Provider Name:       Hospital Affiliation:

Provider License Number:       NPI Number:

Mailing Address:

Telephone Number:       Email:

Specialty:

Board Certified:       Expiration:

Do you have any actions taken against you by the Vermont Board of Medical Practice/Office of Professional Regulation?

(If yes, describe on a separate page.)

 [ ]  QMHP classroom training provided by Vermont Department of Mental Health

 **Location:**  **Date Attended:**

      is in good standing at (hospital name or DOC)

and has no disciplinary action(s) from the medical staff organization.

[ ]  This hospital/DOC endorses this employee to complete physician certifications.

Chief of Medical Staff/Health Services Adinistrator (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITAL/DOC MEDICAL STAFF ENDORSEMENT**

**VERMONT DEPARTMENT OF MENTAL HEALTH**

**Commissioner Designation as a Physician/APRN Who Can Complete the**

**Physician’s Certificate (First Certification)**

I certify that the information provided is true and accurate. I agree to send the Vermont Department of Mental Health any changes to the above information as soon as possible. I acknowledge that as part of this designation the Department will check the Vermont Board of Medical Practice/Office of Professional Regulation’s website to confirm the information above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Online training (A completed quiz must be attached to this application form.)

 **Date of Completion:**

 [ ]  Mock First Certification (Must be attached to this application form.)

**EMERGENCY EXAM TRAINING COMPLETION**

**Instructions**:

1. Please complete this application form after attending the QMHP classroom training or completing the online training module for Physicians/APRNs Completing Physician Certifications on the Vermont Department of Mental Health’s website.
2. Attach quiz answers and mock First Certification to your application for designation as a physician/APRN who can complete the Physician’s Certificate (First Certification).

3. Send both to: DMH Commissioner’s Office, 280 State Drive, NOB 2 North, Waterbury, VT 05671-2010