APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

Initial Certification: _____ **Recertification: _____** **Date: _____**		
Last Name: **First Name:** **M.I.:**		
Managed Care Health Plan:	**License Number:** **Expiration Date:**	**Credentials:** **MD ☐ DO ☐ PA ☐ NP ☐ RN ☐**

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

DHCS Use ONLY:

Provider: **Family Practice ☐ Pediatrics ☐ OB/GYN ☐ Gen. Practice ☐ Internal Medicine ☐**			
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: ☐	**Certificate Number:**
Issue Date:	**Recertification Date:**
Denied: ☐ **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**