical standards of practice and agree to comply with all stated values and guided principles.

By signing below I attest that the information contained herein is correct and complete.

Signature of Applicant: _____

Date: _____

Supervisor Recommendation:

Approve

Disapprove

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Signature of Applicant: _____

Date: _____

*A designated supervisor is mandatory for Peer Specialists/Certified Recovery Coaches, TLLPs, Limited LMSWs, Limited LBSWs, LLPCs; Child Mental Health Professionals, SATSs other than supervisors and SATPs; and Case Managers or Supports Coordinators who are not QMHPs or QIDPs.

*Designated Clinical Supervisor: _____ Degree: _____
PLEASE PRINT

*Designated Child MH Supervisor: _____ Degree: _____
PLEASE PRINT

*A Designated supervisor is mandatory for all staff providing services under a MCBAP Development Plan-Counselor or Development Plan-Supervisor.

*Designated MCBAP Supervisor: _____ Certification: _____
PLEASE PRINT

Section V. Committee Determination

(To be completed by the approving committee or designee only)

The Committee/Designee/Department has reviewed this application enrollment form for credentialing or re-credentialing and recommends a credentialing status of:

- Provisional
 Probationary
 Full
 Does Not Recommend *(Provide Rationale)*

For the following target populations:

- Children (0-3 years)
 Children w/Intellectual/Developmental Disabilities (4-17 years)
- Children w/ Serious Emotional Disturbance (4-17 years)
 Children with Substance Use Disorder
- Adults w/ Intellectual / Developmental Disabilities
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 Co-occurring Disorders (MH/SUD)

Start Date of Term: _____

End Date of Term: _____

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<input type="checkbox"/>	Occupational Therapy Assistant	<input type="checkbox"/> COTA	
<input type="checkbox"/>	Physical Therapist	<input type="checkbox"/> PTR	
<input type="checkbox"/>	Physical Therapy Assistant	<input type="checkbox"/> PTA	
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<input type="checkbox"/>	Registered Dietician	<input type="checkbox"/> RD	
<input type="checkbox"/>	Substance Abuse Treatment Specialist	<input type="checkbox"/> CADC <input type="checkbox"/> CADC- M <input type="checkbox"/> CAADC <input type="checkbox"/> CCS <input type="checkbox"/> CCS-M <input type="checkbox"/> CCJP <input type="checkbox"/> Development Plan <input type="checkbox"/> CCDP <input type="checkbox"/> CCDP-D	
<input type="checkbox"/>	Non-Credentialed Staff		

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<input type="checkbox"/>	Qualified Behavioral Health Professional (QBHP)	
<input type="checkbox"/>	Qualified Mental Health Professional (QMHP)	
<input type="checkbox"/>	Qualified Intellectual Disability Professional (QIDP)	
<input type="checkbox"/>	Certified Peer Support Specialist (PSS)	
<input type="checkbox"/>	Children's Mental Health Professional (CMHP)	
<input type="checkbox"/>	Family Psychoeducation	<input type="checkbox"/> Successful completion of Certified Training
<input type="checkbox"/>	Peer Recovery Coach (SUD)**	<input type="checkbox"/> CPRM <input type="checkbox"/> Certified Recovery Coach (CRC) <input type="checkbox"/> MDHHS Certification <input type="checkbox"/> CCAR Completion
<input type="checkbox"/>	Certified in SUD Prevention	<input type="checkbox"/> CPC-R <input type="checkbox"/> CPC-M <input type="checkbox"/> CPS-R <input type="checkbox"/> Development Plan <input type="checkbox"/> CHES
<input type="checkbox"/>	Gender Competent	
<input type="checkbox"/>	Communicable Disease Trainer	<input type="checkbox"/> HAPIS
<input type="checkbox"/>	Parent Management Training – Oregon Model	<input type="checkbox"/> PMTO
<input type="checkbox"/>	Infant Mental Health Certification	<input type="checkbox"/> IMH
<input type="checkbox"/>	Trauma Focused CBT	<input type="checkbox"/> TFCBT
<input type="checkbox"/>	Board Certified Behavioral Analyst (BCBA)	
<input type="checkbox"/>	Board Certified Aide Behavioral Analyst (BCaBA)	

Credentialing Committee Chairperson/Designee signature below verifies credentialing and privileging of the above-named staff.

 Committee Chairperson/Designee Signature

 Date

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Chairperson/Designee Print Name _____

ATTACHMENT A – Primary Source Verification

(TO BE COMPLETED BY PROVIDER ORGANIZATIONS HUMAN RESOURCE DEPARTMENT OR DESIGNEE)

Name of Practitioner:	Contract Provider:
Degree: College/University: Degree Completion Date: __/__/____	Verification Source: Verified By: _____ Date: _____
Licensure: Expiration Date: _____	Verification Source: Verified By: _____ Date: _____
Certification: Expiration Date: _____	Verification Source: Verified By: _____ Date: _____
Certification: Expiration Date: _____	Verification Source: Verified By: _____ Date: _____
Employee has undergone a satisfactory criminal background check. <i>*must be completed initially and at least every 2-years after</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification Source: Verified By: _____ Date: _____
Satisfactory disciplinary status with regulatory board or agency verified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification Source: http://w3.lara.state.mi.us/free Verified By: _____ Date: _____
Free of Medicare/Medicaid Sanctions: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*must be done initially and monthly on-going</i>	Verification Source: http://exclusions.oig.hhs.gov AND http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-16459--,00.html Verified By: _____ Date: _____
Satisfactory National Practitioner Databank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) query <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification Source: www.npdb.hrsa.gov Verified By: _____ Date: _____
Satisfactory work history review of at least previous five years, or review of full history for those with less than five years' experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification Source: Verified By: _____ Date: _____
Employee has completed the organizations Cultural Compliance Training as required by the CMHSP/PIHP. <input type="checkbox"/> Yes <input type="checkbox"/> No	Verification Source: Verified By: _____ Date: _____

I attest that I have completed the Primary Source Verification as indicated above for the employee indicated.

HR Designee Signature

Date

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All Required Trainings Completed

 Training Designee Signature

 Date

ATTACHMENT B - SPECIALIZED TRAINING/EXPERIENCE

THIS SECTION SHOULD BE COMPLETED BY APPLICANT AND CONFIRMED/APPROVED BY APPLICANTS' SUPERVISOR

SKILLS REQUIRING CLINICAL TRAINING AND/OR CERTIFICATION:

Applicant: Refer to information in your training file or list below specialized training (courses, seminars, conferences, clinical experience) which would qualify you to provide clinical treatment in that specific skill area.

Supervisor: Approve only those skill areas which indicate expertise to provide clinical treatment in the specialty.

Approved by SUPERVISOR

<input type="checkbox"/> ADHD	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> AIDS/HIV/STI	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Autism	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Bi-polar Disorder	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Borderline Personality	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> CBT Behavioral Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Child/Adolescent Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Child/Adolescent Welfare	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Critical Incident Stress Debriefing	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Chronic/Terminal Illness	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Conduct Disorders	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Co-Occurring Disorders (SUD/MH)	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Crisis/Lethality	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Intellectually Disabled Developmentally Disabled	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Dialectical Behavior Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Family Dynamics	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Family Psychoeducation	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Gay/Lesbian/Sexual	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Geriatric (Dementia) Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Grief/Bereavement	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Integrated Dual Disorder Treatment	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Marital/Divorce/Separation	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Mentally Impaired	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Multiple Personality Disorder	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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<input type="checkbox"/> Oppositional/Defiant Disorders	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Panic/Phobia	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Parenting	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Relationships	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> School Related Problems	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Self-Esteem	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Supports Intensity Scale (SIS)	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> SUD Prevention	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Substance Use Disorder	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Trauma/PTSD	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Victimization	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Women's Issues	<input type="checkbox"/> Certificate on File	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Supervisor Signature: _____

Supervisor Name: _____
Please print

Date: _____

**You are expected to keep copies of transcripts, certificates, resumes, supervisory reference letters, etc. or verification of educational experiences in your own personal files. Where certain trainings or certificates are required for credentialing, these records should also be on file in your credentialing file at the Provider Organization.*

**Some competencies or skills do not require specific training or education but may be acquired through experience. Examples of these skills might be the knowledge of a foreign language or cultural group. Please do your best to describe how you are qualified in the areas identified. The list is meant to be an accurate reflection of your abilities and skills and, thereby, an account of those services and skills that your agency can offer.*

4.11.2019

Form #: 1300

Rev. 4/2019

Policy Reference:01-003-0011

C:\Users\Jill_V\Desktop\RFP\Attachment O- Practitioner Application.docx