Email

SANTA CLARA COUNTY
Behavioral Health Services

Clinician Credentialing form

11384586

This form should only be filled out by clinicians providing direct services

** If filling out by hand, please use a black pen. No markers please.*

** Use CAPITAL letters. Do not let the writing touch the edges of the boxes:* A B C D

** Write numerals like this:* 1 2 3 4 5 6 7 8 9 0

1 ○ New ○ Update ○ Removal

2 Provider's (Clinician's) Last Name

3 Provider's (Clinician's) First Name

4 Provider's (Clinician's) Middle Name

5 Hire Date Y Y Y Y . M M . D D

6 DEA Number (if applicable)

7 UniCare Provider Code

8 NPI Number - Type 1 (Clinician)

9 Taxonomy Code

10 Taxonomy / NPI Enumaration Date Y Y Y Y . M M . D D

11 Provider's (Clinician's) Email

12 California Professional Certification Number

13 Professional Cert. Effective Date Y Y Y Y . M M . D D

14 Professional Cert. Expiration Date Y Y Y Y . M M . D D

15 **Mark the license you have**

APCC	LPCC	ASW	LCSW	AMFT	LMFT	REG PSYCHOLOGIST	LICENSED PSYCHOLOGIST	PSY TECH	LVN	RN	NP	MD	RADT	RADT II	CADC I	CADCII	CADC-CAS	LAADC	LAADC-S	CAODC	CAODC-A	CAODC-CS
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

16 List any board certification, special training, experience or specialization:

17 List any cultural capabilities (i.e. TAY, Veterans, etc.)

18 **Language Capacity** ○ American Sign Language ○ Arabic ○ Armenian ○ Cambodian ○ Cantonese ○ English ○ Farsi ○ Hmong ○ Korean ○ Mandarin ○ Other Chinese ○ Russian ○ Spanish ○ Tagalog ○ Vietnamese

19 Cultural Competency Training (hrs)

20 Telehealth Provider ○ Yes ○ No

SANTA CLARA COUNTY
Behavioral Health Services

Clinician Profile

[redacted]
11384586

21	Have you ever had any suspension or curtailment of hospital or clinic privileges?	○ Yes ○ No	If yes, please attach a list.
22	Have you ever had any liability claims filed against you?	○ Yes ○ No	If yes, please attach a list.
23	Have you ever had any sanctions from participating in Medicare/Medicaid/Medi-Cal?	○ Yes ○ No	If yes, please attach a list.
24	Have you ever had any sanctions, limitations or revocation of your license by any state agency or licensing board?	○ Yes ○ No	If yes, please attach a list.

25 **Organization Name**

L-Codes for locations where you provide services	Full Time Equivalent (Enter the number of hours per week available for DMC Services)	Full Time Equivalent (Enter the # of hours/week)
26 L Code 1 L-000	27	28
29 L Code 2 L-000	30	31
32 L Code 3 L-000	33	34
35 L Code 4 L-000	36	37

38 **Exit Date**

Y Y Y Y . M M . D D

39 **Comments**

I attest that as a network provider who delivers services for the Behavioral Health Services Department that:

1. I do not have any limitations or inabilities that affect my capacity to perform any of the position's essential functions, with or without accommodation;
2. I have never lost my license / credential or had a felony conviction; 3. I have never lost or had any limitation of privileges or disciplinary action;
4. I do not use illicit substances. 5. I attest to the accuracy and completeness of the information provided.

40 **Enter your name in lieu of your signature**

41 **Date**

Y Y Y Y . M M . D D