

Impaired Practitioner Programs

Treatment Program Application

Name of Treatment Facility: _____

Address of Services:

Mailing Address (if different):

Street Address

Address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

Fax Number

Fax Number

E-mail Address

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

Clinical Director

License Type

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

Alternate Contact Person/Title

Telephone Number/Extension

Telephone Number/Extension

E-mail Address

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: _____

Residential/PHP:

Telephone number for **participants** to call

Length of program: _____

Cost: _____

Length of time to get into the program: _____

Describe Continuing Care program available: _____

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):

Telephone number for **participants** to call

Outpatient Costs: _____

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.

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

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