CNHN MEMBERSHIP APPLICATION

Practice Name:			
Address:			
City:		State:	Zip Code:
Tax ID:		# of Sites:	
Patient Line:	Fax Line:	Office Hours:	Weekend Hours:
Practice/Office Manager:	Practice/Office Manager Phone:	Practice Email:	Practice Website:

First Name	Last Name	Title	NPI	Gender	Multiple Locations	Specialty	Accepting New Patients	Language(s)
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	
					☐		☐Yes ☐No	

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby apply for membership to Children's National Health Network (CNHN) for the above named practice & medical staff. I attest that all listed medical staff are "in good standing" regarding licensure and insurance. I agree to update information in this application form as such information becomes available and such additional information as may be requested by CNHN or its authorized representatives in connection with this application and from time to time with respect to CNHN membership. I certify, to the best of my knowledge, that the information provided on this application to CNHN is true, complete and accurate. I understand that any significant error in, or omission from, this information shall constitute cause for denial of my application. I agree to abide by the terms of CNHN vaccine and other contracts. Failure to do so may constitute cause for practice removal from that contract or CNHN.

Signature of Applicant:	Print Name of Applicant:
Title:	Date: