



**PROFESSIONAL TRAINING
AND EXPERIENCE FORM**

DIVISION OF SPECIALIZED CARE
FOR CHILDREN
3135 Old Jacksonville Road
Springfield, IL 62704-6488
Toll Free (877) 791-5170
Fax (217) 558-0773

PROVIDER INFORMATION

Name, First: _____ MI: _____ Last: _____

Title: _____ Specialty(s): _____ Male Female

Primary Site Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: (____) _____ Fax: (____) _____

E-Mail Address: _____ Contact Person: _____

Languages Spoken (*other than English, including sign language*): _____

Estimated percentage of present practice which involves care of children (0-18 years of age): _____ %

Hospital privileges at: _____

EDUCATION/TRAINING
(May submit a curriculum vitae or resumé in lieu of completing this section)

Post High School Education and Specialty Training	Dates Attended	Degree	Certificate	Year Awarded

PROFESSIONAL LICENSURE/ABMS CERTIFICATION
(May submit a curriculum vitae or resumé in lieu of completing this section)

Professional Licensure (Identify Discipline)	License Number	State	Expiration Date

ABMS/AOA Certification (Physicians Only)	Certificate Number	Awarded	Expiration Date

If not board certified	<u>Anticipated</u> Date for Written Exam: _____ <u>Anticipated</u> Date for Oral Exam: _____
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(OVER)

PROFESSIONAL EXPERIENCE INVOLVING CHILDREN (within the last five years)

Employer	Dates (month/year)	% of Service Involving Children	Age Group

ADDITIONAL SITES OF SERVICE (if applicable)

Additional site information is required for each site DSCC children will be seen. Please complete the following if you will provide care to DSCC children at sites other than the primary site. Attach a separate page for additional sites if needed.

◆ **If FEIN or insurance coverage is not the same as primary site, you must send a copy of W-9 or Insurance Coverage Certificate.**

Site Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____ ◆

Insurance Coverage: Same as Primary Site If not, list carrier: _____ ◆

Site Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____ ◆

Insurance Coverage: Same as Primary Site If not, list carrier: _____ ◆

Site Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____ ◆

Insurance Coverage: Same as Primary Site If not, list carrier: _____ ◆

Site Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____ ◆

Insurance Coverage: Same as Primary Site If not, list carrier: _____ ◆

I have reviewed the criteria used by The University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), to assess qualifications in my professional discipline. I attest that the information provided is accurate to the best of my knowledge.

Provider's Signature _____ Date _____