Florida Impaired Practitioner Programs

Treatment Provider Application – (Must be resubmitted annually)

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. Psychiatry, Addiction, Sexual Misconduct, Eating Disorders)

_____
Cost

_____
Appointment Length

_____
Length of time to schedule an appointment

Inpatient:

_____
Telephone number for **participants** to call

_____
Types (i.e. Psychiatry, Addiction, Sexual Misconduct, Eating Disorders)

_____
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: _____

Residential/PHP:

_____
Telephone number for **participants** to call

Length of program: _____

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: _____

Maintenance (Suboxone/Methadone/Vivitrol):

_____
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: _____
_____

A daily program schedule and healthcare specific programing components must be provided.

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

1. Inform IPN/PRN immediately at the time of entry into treatment.
   1-800-840 2720 ext. 0 (IPN) 1-800-888-8776 ext. 0 (PRN).

2. Inform IPN/PRN if the participant leaves against medical advice, there are problems with treatment compliance, positive drug screens, or there is a change in the level of care, within 1 business day.

3. Weekly written progress report.

4. Provide continuing care recommendations.

5. Provide a statement of ability to practice and any recommendations regarding practice limitations.

6. Provide preliminary discharge information within 5 business days prior to discharge.

7. Provide an initial discharge plan within within 5 business days of discharge.

8. Provide a full written discharge summary within 30 days of discharge.

9. 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.

10. IPN/PRN must also be notified of any changes that have occurred to the application, such as: (phone numbers, e-mail addresses, etc…)

11. Current Malpractice Insurance certificates must be provided in this packet.

12. Please include 2 copies of your facilities brochure with services provided.

13. The Medical Director, Clinical Director or Program Director is required to attend our annual treatment provider training.

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 Thomas, Administrative Assistant
P.O. Box 16510
Fernandina Beach, FL 32035

For Office Use:
Certifications:
Licenses:

Approved:

_____ _____
Signature Date