

CNHN Membership Application

NOTE: IF PRACTICE OPERATES MORE THAN ONE LOCATION, PLEASE COPY AND COMPLETE FORM FOR EACH SEPARATE ADDRESS AND LIST DOCTORS FOR THAT ADDRESS ONLY. CURRENT COPIES OF STATE MEDICAL LICENSE & DEA CERTIFICATE *MUST* BE SUBMITTED WITH NEW APPLICATIONS FOR MEMBERSHIP & VACCINE CONTRACT PARTICIPATION. ATTACH ADDITIONAL SHEET OF PAPER, IF NECESSARY.

APPLICATION PROCESS: <input type="checkbox"/> INITIAL APPLICATION <input type="checkbox"/> UPDATE		DATE:
PRACTICE NAME:		
PRACTICE ADDRESS:		
CITY:	STATE:	ZIP CODE:
TAX ID NUMBER:	# OF SITES: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	
PATIENT LINE:	ADMIN. LINE:	AFTER HRS. LINE:
FAX LINE:	OFFICE HOURS:	WEEKEND HOURS:
OFFICE MANAGER:	PHONE:	EMAIL:
PRACTICE EMAIL:	PRACTICE WEBSITE:	
WOULD YOU LIKE TO BE LISTED IN CNMC "FIND A PEDIATRICIAN" REFERRAL SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

PHYSICIAN INFORMATION

PHYSICIAN NAME:		EMAIL:
NPI NUMBER:	<input type="checkbox"/> APPLIED	ADDITIONAL LANGUAGE(S):
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPECIALTY: <input type="checkbox"/> GEN. PEDS. <input type="checkbox"/> OTHER:	ACCEPTING NEW PATIENTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

PHYSICIAN INFORMATION

PHYSICIAN NAME:		EMAIL:
NPI NUMBER:	<input type="checkbox"/> APPLIED	ADDITIONAL LANGUAGE(S):
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPECIALTY: <input type="checkbox"/> GEN. PEDS. <input type="checkbox"/> OTHER:	ACCEPTING NEW PATIENTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

PHYSICIAN INFORMATION

PHYSICIAN NAME:		EMAIL:
NPI NUMBER:	<input type="checkbox"/> APPLIED	ADDITIONAL LANGUAGE(S):
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPECIALTY: <input type="checkbox"/> GEN. PEDS. <input type="checkbox"/> OTHER:	ACCEPTING NEW PATIENTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

PHYSICIAN INFORMATION

PHYSICIAN NAME:		EMAIL:
NPI NUMBER:	<input type="checkbox"/> APPLIED	ADDITIONAL LANGUAGE(S):
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPECIALTY: <input type="checkbox"/> GEN. PEDS. <input type="checkbox"/> OTHER:	ACCEPTING NEW PATIENTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby apply for membership in Children's National Health Network (CNHN) for the above-named practice & physicians. I attest that all listed physicians are "in good standing" regarding licensure, malpractice, hospital & insurance plan affiliation & accreditation. I agree to update current information regarding all information appearing in this application form as such information becomes available and such additional information as may be requested by CNHN or its authorized representatives in connection with this application and from time to time with respect to CNHN membership. I certify, to the best of my knowledge, that the information provided on this application to the CNHN is true, complete and accurate. I understand that any significant error in, or omission from, this information shall constitute cause for denial of my application. I agree to abide by the terms of CNHN vaccine and other contracts. Failure to do so may constitute cause for practice removal from that contract or CNHN.

Signature of applicant:		Date:
Print name of Applicant:	Title:	