Child Guidance Center
Credentialing Application

Demographic Information:

First Name | Middle Name | Last Name | Suffix | Previous Last Name

Home Address | City | State | Zip

Phone Number | Other Phone Number | Birth Place (City, State, Country)

Date of Birth | Social Security Number | Driver's License # | Marital Status

Position Information:

Team | Job Title | Direct Supervisor | Program Director

Date of Hire | Primary Work Site

Professional/Educational:

Name of College/University (Graduate Degree Earned) | Degree | Dates Attended (mm/yyyy - mm/yyyy)

Address | Phone Number | Graduation Date (mm/yyyy)

Additional Training/Training Institution | Date of Training (mm/dd/yyyy)

Address | Certification Number (attach necessary certificates)

License Information (List ALL current licenses and any others held in the last 5 years):

State | License Type | License Number | Date First Issued | Expiration Date

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Board Certification or National Certification (If applicable):

Name of Board | Specialty of Certification | Date First Certified | Expiration Date

Recertification Required? Yes No

Professional Memberships **(if applicable):**

Organization: Organization: Organization:

DEA **(Medical providers only):**

Federal DEA Number Date Issued Expiration Date

Provider Numbers **(if applicable):**

Medicaid Provider Number Effective Date

NPI Number Commercial Ins. Provider Panels

Professional Liability Insurance: List any other liability insurance maintained, policy must be in your name.

** Child Guidance Center maintains professional liability insurance for provider.*

Name of Carrier Policy Number Coverage Dates

Address City State Zip

Coverage Limits (Occurrence/Aggregate) Occurrences Claims Made

Have any settlements or judgements been made against you or your practice in a professional liability case?	Yes	No
Are there any pending suits, settlements or judgements being made against you or your practice? If yes, please provide documentaion.	Yes	No

Attestations

NOTE: If you have marked "yes" to any of the below questions, please attach an explanation.

Personal History Information:

Question	Answer
Have you experienced any physical or mental impairment that would substantially impede your ability to carry out the scope of your duties?	No Yes
Have you suffered any chemical dependence/substance abuse impairment that have/may interfere with your job performance?	No Yes
Have you ever been suspended or excluded from participation in Medicaid or Medicare programs?	No Yes
Have you ever or do you currently have any criminal investigations against you or your practice?	No Yes
Have you ever been found guilty of civil or criminal charges?	No Yes

License Sanction Information:

Question	Answer
Has your professional license to practice in any jurisdiction been limited, suspended. revoked, restricted or denied?	No Yes
Have you ever voluntarily relinquished your professional license to practice?	No Yes
Have you ever been, or are you currently being investigated by the Department of Business and Professional Regulation?	No Yes
Has your Drug Enforcement Agency (DEA) registration/certification ever been limited, suspended, restricted, revoked, or denied?	No Yes
Have you ever voluntarily relinquished your DEA registration/certification?	No Yes
Have you ever been suspended or excluded from participation in Medicaid or Medicare programs?	No Yes

Hospital/Organization Membership:

Question	Answer
Has your membership status, clinical privileges and/or application ever been denied, suspended, reduced or not renewed at any hospital, managed care organization or any other facility or institution?	No Yes
Have you ever voluntarily relinquished your membership status and/or clinical privileges at any hospital, managed care organization or any other facility or institution?	No Yes
Are you currently under investigation by any hospital, managed care organization or any other facility or institution?	No Yes
Have you relinquished or had your membership removed in any professional organization?	No Yes

Print Name	Signature	Date
Program Director Name	Signature	Date

Attestation Statement and Authorization for Release of Information:

I, the undersigned, hereby attest that the information given in or attached to this application is accurate, true and complete, and fairly represents the current level of my training, experience, capability and competence to practice at the level requested for credentialing in the field of behavioral health. My re-credentialing application contains information regarding my ability or inability to perform the essential functions of the position, with or without accommodations. I understand that, as an employee of Child Guidance Center who delivers therapeutic services to clients of this agency, ongoing monitoring of practitioner sanctions, complaints and quality issues is required. I give my permission to authorized Child Guidance Center representatives to access data base information and other records related to my professional practice for the purpose of monitoring, and/or reviewing the aforementioned, as necessary to comply with credentialing practices.

I, specifically authorize Child Guidance Center and/or authorized representatives, and third parties to release information upon request. I extend immunity to and release from any and all liability, Child Guidance Center, its authorized representatives, and any third parties, for any act performed in good faith and without malice, regarding communications, reports, records, recommendations or disclosures involving me, performed, made, requested or received by Child Guidance Center, its authorized representatives or any third parties, including otherwise privileged or confidential information. I agree that this authorization for release of information expires two years from the signature date of this form.

Print Name	Signature	Date

Clinical Activities and Provisional Scope of Care Checklist

Name Licence Type

Please check the appropriate boxes below indicating the level of service you can provide

	MD	**ARNP**	**Licensed MA/MS/MSW**
Psychiatric Evaluation	☐	☐	☐
Psychiatric Record Review	☐	☐	☐
Medication Management	☐	☐	☐
Clinic Visit (verbal Interaction)	☐	☐	☐
Initiating Involuntary Examination	☐	☐	☐
Administer Medication, Injections, Specimen Collection	☐	☐	☐
Brief Behavioral Health Status Exam	☐	☐	☐
In-Depth Assessment	☐	☐	☐
Bio-Psychosocial Assessment	☐	☐	☐
Rating Inventories/Scales (CFARS/FARS)	☐	☐	☐
Comprehensive Behavioral Healh Assessment	☐	☐	☐
Treatment Planning (required signature)	☐	☐	☐
Individual/Family Therapy	☐	☐	☐
Treatment Planning (required signature)	☐	☐	☐
TBOS	☐	☐	☐
Group Therapy	☐	☐	☐
Crisis Emergency Support Services	☐	☐	☐

Program Director Signature ______________________ Date ______________

Specialty Information

Check all applicable boxes

Are you fluent in any other language?	☐	Which language?
Can you read and translate in the language noted?	☐	
Are you a certified ASL translator?	☐	
Are you proficient in ASL?	☐	

Indicate all that apply. You must have at least two years' experience in order to qualify as having proficiency in the specialty.

	Specialty	Yrs		Specialty	Yrs
☐	ADHD	____ Yrs	☐	Eating Disorders	____ Yrs
☐	Adolescent/Children's Issues	____ Yrs	☐	EMDR	____ Yrs
☐	Adoptions	____ Yrs	☐	Expert Testimony for Court	____ Yrs
☐	AIDS/HIV	____ Yrs	☐	Fetal Alcohol Spectrum Disorder	____ Yrs
☐	Alcohol Abuse	____ Yrs	☐	Gender Issues	____ Yrs
☐	Anxiety/Panic Disorders	____ Yrs	☐	Geriatric/Aging Issues	____ Yrs
☐	Art Therapy	____ Yrs	☐	Grief/Loss	____ Yrs
☐	Attachment Issues	____ Yrs	☐	Infant Mental Health	____ Yrs
☐	Autism/Asperger's	____ Yrs	☐	Learning Disabilities	____ Yrs
☐	Behavior Management	____ Yrs	☐	Neurolingistic Programming	____ Yrs
☐	Biofeedback	____ Yrs	☐	Pain Management	____ Yrs
☐	Certified Behavior Analyst	____ Yrs	☐	Personality Disorders	____ Yrs
☐	Chemical Dependency	____ Yrs	☐	Phobias	____ Yrs
☐	Child Protection/Foster Care	____ Yrs	☐	Physical Abuse	____ Yrs
☐	Children's Traumatic Incident Reduction	____ Yrs	☐	Play Therapy	____ Yrs
☐	Comprehensive Assessments	____ Yrs	☐	Post Traumatic Stress Disorder	____ Yrs
☐	Couples	____ Yrs	☐	Problems of the Disabled	____ Yrs
☐	Court Ordered Evaluation	____ Yrs	☐	Psychological Testing	____ Yrs
☐	Critical Incident Stress Debriefing	____ Yrs	☐	SED Children	____ Yrs
☐	Depression	____ Yrs	☐	Serious & Persistent Mentally ill	____ Yrs
☐	Development Disorders	____ Yrs	☐	Sexual Abuse	____ Yrs
☐	Domestic Violence - Child	____ Yrs	☐	Stress Management	____ Yrs
☐	Domestic Violence - Adult	____ Yrs	☐	Violence Issues	____ Yrs
☐	Drug Abuse	____ Yrs	☐	Women's Issues	____ Yrs
☐	Dual Diagnosis: MH/Substance	____ Yrs	☐	Other	____ Yrs

______________________________ ______________________

Practitioner Signature Date

After careful review of the work history and/or demonstrated performance of this practicioner, I certify that specialties

______________________________ ______________________

Program Director Signature Date

Director's Attestation

Name	License Type:
Scope of Practice	Child and Adolesent Adult Other

Service Area	Needs Improvement	Satifactory	Excellent
Client Satisfaction			
Clinical Skills			
Utilization Management			
Record Documentation			
Peer Interactions			
Reliability			
Professional Development			
Job Engagement			

If improvement is indicated, please indicate what specific corrective action is needed

Comments

Program Director Signature

Date