Medical Enrollment Packet

Please complete **ALL** sections below. If any section is not applicable, please put "N/A." If this form is incomplete, or if it is not signed and dated, it will be returned with request for completion. Please note that this form is now required in order to complete enrollment with CCNV.

Practitioner Information

Practitioner Name: ____

Practitioner NPI: ____

Are you a PCP? ____ Yes ____ No

Employment Status ____ Full Time ____ Part Time ____ Locum

Practice Information

Current Practice Location: ____

Practice Location Address: ____

Practitioner Hours: Monday: _____________. Tuesday: _____________. Wednesday: _____________.

Thursday: _____________. Friday: _____________. Saturday: _____________.

Sunday: _____________.

Malpractice History

Please provide **<u>5 YEARS</u>** of malpractice history in the space below. Dates **<u>must</u>** be in month/year format. If you have a copy of the malpractice certificate(s), please include a copy with this application. If you need more space, please continue on a separate sheet and include with this application.

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By my affixed signature, I, ________________________________ (print name), do hereby attest that I am no longer employed with the entities listed below. Any and all association with said entities has been terminated on the effective date listed below.

Former Employer	Tax ID #	PCP or Specialist	Termination Date
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

By my affixed signature, I, ________________________________ (print name), do hereby attest that I remain employed by the entities listed below.

Former Employer	Tax ID #	PCP or Specialist	Specialty
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

Printed name: ____

Signature: ____ Date: _______________