Employee Network, Inc.
PROVIDER APPLICATION

A. General Provider Information

Last Name	First Name	Middle Initial	Professional Designation or Title
Preferred Mailing Address (Line 1)	Preferred Mailing Address (Line 2)		
City	State / Zip		Telephone
Social Security Number **(REQUIRED)**	Date of Birth **(REQUIRED)** / Sex		E-Mail Address **(REQUIRED)**

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)	*Type of Corporation*
Preferred Billing Address (Line 1)	Preferred Billing Address (Line 2)
City / State / Zip	Telephone
Employer Identification Number (EIN) / W-9 on file (*submit form if blank*)	Your Medicare/UPIN Number / Your Medicaid Number

Identify any foreign language(s) or sign language that you speak fluently in treating patients (select no more than 5):

☐ Arabic (AR) ☐ Chinese (CH) ☐ Farsi (FA) ☐ French (FR) ☐ German (GE)
☐ Hebrew (HE) ☐ Hindi (HI) ☐ Italian (IT) ☐ Japanese (JA) ☐ Korean (KO)
☐ Laotian (LA) ☐ Portuguese (PO) ☐ Russian (RU) ☐ Sign Language (SL) ☐ Spanish (SP)
☐ Vietnamese (VI) ☐ Tagalog (TA) ☐ Other (specify): _____

B. Practice Information (Primary Office Site)

Practice Name (if a DB/A)	*# of years at this site*
Practice Physical Address (Line 1)	Practice Physical Address (Line 2)
City / State / Zip	Appointment Telephone
Office Manager (if applicable)	Fax Telephone

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes ☐ No ☐ Is this office accessible to public transportation? Yes ☐ No ☐

C. Referral Information (Primary)

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice
Child (up to age 12)	
Adolescent (13 - 17)	
Adult (18 - 64)	
Geriatric (65+)	

Business Lines	% of Practice
Group Health (PPO)	
Capitation (HMO)	
Workers Compensation	
Personal Injury	

D. Practice Information (Secondary Office) **(please copy for additional physical locations)**

Practice Name			
Practice Physical Address (Line 1)		Practice Physical Address (Line 2)	
City	State	Zip	Appointment Telephone
Office Manager (if applicable)			Fax Telephone

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)			
Billing Address (Line 1)		Billing Address (Line 2)	
City	State	Zip	Telephone
Employer Identification Number (EIN)	W-9 on file (*submit form if blank*)	Your Medicare/UPIN Number	Your Medicaid Number

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Is this office handicapped accessible? Yes __ No __ Is this office accessible to public transportation? Yes __ No __

E. Referral Information (Secondary)

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice
Child (up to age 12)	
Adolescent (13 - 17)	
Adult (18 - 64)	
Geriatric (65+)	

Business Lines	% of Practice
Group Health (PPO)	
Capitation (HMO)	
Workers Compensation	
Personal Injury	

F. Licence/Certification Information

DRUG CERTIFICATE: If applicable, listed below is your current DEA/CDS Certificate on file with Employee Network. If the certificate has expired, or if you have changes to report, strike out the incorrect information and make the necessary corrections.

DEA Certificate #	Exp. Date

(NOTE: to expedite credentialing, please enclose a copy of your DEA certificate even if it has not expired.)

CDS Certificate #	Exp. Date

(NOTE: to expedite credentialing, please enclose a copy of your CDS certificate even if it has not expired.)

PROFESSIONAL LICENSE (S): Listed below is (are) your current professional license(s) on file with Employee Network. If a license has expired, or if you have changes to report, strike out the incorrect information and make corrections. To expedite credentialing, submit a copy of your current state license even if it is not listed as expired below.

Board Name	Certificate #	Cert. Date	Exp. Date

G. Malpractice Insurance

Listed below is your current malpractice carrier on file with Employee Network. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage, even if the policy below has not expired.

Current Carrier (Name and Certificate Number)	**Policy Number**	**Dates of Coverage**	**Coverage Limits**

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	**Policy Number**	**Dates of Coverage**	**Reason for Changing Carriers**

H. Education Information

Educational Institution (include name and complete address)	Degree	From (mm/yy)	To (mm/yy)
Undergraduate			
Graduate/Medical School			
Internship			
Residency			
Fellowship			

If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)? Yes ☐ No ☐

CONTINUING EDUCATION: List any continuing education seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	Sponsoring Organization (Name and Address)	Date Completed (mm/dd/yy)	# of CEUs Awarded

BOARD CERTIFICATION/SPECIALTY: Listed below are any board certifications currently on file with Employee Network, Inc.

Board Name	Certificate #	Cert. Date	Exp. Date

I. Work History

This section may be used for work history. Please indicate any changes below. **Please explain fully any gaps of six months or more on a separate sheet of paper.** A current Curriculum Vitae (must specify month and year) may be submitted.

From (Month/Year)	To (Month/Year)	Description of Activities

J. HOSPITAL PRIVILEGES

Listed below, if applicable, are the current hospital privileges we have on file for you. Please update these if necessary.

Primary Admitting Facility	Address	Type of Privilege

Other Hospital Privileges	Address	Type of Privilege

CALL COVERAGE: Each practitioner providing care for Employee Network members must arrange for 24-hour coverage. Identify your coverage practitioner(s) by name. It is strongly preferred that your covering practitioner(s) also participate in the Employee Network network. If not, services performed in your absence are subject to the terms of the Participating Practitioner Agreement.

Call Coverage Practitioner	Licensure Level	Telephone
Call Coverage Practitioner	Licensure Level	Telephone
Call Coverage Practitioner	Licensure Level	Telephone

ANSWERING SERVICE: Indicate how you can be reached after hours:

Answering Service Name	Phone #:
Beeper #	Voice Mail #

K. Attestation

NOTE: If "**YES**" is checked, **please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Health Status:** Do you currently have any physical, mental, or emotional condition which may impair your ability to render the professional services which are the subject of this application?.....	☐ Yes	☐ No
a. Do you currently use illegal drugs or abuse drugs or alcohol?.....	☐ Yes	☐ No
2. **Insurance Coverage:** Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?.....	☐ Yes	☐ No
3. **License:** Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?.....	☐ Yes	☐ No
a. Have you ever voluntarily surrendered your license?.....	☐ Yes	☐ No
b. Are formal charges pending against you at this time?	☐ Yes	☐ No
4. **DEA:** Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?.....	☐ Yes	☐ No
5. **Hospital Privileges:** Has any hospital ever dismissed you from its staff?.....	☐ Yes	☐ No
a. Has any hospital ever revoked, suspended, or limited your privileges?.....	☐ Yes	☐ No
b. Has any hospital initiated either type of aforementioned action by formal notice to you?.....	☐ Yes	☐ No
c. Has any hospital refused or denied you privileges?.....	☐ Yes	☐ No
d. Have you ever voluntarily surrendered your hospital privileges?.....	☐ Yes	☐ No
6. **Hospital Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges?.....	☐ Yes	☐ No
7. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured?.....	☐ Yes	☐ No
8. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?.....	☐ Yes	☐ No
9. **Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude?.....	☐ Yes	☐ No
a. Have you ever been named as a defendant in any criminal proceeding?.....	☐ Yes	☐ No
10. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society hospital medical or clinical staff)?.....	☐ Yes	☐ No
11. **Malpractice Action:** Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?.....	☐ Yes	☐ No
a. To your knowledge, is any malpractice action against you currently pending?.....	☐ Yes	☐ No

I hereby attest that the information above is true and correct.

Signature Date (mm/dd/yy)

PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, Employee Network will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize Employee Network *and/or its Credentials Verification Organization (CVO)* to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Employee Network *and/or its CVO*. I release Employee Network and its employees and/or its *CVO* and all those whom Employee Network and/or its *CVO* contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to Employee Network and/or its *CVO* of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

_____ Date (mm/dd/yy):___/___/_____
Signature of Applicant

_____
Name (Please Print)

RETURN COMPLETED APPLICATION TO:

EMAIL TO: CMurphy@eniweb.com or
PRINT & RETURN COMPLETED APPLICATION TO:
Employee Network, Inc.
ATTN: Network Development
1040 Vestal Parkway East
Vestal, NY 13850
P: (800) 364-4748 Ext. 2250
F: (607) 754-8762

REQUIRED DOCUMENTATION TO ACCOMPANY THIS APPLICATION

- ***COPY OF CURRICULUM VITAE***
- ***COPY OF CURRENT STATE LICENSE AND/OR LICENSE REGISTRATION CERTIFICATE***
- ***COPY OF CURRENT STATE CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATE***
- ***COPY OF CURRENT FEDERAL DRUG ENFORCEMENT AGENCY (DEA) CERTIFICATE***
- ***COPY OF CURRENT MALPRACTICE INSURANCE FACE SHEET***

Practice Indicators

Provider/Agency Name: _____

Address: _____ Phone #: ( )

_____ Fax #: ( )

_____

Provider/Agency that provides coverage:

Address: _____

_____ Phone #: ( )

_____ Fax #: ( )

Provider/Agency that provides crisis coverage:

Address: _____

_____ Phone #: ( )

_____ Fax #: ( )

Percentage of cases brought to closure within:

____ 0-6 Sessions ____ 7-12 Sessions ____ 13-20 Sessions ____ 21+ Sessions

Percentage of practice related to: (*Please indicate with a A* those in which you have specific training and experience and attach documentation*)

____ Children	____ Adolescents	____ Couples
____ Elderly	____ Family Issues	____ Marital/Relationship
____ Christian Counseling	____ Alternative Lifestyles	____ Bereavement
____ Anxiety/Panic	____ Depression	____ Eating Disorders
____ Personality Disorders	____ Sexual Dysfunction	____ Substance Abuse
____ Trauma	____ Workplace Issues	____ Critical Incident (CISD)
____ Biofeedback	____ Psychological Testing	____ Other

Please return to the address listed above.