Impaired Practitioner Programs

Treatment Program Application

Name of Treatment Facility: ____

Address of Services:

____
Street Address

____
City, State, Zip Code

____
Telephone Number

____
Fax Number

____
E-mail Address

Mailing Address (if different):

____
Address

____
City, State, Zip Code

____
Telephone Number

____
Fax Number

____
Website

Program Certification/Licensure: (JCAHO, CARF, etc…):
____

Program State Licensure: (State and Number): ____

Your program must have at least two licensed treatment providers, one of which must be a Physician (M.D., D.O.) certified in your program specialty.

____
Medical Director

____
License Type

____
Clinical Director

____
License Type

(Please attach copies of certifications and licenses for the program and the above providers, include their malpractice insurance and CV for verification)

PRN/IPN requires there to be one point of contact and an alternative for all PRN/IPN participants

____
Contact Person/Title

____
Telephone Number/Extension

____
E-mail Address

____
Alternate Contact Person/Title

____
Telephone Number/Extension

____
E-mail Address

Evaluation Services offered by the Program:

Outpatient:

____
Telephone number for **participants** to call

____
Types (i.e. Psy, CD, Boundary)

____
Cost

____
Appointment Length

____
Length of time to schedule an appointment

Inpatient:

____
Telephone number for **participants** to call

____
Types (i.e. Psy, CD, Boundary)

____
Cost

____
Length of stay

____
Length of time to schedule an evaluation

Treatment Services offered by the program:

Detoxification:

____
Telephone number for **participants** to call

Inpatient or Outpatient: ____________________

Length of stay: ___________________________

Cost: ___________________________________

Length of time to get into the program: _______

Intensive Outpatient:

____
Telephone number for **participants** to call

Length of program: _______________________

Hours per week: _________________________

Cost: ___________________________________

Length of time to get into the program: _______

Residential/PHP:

____
Telephone number for **participants** to call

Length of program: ________________________

Cost: _________________________________

Length of time to get into the program: _______

Maintenance (Suboxone/Methadone):

____
Telephone number for **participants** to call

Outpatient Costs: ________________________

Describe Continuing Care program available: ____
____

Please describe the types of self help programs available and other educational, therapeutic activities, specific to impaired professionals: ____
____

Requirements to be an approved treatment provider for IPN, PRN, and the DOH:

1. Inform IPN/PRN immediately of entry into treatment.
2. Inform IPN/PRN if the participant leaves against medical advice, there are problems with treatment compliance, and positive drug screens.
3. Weekly progress report.
4. Notify IPN/PRN of any changes in treatment status.
5. Provide continuing care recommendations including ability to practice and any restrictions on the practice to be included in the participant's contract.
6. Provide preliminary discharge information one week prior to discharge.
7. Provide a full written discharge summary within one week of discharge.

IPN/PRN must be notified of any changes to the Medical Director or the Clinical Director within three (3) days and be provided CV, Licenses, and Certifications.

Malpractice Insurance certificates must be provided in this packet.

Failure to comply with these requirements will result in the program being removed from the approved Treatment Provider list.

I hereby certify that all of the information provided above is complete, true, and correct to the best of my knowledge.

______________________________ ______________
Signature Date

______________________________ ______________
Print Name Title

Mail completed copy of application and attachments to:

Professionals Resource Network, Inc.
Attn: Heather Wilder, Administrative Assistant
P.O. Box 16510
Fernandina Beach, FL 32035

For Office Use:
Certifications:
Licenses:

Approved:

______________________________ ______________
Signature Date