Provider Credentialing Information

Full/Legal Name: ____

Previous Name (if applicable): ____________________________________

Date of Birth: _________________________ City, State of Birth: __________________________

Social Security Number: ___________________________

CAQH #: ___________________________ NPI #: ___________________________________

Work Email: ____

Provider Specialty (Circle One): BCBA OT SLP PT

License #: ________________________________ Expiration Date: ______________________

Certification #: ____________________________ Expiration Date: ______________________

Education:

Undergrad School: _______________________________________ City, State: ___________________

Degree Obtained: _______________________________________ Graduation Date: ______________

Graduate School: _______________________________________ City, State: __________________

Degree Obtained: ____ Graduation Date: _____________

Languages Spoken: _________________________________

CPR Certification: Y / N Expiration Date: __________________________

First Aid Certification: Y / N Expiration Date: __________________________