Florida Impaired Practitioner Programs

Treatment Provider Application (Initial)

Name of Treatment Facility: ____

Address of Services:	Mailing Address (if different):
Street Address	Address
City, State, Zip Code	City, State, Zip Code
Telephone Number	Telephone Number
Fax Number	Fax Number
E-mail Address	Website

Is your facility State/DCF licensed? YES NO (Please Circle) (If yes, please provide certificate)
Is your facility CARF/JCAHO accredited? YES NO (Please Circle) (If yes, please provide accreditation)

Your program must have at least two licensed treatment providers, one of which must be a Physician Medical Director (M.D., D.O.)

Medical Director	Clinical Director
License Type	License Type

(Please attach copies of certifications and licenses for the program and the above providers, include their malpractice insurance and CV for verification)

PRN/IPN requires there to be one point of contact and an alternative for all PRN/IPN participants

Contact Person/Title	Alternate Contact Person/Title
Telephone Number/Extension	Telephone Number/Extension
E-mail Address	E-mail Address

Treatment Services Offered by the Program:

Withdrawal Management:

____
Telephone number for **participants** to call

Inpatient or Outpatient or Both: _____________

Length of stay: ___________________________

Cost: __________________________________

Intensive Outpatient:

____
Telephone number for **participants** to call

Length of program: _______________________

Hours per week: _________________________

Cost: __________________________________

Residential/PHP:

____
Telephone number for **participants** to call

Length of program: ________________________

Cost: __________________________________

Maintenance (Buprenorphine/Methadone/Naltrexone):

____
Telephone number for **participants** to call

Costs: ________________________

Describe Continuing Care program available: ____

Please describe the types of self-help programs available and other educational, therapeutic activities, specific to impaired professionals: ____

Checklist of Treatment Services Offered by the Program:

Treatment Capabilities:

- ☐ Psychiatric
- ☐ Substance Use Disorders
- ☐ Dual
- ☐ Boundary/Professional Sexual Misconduct
- ☐ Behavioral Issues
- ☐ Eating Disorders
- ☐ Outpatient Relapse Prevention (RP)
- ☐ SUD Education
- ☐ Other Addiction: ________________________
- ☐ Trauma Processing (Beyond Trauma Informed)
- ☐ Gender Specific
- ☐ Impaired Professionals Specific Groups and Healthcare Specific Lectures
- ☐ LGBTQIA+ Specific
- ☐ Compulsive Sexual Behavior
- ☐ Other: ___________________________

Financial:

- ☐ No Insurance
- ☐ In-Network Insurance Accepted
- ☐ Self Pay
- ☐ Out of Network Insurance Accepted
- ☐ Sliding Scale Available
- ☐ Scholarships Available

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

A daily program schedule and healthcare specific programing components must be provided.

Requirements to be an approved treatment provider for IPN, PRN, and the DOH:

1. Inform IPN/PRN immediately at the time of entry into treatment.
   1-800-840 2720 ext. 0 (IPN) 1-800-888-8776 ext. 0 (PRN).

2. Inform IPN/PRN if the participant leaves against medical or clinical advice, there are problems with treatment compliance, positive drug screens, or there is a change in the level of care, within 1 business day.

3. Inform IPN/PRN of unplanned discharge or termination of treatment within 1 business day.

4. Weekly written progress report.

5. Provide continuing care recommendations.

6. Must state in writing that the practitioner is or is not able to practice with reasonable skill and safety. This must be done by an M.D. or D.O. If your facility is unable to provide this statement, this will result in immediate removal from our approved list.

7. Provide initial discharge plan 5 business days prior to discharge.

8. Provide a full written discharge summary within 30 days of discharge.

9. IPN/PRN must be notified of any changes to the Medical Director or the Clinical Director within three (3) business days and be provided CV, Licenses, and Certifications.

10. IPN/PRN must also be notified of any changes that have occurred to the application, such as: (phone numbers, e-mail addresses, etc…)

11. Current Malpractice Insurance certificates must be provided in this packet.

12. Please include a copy of your facility brochure with services provided.

13. Must include a work product of the facility's discharge summary with this application.

14. The Medical Director, Clinical Director or Program Director is required to attend our annual treatment provider training.

15. All documents must be submitted within two weeks of training.

16. If you are applying to be approved as healthcare specific, you must provide proof and schedule along with the singed guidelines.

Failure to comply with these requirements will result in the program being removed from the approved Treatment Provider list.

I hereby certify that all of the information provided above is complete, true, and correct to the best of my knowledge.

______________________________ ______________

Signature Date

______________________________ ______________

Print Name Title

Mail/Email/Fax completed copy of application and attachments to:

Professionals Resource Network, Inc.
Attn: Heather Thomas, Administrative Assistant – heather@flprn.org
P.O. Box 16510
Fernandina Beach, FL 32035
Fax: (904) 261-3996

For Office Use:
Certifications:
Licenses: