

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

Attachment A

Initial Certification: _____ Recertification: _____ Date: _____					
Last Name:		First Name:		M.I.:	
Managed Care Health Plan:	License Number:		Credentials:		
	Expiration Date:		MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> RN <input type="checkbox"/>		
Trainings:					
Date:	Summary of Course Content:			Instructor:	
Site Reviews Completed in the past 12 months: Use extra sheet for additional sites					
Site NPI Number:	Provider Name:	Address:		Date:	FSR and/or MRR Scores:
					CAPs Issued (Y/N):

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QI Experience in the last 5 years:

Date	Employer	Title and Primary Responsibilities

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DHCS Use ONLY:

Provider: Family Practice <input type="checkbox"/> Pediatrics <input type="checkbox"/> OB/GYN <input type="checkbox"/> Gen. Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/>			
Provider Name and NPI Number:			
Provider Address and Telephone Number:			
Inter-Rater Date: Findings:			
Inter-Rater Score:	MT Candidate	FSR:	MRR:
Inter-Rater Score	DHCS	FSR:	MRR:

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Approved: <input type="checkbox"/>	Certificate Number:
Issue Date:	Recertification Date:
Denied: <input type="checkbox"/> Please provide comments/actions/recommendations:	
Completed By:	
Date:	

Site Reviews Completed:					
Site NPI Number	Provider Name and NPI Number	Address	Date	FSR and/or MRR Score	CAPs issued