County of Santa Clara Participating Practitioner Application
Interns and Trainees, Paraprofessionals, Mental Health Rehabilitation Specialists

This application is submitted to: Behavioral Health Services Department, herein, this Healthcare Organization

I. INSTRUCTIONS

This form should be typed. If more space is needed than provided on the original, attach additional sheets andreference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application:

- Face Sheet of Professional Liability Policy or Certification with a letter stating the applicant is covered by the Agency's insurance.
- Curriculum Vitae or professional resume
- For interns and trainees, a placement agreement or contract signed by the applicant, supervisor, or training coordinator and school placement liaison is required. The agreement must specify the duration of the contract.
- For MHRS, provide a copy of MHRS Certificate

II. IDENTIFYING INFORMATION

Legal Last Name:	**Legal First Name:**	**Legal Middle Name:**
Is there any other name under which you have been known? Name(s):		
Mailing Address:	**City:**	
Home Telephone Number:	**State:**	**Zip code:**
Mobile Number: **Email Address:**	**Cultural Capabilities:**	
Birth Date: / **Birthplace (City/State):**	**Country**	
Social Security No.: / **NPI:**	**Gender:** **Non-Binary** **Male** **Female**	
Specialty: / **Taxonomy Code:**	**Race/Ethnicity (voluntary):**	
Languages Spoken (other than English):	**Provider Start Date:**	

III. AGENCY INFORMATION

Agency Name (if applicable):	**Agency Program Name:** **Mental Health** **SUTS**	
Primary Office Street Address:	**City:**	
Supervisor Name: **License:** **NPI:**	**State:**	**Zip code:**
Telephone Number:	**Fax Number:**	
Office Manager/Administrator Name/Title:	**Telephone Number:**	
Office Email Address:	**Fax Number:**	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	
Agency Medicare UPIN/National Provider Identifier (NPI):	**Agency Medi-Cal Number:**	
Secondary Office Street Address:	**City:**	

	State:	**Zip code:**
Office Manager/Administrator Name/Title:	**Telephone Number:**	
	Fax Number:	
Name Affiliated with Tax ID Number (if different than Agency Name):	**Federal Tax ID Number (if different than the Agency Tax ID Number):**	
Tertiary Office Street Address:	**City:**	
	State:	**Zip code:**
Office Manager/Administrator Name/Title:	**Telephone Number:**	
	Fax Number:	
Name Affiliated with Tax ID Number (if different than Agency Name):	**Federal Tax ID Number (if different than the Agency Tax ID Number):**	

IV. COLLEGE EDUCATION (Attach additional sheets if necessary and appliable. Reference this section number and title)

College or University Name:	**Degree:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:**	**State:** **Country:**	**Zip code:**

V. GRADUATE EDUCATION (Attach additional sheets if necessary and applicable. Reference this section number and title)

Professional School:	**Degree:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:**	**State:**	**Zip code:**

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/ EXPERIENCE (Attach additional sheets if necessary. Reference this section number and title)

Agency/Institution:	**Supervisor/Program Director:**	**License Number:** **NPI Number:**
Mailing Address:		
City:	**State:** **County:**	**Zip code:**
Type of Internship:		
Specialty:	**From:** (mm/yy)	**To:** (mm/yy)

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VII. CERTIFICATION/REGISTRATION (Remember to attach copies of documents)		
Registration/Certification Number:	Issue Date:	Expiration Date:
Type of /Registration/Certification:		

VIII. ATTESTATION QUESTIONS	
Please answer the following questions "yes" or "no." If your answer to questions A through F is "yes," please provide full details on Addendum A. Provide an explanation of the incident(s), the date(s) it occurred, the results of the incident, and the date of the conclusion.	
A. Have you had a professional license/certification or privileges that were denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	
	Yes No
B. Have you ever been disciplined by a post-secondary educational institution or by any employer?	
	Yes No
C. Have you ever had a license that was denied certification/recertification by a specialty board or has your eligibility, certification, or recertification status changed (other than changing from eligible to certified)?	
	Yes No
D. Have you ever been convicted of a felony?	
	Yes No
E. Do you presently use any drugs illegally?	
	Yes No
F. Do you have any limitation on your ability to perform all the services required by your agreement with the Healthcare Organization to which you are applying, according to accepted standards of professional performance and without posing a direct threat to the safety of patients (other than a need for a reasonable accommodation)?	
	Yes No

I hereby affirm that the information submitted in this Section VIII, Attestation Questions, and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in the denial of my application.

Print Name Here:____

Signature____**Date**____________________

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance, including the criminal background check or Life Scan report obtained by my employer ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., the County of Santa Clara's credentialing verification organization, Valley Health Plan, hospital medical staffs, medical groups, independent practice associations{IPAs}, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claim history}, licensing authorities, and businesses and individuals acting as their agents collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this HealthcareOrganization, engaged in quality assessment, peer review, and credentialing on behalf of this Healthcare Organization, and all persons and entities providingcredentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with the evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state andfederal law and regulation, if applicable.

I the undersigned and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professionalcompetence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days if there is any change in the information I gave and/or attested to above.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application, or employment. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages **3 and 4**.

Print Name Here:____

Signature____**Date**____________________

(Stamped Signature Is Not Acceptable)