PACIFIC NORTHWEST PROVIDERS

P.O. Box 12249
Portland, OR 97212

PacificNWProviders@gmail.com
800.875.9213
FAX 503.389.1406

Application Instructions

1. Please fill out application completely, and sign and date signature page.
2. Provide 3 professional references (one should be a current member of Pacific Northwest Providers, if possible), including phone number and email address.
3. Enclose a copy of your resume/curriculum vitae, including education, credentials, and professional memberships.
4. Enclose a copy of proof of liability coverage indicating coverage limits and expiration date (photocopy of face sheet.)
5. Enclose a copy of your current license.
6. Enclose payment of $50.00 nonrefundable application fee made payable to: **Pacific Northwest Providers**

You will be notified when your application is complete. The Membership Committee will review all written materials and will interview applicants who meet selection criteria.

Please post, email, or FAX your application materials to PNP. Contact information is listed above.

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Date

Provider Profile

Last Name (print or type) First Name Middle Initial

Degree License Type

Sex Date of Birth Social Security #

Principal Office Address

Street Suite

City State Zip

Office Phone Fax email address

Second Office Address

Street Suite

City State Zip

Office Phone Fax email address

Billing Tax ID Number, NPI#

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Number of years in practice at these locations_______________

Type of Practice Solo______ Group______ Other______________

Corporation/Group Name_______________________________________

Office Hours:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
______	______	_______	_________	_______	______	________

Average Weekly Caseload___________________

What are your provisions for afterhours care, weekends and backup coverage?

____

____

Licensing

List below all states which you are licensed to practice:

Primary State of Licensure______________________

Type of License___________ Date Issued_______ Expire Date__________

License Number______________________

Secondary state of licensure______________________

Type of License__________ Date Issued________ Expire Date_________

Psychiatrist

Board Certified: Yes___ No___ Date__________

Name of Board
DEA#_________ Medicare#____________ NPI#______________________

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Privileges

Physician Applicants

Hospitals at which you have admitting privileges (include psychiatric and chemical dependency hospitals).

Name ______________________ Location ______________________

Name ______________________ Location ______________________

Name ______________________ Location ______________________

Non-Physicians Applicants

Where do you refer your patients when they require hospitalization or additional treatment (indicate facilities, psychiatrists and/or practitioners)?

Name ______________________ Location ______________________

Name ______________________ Location ______________________

Name ______________________ Location ______________________

All Applicants

Chemical dependency programs, partial hospitalization, residential treatment programs and other step-down programs to which you admit/refer.

Name ______________________ Location ______________________

Name ______________________ Location ______________________

Social and community agencies where you consult

Name ______________________ Location ______________________

Name ______________________ Location ______________________

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Professional References

1. ____
Name and Title | Phone

____
Relationship | Email Address

2. ____
Name and Title | Phone

____
Relationship | Email Address

3. ____
Name and Title | Phone

____
Relationship | Email Address

Managed Care Experience

Briefly describe your experience in Managed Care Programs in behavioral health, including pre-treatment authorization, concurrent reviews and quality assurance.

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Please respond to each of the following questions. If you answer yes to any of these questions, please explain on a separate sheet of paper.

1. Has your clinical license/certification ever been revoked, suspended, or limited? Yes___ No___

   a. Is there action pending? Yes___ No___

2. Have you ever been subject to disciplinary review action by the State Licensing Boards, County, State or Professional Society, Hospital, Medical or Clinical Staff Yes___ No___

3. Have you ever been convicted or pleaded guiltily to a felony? Yes___ No___

4. Have you ever had a professional liability judgment or settlement levied against you? Yes___ No___

5. Have your privileges at any hospital ever been suspended, revoked, or not renewed? Yes___ No___

6. Do you suffer from any physical or mental condition which impairs your ability to practice? Yes___ No___

7. Has your narcotics license ever been revoked, suspended or limited? Yes___ No___

8. Have you even been denied professional liability Insurance or has your insurance ever been cancelled, renewal refused, or premiums been surcharged because of claims? Yes___ No___

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Signature of Applicant Date

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I certify that the information contained herein is correct and complete to the best of my knowledge. I understand that any misrepresentations or omissions from this application constitute cause for denial of membership or dismissal, now or in the future.

In making this application, I agree to follow the ethical principles of my respective professional association.

By this application I agree to be available for interview and authorize PNP to consult with individuals, agencies, institutions, and/or hospitals with which I have been associated, and with others, including past and present malpractice carriers, who may have information bearing on my professional competence. I hereby consent that PNP can review any materials or persons to evaluate my professional qualifications, as well as my moral and ethical qualifications for PNP membership.

I hereby release from liability all representatives of PNP for their acts preformed in good faith and without malice in connection with evaluating my application, qualifications and credentials. I also release from liability any and all individuals or organizations who provide information in good faith and without malice concerning my credentials, qualifications, competence, and ethics, for membership in PNP, I also hereby consent to the release of such information.

To the best of my knowledge, I am aware of no health impairment, either physical or mental, that would adversely affect my professional performance or judgment in the treatment of my patients/clients.

____ __________________

Signature of Applicant Date