NYS Department of Health
Division of Eligibility & Marketplace Integration
State Disability Review Unit
***CONSULTANT ENROLLMENT FORM**

APPLICANT INFORMATION

CONSULTANT NAME	LAST			FIRST			DATE OF BIRTH	MO	DAY	YR	
CORPORATE GROUP NAME (IF DIFFERENT)							APPLICATION DATE	MO	DAY	YR	
FED EMP ID NO.		SOC SEC NUMBER					LANGUAGES SPOKEN				
LICENSE NO		REGISTRATION END DATE	MO	DAY	YR	STATE		PAYEE ID NUMBER	(LEAVE BLANK)		

ATTACH COPY OF CURRENT REGISTRATION

EDUCATION AND TRAINING

	NAME AND ADDRESS OF INSTITUTION (City and State or Country if outside USA)	DATES FROM MO	DATES FROM YR	DATES TO MO	DATES TO YR	DEGREE/SPECIALTY
MEDICAL						
INTERNSHIP						
RESIDENCY						
FELLOWSHIP						
ADD'TL TRAINING						

If Foreign Medical School Graduate, E.C.F.M.G. Number:

U.S. SPECIALTY BOARD CERTIFICATION(S)	CERTIFICATION DATE		
NAME OF BOARD	MO	DAY	YR

NYS WORKERS COMPENSATION BOARD INFORMATION

WCB Code Letters:			Board Eligibility:
Have you ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare or by any other Federal or Federally assisted program in any State?	**YES** ☐	**NO** ☐	I have read the Conditions Governing Referrals for Consultative Examinations and agree to abide by its requirements and I certify that all statements completed herein and attached documents are accurate.
Have you ever been convicted of stealing, welfare fraud, public assistance fraud, Medicaid or Medicare fraud in any State?	**YES** ☐	**NO** ☐	
Has your license ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?	**YES** ☐	**NO** ☐	SIGNATURE OF CONSULTANT
Is there currently pending any proceedings that could result in the above stated sanctions?	**YES** ☐	**NO** ☐	DATE SIGNED

*** For medical groups, partnerships, P.C.'s, etc., this cover page must be completed for each physician, psychologist or social worker who will be performing examinations for SDRU.**

PLEASE COMPLETE REVERSE SIDE

PAY TO ADDRESS/CORRESPONDENCE ADDRESS:

ATTENTION				TELEPHONE NUMBER	
STREET					
CITY		STATE		ZIP CODE	

SERVICE ADDRESS INFORMATION:

ATTENTION				TELEPHONE NUMBER	
STREET					
CITY		STATE		ZIP CODE	

EXAMINATIONS	TESTS	TEST EQUIPMENT MANUFACTURER	MODEL/AGE

SERVICES TO BE REFERRED TO OUTSIDE SECONDARY SOURCE

PROVIDER NAME	ADDRESS	TELEPHONE NUMBER	SERVICES

REFERRAL/OFFICE INFORMATION

Number of referrals able to accept per Age Range Limitations?

Willing to accept all referrals? ☐ Yes ☐ No

Willing to do home visits? ☐ Yes ☐ No

Languages spoken other than English:

Scheduling or referral Limitations:

	NAME	**DAYS/HOURS CAN BE REACHED**
Office Administrative Contact	_____	_____
Physician Contact	_____	_____

Specify any licensure/certification standards met (Article 28, 47, etc.) _____