

Practitioner Data Sheet

The following information is required for DOI and internal reporting

Practitioner Name: _____
(Last Name) (First Name) (MI) (Credential based on licensure)

Social Security #: _____ **DOB:** _____ **Male** **Female**

State License #: _____ **State:** _____

Additional State License #: _____ **State:** _____

DSHS #: _____ **UPIN #:** _____ **DEA #:** _____ **Medicare #:** _____
(if applicable)

Individual NPI #: _____

Foreign Languages Spoken: _____

Specialty(s):

1) _____ **Board Status:** N/A Board Certified Board Eligible
(Primary Specialty) (check one. If other, please explain)

2) _____ **Board Status:** N/A Board Certified Board Eligible
(Secondary Specialty) (check one. If other, please explain)

Clinic/Group Name: _____

Group NPI #: _____

Start Date at Clinic/Group: _____

Primary practice address: _____
(Street Address - City - State - Zip Code)

Services available: Wheelchair Accessible? Interpretive Services?

Tax ID#: _____ **Office Hours:** _____

Phone (_____) _____ Phone - Fax (_____) _____

Pay to Address: _____

Mailing Address: (ie., correspondence) _____

E-mail address (clinic): _____ **E-mail address (practitioner):** _____

If more than one practice location, please attach list and provide the same information for each location.

Form completed by: _____ **Date:** _____