State of California – Health and Human Services Agency
California Department of Public Health

SAVE AS | PRINT FORM | CLEAR FORM

Legal Name of Applicant: ______________________ Date: ______________________

National Provider Identifier: ______________________

1. ADDITIONAL PRACTITIONERS PROVIDING CPSP SERVICES

(A) PRACTITIONER NAME	(B) CPSP PRACTITIONER TYPE (MD/DO, CNM, NP, PA, LM, RN, LVN, SW, PSY, MFT, RD, HE, CCE, CPHW)	(C) PRACTITIONER QUALIFICATIONS	(D) SERVICE(S) PROVIDED* OB	B	CO	HE	N	PSY	CC	CON	P	(E) YRS OF EXP.
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
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	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______
	Select One	LIC/CERT/REG#: ______ SCHOOL: ______ DEGREE: ______ YEAR: ______										______

* OB = Obstetrics/Gynecology B = Back-Up Physician CO = Client Orientation
HE = Health Education N = Nutrition PSY = Psychosocial
CC = Case Coordination CON = Consultation P = Protocol Approval

Legal Name of Applicant: _____ Date: _____

National Provider Identifier: _____

2. CPSP PROVIDER OVERVIEW TRAINING

STAFF NAME	TITLE OF TRAINING	DATE OF TRAINING	PLANNED/SCHEDULED TRAINING DATE