UIC SPECIALIZED CARE FOR CHILDREN

PROFESSIONAL TRAINING AND EXPERIENCE FORM

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

Facility Name: _____ FEIN #: _____

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

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

E-mail Address: _____ Contact Person: _____

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

Hospital privileges at: _____

EDUCATION/TRAINING

College/University	Years Attended	Degree Earned

Audiologist: Please list your 4th year placement _____

LICENSURE/CERTIFICATION

Profession	License #	State	Expiration Date

Certification	Certificate #	Awarded Date	Expiration Date

For physicians not board certified, please indicate:	Anticipated Date for Written Exam: _____ Anticipated Date for Oral Exam: _____

PAID PROFESSIONAL WORK EXPERIENCE

Name(s) of Employer(s)	Dates (MM/YY to MM/YY)	Estimated Pediatric % (0-18 yrs)

Audiologists		
Auditory Brainstem Response Testing (Full Scale Only)	☐ Yes	☐ No
Otoacoustic Emissions Testing	☐ Yes	☐ No
Speech Language Pathologists		
Augmentative Communication Device Evaluations/Services	☐ Yes	☐ No
Physical/Occupational Therapists		
Wheelchair Evaluations	☐ Yes	☐ No
Orthotists/Prosthetists		
Orthotic/Prosthetic Fabrications On Site	☐ Yes	☐ No
Nurse Practitioners		

Physician(s) with whom you have a working collaborative agreement: _____

LIABILITY INSURANCE INFORMATION

The University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC) requires that all providers providing services to UIC-DSCC clients maintain professional and general liability insurance as requested by law in Illinois or state of practice.

Failure of UIC-DSCC to obtain proof of coverage shall not be deemed to be a waiver of the coverage requirement.

♦ **Proof of coverage is required. Please include a copy of your certificate.**

Professional Liability Insurance Company: _____

Policy Holder: _____ Policy Number: _____

Commercial Liability Insurance Company: _____

Policy Holder: _____ Policy Number: _____

ADDITIONAL PRACTICE LOCATIONS

♦ **If applicable, list your additional sites of service. You must include a copy of W-9 and/or insurance certificate if the FEIN or insurance coverage is different than your primary location.**

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: _____ ♦

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/designee attest that the information provided is accurate to the best of my knowledge and give UIC-DSCC permission to verify such as needed.

Provider's/Designee's Signature _____ Date _____