

**APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION**

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

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**QI Experience in the last 5 years:**

Date	Employer	Title and Primary Responsibilities

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**DHCS Use ONLY:**

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

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

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