Florida Impaired Practitioner Programs
Evaluator Application

Name: _____

Address: _____

Telephone #: _____ Alternate Telephone#: _____

Fax: _____ Email Address: _____

Contact person for appointments: _____

Areas of Expertise: _____

Telephone Number for participants to call: _____

Cost Range: _____ Length of time needed to get an appointment: _____

Length of appointment: _____

Requirements to be an approved Evaluator for IPN, PRN, and DOH:

1. Inform IPN/PRN of the date and time of the evaluation.
2. Return the Initial Evaluation form to IPN/PRN within one (1) business day.
3. Return the Full Written Evaluation to IPN/PRN within ten (10) business days.
4. Collaterals must be done and noted on the evaluation.
5. Releases are to be signed prior to the start of the evaluation. **Refusal to sign the releases requires the discontinuation of the evaluation and immediate notification to IPN/PRN.**
6. Recommendations must be made on the need for monitoring, continuing care, and safety to practice.
7. You must be able to schedule and perform evaluations within a reasonable length of time, preferably within seven (7) days of initial call if possible.
8. By agreeing to be an evaluator, you agree to be available to the Department of Health and appear at a Department of Administrative Law Hearing if needed.

Please answer the following:

1.	Have you ever been disciplined by a State Board, hospital, or other entity?	YES / NO
2.	Have you been cited, arrested, charged with, convicted of or pled guilty or nolo contendere to a violation of any municipal, state, or federal statute including any that have been expunged or judicially removed for any reason with the exception of misdemeanor traffic violations that do not involve the use of drugs or alcohol?	YES / NO

3.	Has your application for any professional license, certificate, or registration been denied by any state licensing board or federal authority?	YES	NO
4.	Has your professional license, certificate, or registration been the subject of investigation or revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action by any state licensing board or federal authority?	YES	NO
5.	Have you ever voluntarily surrendered any professional license, or agree with any licensing authority not to re-seek licensure in order to avoid disciplinary action, investigation, or inquiry?	YES	NO
6.	Was your application for staff or clinical privileges at any hospital, clinic, or other health care institution denied?	YES	NO
7.	Has your participation in any private, federal, or state health insurance program been terminated, non-renewed, denied, suspended, restricted, placed on probation, or are you the subject of a current investigation or proceeding by such entities?	YES	NO
8.	Have you surrendered your state or federal controlled substances permit or registration?	YES	NO

If you answered yes to any of the aforementioned questions, please include an explanation on a separate cover.

Please attach copies of licenses, certifications in the area of expertise, CV, and Malpractice Insurance.

I agree to abide by the requirements to become/maintain my status as an evaluator. I hereby certify that all of the information provided above is complete, true, and correct to the best of my knowledge.

_____ _____

Signature Date