



**PROFESSIONAL TRAINING
AND EXPERIENCE FORM**

DIVISION OF SPECIALIZED CARE
FOR CHILDREN
2815 West Washington, Suite 300
P.O. Box 19481
Springfield, IL 62794-9481
Springfield Area 558-2001
Toll Free (877) 791-5170
FAX (217) 793-0773

* Name, First _____ MI _____ Last _____

Title _____ Degree(s) _____ (Optional) Male _____ Female _____

Primary Professional Address _____

City _____ State _____ Zip _____ County _____

* Phone (____) _____ Fax (____) _____ E-Mail Address _____

URL _____

(Note: Additional sites of service may be listed on back of page)

* FEIN _____

* Social Security Number _____ Medicaid Provider Number _____

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

Evening Hours: _____ Weekend Hours: _____

Is your facility wheelchair accessible? _____

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

Hospital privileges at: _____

POST HIGH SCHOOL EDUCATION AND SPECIALTY TRAINING	DATES ATTENDED	DEGREE/ CERTIFICATE	YEAR AWARDED
PROFESSIONAL LICENSURE (Identify Discipline)	LICENSE #	STATE	EXPIRATION DATE
ABMS CERTIFICATION (Physicians Only)	CERTIFICATE #	AWARDED	EXPIRATION DATE
IF NOT YET BOARD CERTIFIED	Anticipated Date for Written Exam: _____		
	Anticipated Date for Oral Exam: _____		

***Must be completed even if a curriculum vita or resume is attached.**

PROFESSIONAL EXPERIENCE INVOLVING CHILDREN (within the last five years)		
Dates of Service (month / year)	Description of Pediatric Population Served	% of Service Involving Children

ADDITIONAL SITES OF SERVICE	
<p>The Administrative Rules under which we operate require that health care professionals be credentialed at each site from which services will be provided and billed. Please complete the following if you will provide care to DSCC children at sites other than that listed in the heading (offices, clinics, hospitals, etc.)</p>	
Professional address _____ City _____ State _____ Zip _____ County _____ Appointment phone number _____	
FEIN _____ Professional liability insurance company: <input type="checkbox"/> Same as primary site. Additional insurance carrier _____ Policy number _____	Evening Hours _____ Weekend Hours _____ Policy holder _____
Professional address _____ City _____ State _____ Zip _____ County _____ Appointment phone number _____	
FEIN _____ Professional liability insurance company: <input type="checkbox"/> Same as primary site. Additional insurance carrier _____ Policy number _____	Evening Hours _____ Weekend Hours _____ Policy holder _____

Please add additional sheets if needed.