

INDEPENDENTLY LICENSED PRACTITIONER

NEW RENEW

APPLICANT INFORMATION

PRACTITIONER NAME: _____

PHYSICAL ADDRESS: _____
Street City County State Zip Code

MAILING ADDRESS: _____
(if different) *Street City County State Zip Code*

E-MAIL ADDRESS: _____

PHONE NUMBER: _____

TAXPAYER ID # (TIN): _____

HOURS OF OPERATION: _____

The applicant affirms receipt of the *Behavioral Health Independently Licensed Practitioners Certification Manual* standards and agrees to comply with these standards, as indicated by the signature below:

Signature of Applicant

Date

INDEPENDENTLY LICENSED PRACTITIONER

NEW APPLICANT

1. Completed W-9
2. Any required business license(s)
3. Copy of current practitioner license
4. Copy of Family Involvement Policy

RENEWING APPLICANT

1. Current copy of ILP Certification
2. Completed W-9
3. Copy of current practitioner license
4. Copy of all required annual reports since last certification issuance

*Additional information may be requested and required upon review of application(s) for licensure.