Florida Impaired Practitioner Programs
Evaluator Application (Initial)

Name: _____

Address: _____

Telephone #: _____ Alternate Telephone #: _____

Fax #:_____ E-mail Address: _____

Contact person for appointments: _____

Telephone Number for participants to call: _____

Cost Range: _____ Length of time needed to get an appointment: _____

Does cost range include toxicology testing? YES or NO **(Please Circle)**
I am requesting toxicology facilitation by PRN or IPN. YES or NO **(Please Circle)**

Time spent face to face with Evaluator_____

Virtual Services (Please provide additional information on any telehealth services you offer, if applicable):
_____
_____

Please Indicate Your Area(s) of Expertise:

- ☐ Substance Use Disorder(s)
- ☐ Psychiatry
- ☐ Boundary/Professional Sexual Misconduct
- ☐ Comprehensive Neurocognitive Testing
- ☐ Psychological Testing with level (c) Cognitive Testing, Personality Testing, and Continuous Performance Testing
- ☐ Personality Disorders
- ☐ ADHD
- ☐ Sexual Compulsivity
- ☐ Polygraphy
- ☐ Eating Disorders
- ☐ Neurology
- ☐ MRO
- ☐ Trauma

Requirements to be an approved Evaluator for IPN, PRN, and DOH:

1. Inform IPN/PRN of the date and time of the evaluation
2. Return the Initial Evaluation form to IPN/PRN within one (1) business day.
3. Return the Full Written Evaluation to IPN/PRN within ten (10) business days.
4. Collaterals must be done and noted on the evaluation. 3 sources of direct appropriate collateral information, excluding information provided by the programs or reasonable explanation otherwise is expected.
5. Toxicology to include: Urine toxicology with EtG, EtS, PEth, hair/nail. Our programs require an observed sample for a 10-panel urinalysis which includes the drug of choice and EtG/EtS, PEth test, minimum 5 panel hair test. If you do not arrange toxicology testing, notify IPN/PRN of the scheduled evaluation date so that testing can be obtained by IPN/PRN within the required 48-hour time frame.
6. Releases are to be signed prior to the start of the evaluation. **Refusal to sign the releases requires the discontinuation of the evaluation and immediate notification to IPN/PRN.**
7. Recommendations must be made on the existence of an impairing condition, need for monitoring, and safety to practice if treatment intervention is indicated.
8. You must be able to schedule and perform evaluations within ten (10) business days of the initial call. If you are unable to schedule within 10 business days, please refer the person back to PRN/IPN. Do not recommend alternative providers.
9. By agreeing to be an Evaluator, you agree to be available to the Department of Health and to appear at Department of Administrative Law Hearings and to testify.
10. You must submit a copy of your work product along with the other required application documents.

Please answer the following:

1. Have you ever been disciplined by a State Board, hospital or other entity?	**YES**	**NO**
2. Have you been cited, arrested, charged with, convicted of or pled guilty or nolo contendere to a violation of any municipal, state, or federal statute including any that have been expunged or judicially removed for any reason with the exception of misdemeanor traffic violations that do not involve the use of drugs or alcohol?	**YES**	**NO**
3. Has your application for any professional license, certificate, or registration been denied by any state licensing board or federal authority?	**YES**	**NO**
4. Has your professional license, certificate, or registration been the subject of investigation or revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action by any state licensing board or federal authority?	**YES**	**NO**
5. Have your ever voluntarily surrendered any professional license, or agree with any licensing authority not to re-seek licensure in order to avoid disciplinary action, investigation, or inquiry?	**YES**	**NO**
6. Was your application for staff or clinical privileges at any hospital, clinic, or other health care institution denied?	**YES**	**NO**
7. Has your participation in any private, federal, or state health insurance program been terminated, non-renewed, denied, suspended, restricted, placed on probation, or are you the subject of a current investigation or proceeding by such entities?	**YES**	**NO**
8. Have you surrendered your state or federal controlled substances permit or registration?	**YES**	**NO**
9. Do you hold a license in another State? If so, please provide a copy of your license.	**YES**	**NO**

If you answered yes to any of the aforementioned questions, please include an explanation on a separate cover.

If the practitioner has participated in and has been monitored by PRN/IPN or another state PHP, he or she must have successfully completed monitoring before consideration will be given to allowing him or her to be an approved Evaluator.

Please attach copies of your work product, licenses, certifications or other documentation supporting your assertion of your experience in the areas indicated, board certification in psychiatry or addiction medicine.

Please include a copy of your C.V. and liability insurance with this application.

Once application is submitted, you must notify PRN of any changes that have occurred, such as: (phone numbers, e-mail addresses, etc.)

I agree to abide by the requirements to become/maintain my status as an Evaluator. I hereby certify that all of the information provided above is complete, true, and correct to the best of my knowledge.

Applications can be emailed or faxed to PRN at heather@flprn.org or 904-261-3996.

_____ _____

Signature Date