

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 <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):

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

QI Experience in the last 5 years:

Date	Employer	Title and Primary Responsibilities

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

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

APPLICATION FOR DHCS SITE REVIEW MASTER TRAINER CERTIFICATION

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