ProviDRs Care

In connection with and as a part of my application for membership in ProviDRs Care Network, I authorize ProviDRs Care Network to obtain information concerning my education, professional competence and ethics, prior professional memberships, character and experience from all parties possessing such information, including, but not limited to educational institutions, boards, and professional societies.

I release from liability and from the restrictions of the Family Educational Rights and Privacy Act of 1974, ProviDRs Care Network, and the parties from whom such information is requested, and their respective representatives who in good faith and without malice, request, transmit or provide such information.

I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to the Network. I attest that I will continue to maintain active admitting and staff privileges at a Network participating hospital or I have otherwise indicated on this application.

ProviDRs Care Network does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.

_____
Practitioner Signature

_____
Date

_____
Print Practitioner Name

_____
Primary Service Address

_____
City State Zip

Please provide the following information

_____
CAQH Number

_____
Provider NPI Number

_____
Tax ID Number

Please attach the following documents

☐ W-9

☐ Professional Liability Insurance

☐Collaborative Practice Agreement

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