Phone: (904) 878-1105 Fax: (904) 398-7871

Provider Name: ______________________________

Effective Date: ______________________________

Provider Type: ☐MD ☐DO ☐ARNP ☐PA ☐PT ☐OT ☐OTHER __________

Board Certified: ☐YES ☐NO

Specialty: ______________________________

Life Support Training: ☐BLS ☐ACLS ☐PALS ☐ATLS ☐OTHER __________

Supervising Physician (Mid-Level Only): ______________________________

Training Locations:
- Medical Education: ______________________________
- Internship: ______________________________
- Residency: ______________________________
- Fellowship: ______________________________

DEA Number: ______________________________

PECOS/NPI Number: ______________________________

CAQH Number: ______________________________

Medicaid Number: ______________________________

Medicare Number: ______________________________

Please attach the following that apply:

- Medical License
- All Diplomas: ☐Undergraduate ☐Graduate ☐Postgraduate
- CV
- DEA License
- Malpractice Insurance facesheets for the last 10 years
- Drivers License
- Board Certificate
- Copy of Tax-ID or SSN card