

**NYS Office of Temporary & Disability Assistance
Division of Disability Determinations**

DDD-4095 [09/02]

***CONSULTANT ENROLLMENT FORM
APPLICANT INFORMATION**

CONSULTANT NAME		LAST		FIRST		DATE OF BIRTH		MO	DAY	YR	
CORPORATE GROUP NAME (IF DIFFERENT)						APPLICATION DATE			MO	DAY	YR
FED EMP ID NO.		SOC SEC NUMBER				LANGUAGES SPOKEN					
LICENSE NO		REGISTRATION END DATE	MO	DAY	YR	STATE		PAYEE ID NUMBER	(LEAVE BLANK)		

**ATTACH COPY OF CURRENT REGISTRATION
EDUCATION AND TRAINING**

	NAME AND ADDRESS OF INSTITUTION (City and State or Country if outside USA)	DATES				DEGREE/SPECIALTY
		FROM		TO		
		MO	YR	MO	YR	
MEDICAL						
INTERNSHIP						
RESIDENCY						
FELLOWSHIP						
ADD'TL TRAINING						

If Foreign Medical School Graduate, E.C.F.M.G. Number:

U.S. SPECIALTY BOARD CERTIFICATION(S)	CERTIFICATION DATE		
NAME OF BOARD	MO	DAY	YR

NYS WORKERS COMPENSATION BOARD INFORMATION

WCB Code Letters:		Board Eligibility:	
Have you ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare or by any other Federal or Federally assisted program in any State?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	I have read the Conditions Governing Referrals for Consultative Examinations and agree to abide by its requirements and I certify that all statements completed herein and attached documents are accurate. _____ SIGNATURE OF CONSULTANT _____ DATE SIGNED
Have you ever been convicted of stealing, welfare fraud, public assistance fraud, Medicaid or Medicare fraud in any State?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Has your license ever been revoked, suspended, surrendered, or any way restricted by probation or agreement by any licensing authority in any State?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Is there currently pending any proceedings that could result in the above stated sanctions?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	

*** For medical groups, partnerships, P.C.'s, etc., this cover page must be completed for each physician, psychologist or social worker who will be performing examinations for DDD.**

PLEASE COMPLETE REVERSE SIDE

PAY TO ADDRESS/CORRESPONDENCE ADDRESS:

ATTENTION				TELEPHONE NUMBER	
STREET					
CITY		STATE		ZIP CODE	

SERVICE ADDRESS INFORMATION:

ATTENTION				TELEPHONE NUMBER	
STREET					
CITY		STATE		ZIP CODE	

EXAMINATIONS	TESTS	TEST EQUIPMENT MANUFACTURER	MODEL/AGE

SERVICES TO BE REFERRED TO OUTSIDE SECONDARY SOURCE

PROVIDER NAME	ADDRESS	TELEPHONE NUMBER	SERVICES

REFERRAL/OFFICE INFORMATION

Number of referrals able to accept _____ per _____ Age Range Limitations?

Willing to accept all referrals? Yes No

Willing to do home visits? Yes No

Languages spoken other than English:

Scheduling or referral Limitations:

	<u>NAME</u>	<u>DAYS/HOURS CAN BE REACHED</u>
Office Administrative Contact	_____	_____
Physician Contact	_____	_____

Specify any licensure/certification standards met (Article 28, 47, etc.) _____