

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC. (CDPHP)

Registration Form – Credentialing Data Collection

Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, Certified Genetic Counselor, Locum Tenens

1. Name _____
Last First Middle Initial

2. Date of Birth: _____ Social Security Number: _____

3. Licensure: (PA, NP, CNM, CGC) _____ Area of Specialization: _____

4. Undergraduate School: _____ Address: _____

Degree: _____ Year of Graduation: _____

5. Name & Location of Post- Graduate training: _____

Degree: _____ Year of Graduation: _____

6. Federal Narcotic Prescription Number (DEA): _____

You must hold a current DEA certificate to write ANY prescriptions for a CDPHP member. Please attach a copy of your current DEA registration card. REQUIRED FOR NURSE PRACTITIONERS.

7. State(s) Licensed in: _____ State License #(s) _____

8. Name of current Professional Liability Carrier: _____

Address: _____

Amount of coverage: _____ Policy number: _____ from _____ to _____
Policy period

Please attach proof of current malpractice coverage, showing amount of coverage

9. **Principal** *Office Address: _____

Street City

County State Zip Code Office Telephone

Are you an employee of this practice? _____ Yes _____ no
If no, please explain the nature of your relationship with this practice _____

Name(s) of Physicians with whom you are affiliated at this first office address:

1. _____ 2. _____

3. _____ 4. _____

How many hours a week are you at this first location? _____

***If you change your practice locations or the physicians with whom you are affiliated, please notify CDPHP immediately.**

HAVE YOU REMEMBERED TO ATTACH

- 1. A copy of your current DEA registration card**
- 2. A copy of your current NYS registration certificate**
- 3. Proof of medical malpractice coverage in the amounts of \$1 million per occurrence/\$3 million per year**