

# PROVIDER FORM

Patient: \_\_\_\_\_

Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Provider's Title: (check one):  RN       LPN       CNA       Personal Aide

**Email Address:** \_\_\_\_\_

Nurse License #: \_\_\_\_\_

Certified Nursing Assistant #: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

First Date of Work: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Please attach the following: RN's, LPN's and CNA's must submit items A through E; Personal Aides must submit items C through #

- A. Current Pennsylvania Nurse's License or Certified Nurse Assistant Certificate
- B. Current CPR Card
- C. Current Social Security Card or Pennsylvania Driver's License
- D. Child Abuse Clearance Check
- E. Criminal Background Clearance Check

Credentials may be faxed to 215-977-8228; however, the original of this form must be mailed to:

VACHP  
100 N. 20<sup>th</sup> Street, Suite 201  
Philadelphia, PA 19103