DREAM
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REAL Kids Summer Camp Application

East Harlem and the South Bronx

Application Receipt - Keep this front page for yourself!

I submitted my application on: _____ _____:_____

I submitted my application to: _____

Summer Camp Dates: July 2-August 10

- No program on July 4th
- Youth are only permitted 3 absences, including family vacations
- REAL Kids serves breakfast everyday from 8:30-8:50am

Dismissal Times (Pick-Up)

	Monday - Thursday	Friday
Grades K – 1 (Satchel)	4:45pm	2:45pm
Grades 2 – 5 (Clemente & Robinson)	5:00pm	3:00pm

Physicals

Please write down your own reminder to submit a completed Physical or proof of appointment from your health care provider no later than June 18th!

My child's physical is on _____

○ I have submitted a completed physical form (and immunization for youth grades 4/5)

○ I have submitted proof of appointment

Orientation Dates: Please select one orientation date below:

DREAM Charter School	PS 18	MOSAIC Preparatory	PS 171
1991 Second Ave	502 Morris Avenue	141 E 111th Street	104th Street
5:00-5:45pm	5:30-6:30pm	5:30-6:15pm	Madison Ave
Mondays:	Tuesdays:	Thursdays:	5:45-6:45pm
March 5	**March 6**	**March 15**	Wednesdays:
April 9	**April 10**	**April 12**	**March 14**
May 14	**May 15**	**May 10**	**April 18**
June 4		**June 7**	**May 16**

REAL Kids

Program Application

DREAM collects information in order to best serve the needs of our youth and families.

Please be sure to fill out all information, incomplete applications will not be accepted

FOR OFFICE USE ONLY

RK After School: o PS 171 o MOSAIC Prep o Bronx PS 18 o DREAM Charter School

RK Summer: o Newark o Satchel o Clemente o Robinson o Bronx PS 18

Region	Grade Range	Checklist
◻ East Harlem ◻ South Bronx ◻ Newark	◻ K-1 ◻ 2-3 ◻ 4-5 ◻ 6-8 ◻ 9-12	◻ Contact Information ◻ 3 Emergency Contacts
	Orientation Date:	◻ Waiver Forms
Received by:	Received On Date: _____ Time: _____:_____	◻ Summer Program Physical Form (non-Newark youth) If no, estimated date of completion_____
Entered by:	Entered on:	

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HOUSEHOLD INFORMATION

Address		Apartment:
City	State	Zip Code
Borough: ☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens ☐ Staten Island		

PARTICIPANT INFORMATION

Name:		Sex: ☐ Male ☐ Female	Date of birth: ____/____/_____
Proficient in English: ☐ Yes ☐ No	Primary language:		Youth can walk home alone (Age 10 and above): ☐Yes ☐No
School:		Grade:	OSIS #:
Primary teacher:		Teacher Email Address:	
Eligible for free lunch in school: ☐ Yes ☐ No		Eligible for reduced lunch in school: ☐ Yes ☐ No	
Does participant have an IEP? ☐ Yes ☐ No If Yes, IEP modifications:			
Child Limitations (are there any activities participant cannot participate in):			

Participant Allergies (check all that apply):	Medical Issues (check all that apply):	Participant Race/ethnicity (check all that apply):
☐Peanut ☐ Tree nut ☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Fish ☐ Shellfish ☐ Other (please write in Medical Details below)	☐ Asthma ☐ Diabetes ☐ Seizure Disorder ☐ Obesity ☐ ADD ☐ ADHD ☐ Other (please write in Medical Details below)	☐ Black - African-American ☐ Black – African ☐ Black – Caribbean ☐ Hispanic or Latino ☐ White ☐ Asian ☐ Other

Medical Details (list all medical conditions, medications, issues, and allergies that we should know about):

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PARENT/GUARDIAN 1 INFORMATION

Parent/Guardian name:	Sex: ☐ Male ☐ Female	
Email address :		
Home phone:	Work phone	Cell phone :
Relationship to participant: ☐ Parent ☐ Grandparent ☐ Other If other, please state relationship	Parent/Guardian race/ethnicity (check all that apply): ☐ Black - African-American ☐ Black - African ☐ Black - Caribbean ☐ Hispanic or Latino ☐White ☐ Asian ☐ Other	Marital status ☐ Single ☐ Married ☐ Domestic partnership
Best contact method: ☐ Phone ☐ E-mail ☐ Social Media (facebook)	Best contact time: ☐ Morning ☐ Noon ☐ Evening	
Potential Volunteer Areas (mark all that apply): ☐ New parent group ☐ Plan events ☐ Speak to donors ☐ Community ambassadors	Potential Workshops (mark all that apply): ☐ High School application ☐ College application ☐ Cyber bullying ☐ DOE Evaluation ☐ Sexual education ☐ Parenting Journey ☐ Other	
Proficient in English: ☐ Yes ☐ No	Highest level of education completed: ☐ No High School ☐ High School Diploma ☐ GED ☐ Some College ☐ College ☐ Advanced Degree	Employment Status ☐ Full-Time ☐ Part-Time ☐ Self-employed ☐ Unemployed
Employer:		
Work Address:		
City	State	Zip Code
Work Borough: ☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens ☐ Staten Island		

Has custody of participant: ☐ Yes ☐ No If no, address:		
City	State	Zip Code

Does anyone in the household receive any of the following (please check all that apply): ☐ NYCHA ☐ Section 8 ☐ Public Assistance ☐ Food Stamps (SNAP) ☐ WIC ☐ SSI ☐ Medicaid ☐ Child Health Plus ☐ Family Health Plus ☐ Private Health Insurance	Average household income: ☐ Under $15,000 ☐ $15,000 – $24,999 ☐ $25,000 – $34,999 ☐ $35,000 – $44,999 ☐ $45,000 – $64,999 ☐ $65,000 – $84,999 ☐ $85,000 – $100,00 ☐ Above $100,000
# of children in household (including participant):	# of adults in household (including participant):

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PARENT/GUARDIAN 2 INFORMATION Emergency contact: □ Yes □ No

Parent/Guardian name:	Gender: □ Male □ Female	
Email address :		
Home phone:	Work phone	Cell phone :
Relationship to participant: □ Parent □ Grandparent □ Other If other, please state relationship	Parent/Guardian race/ethnicity (check all that apply): □ Black - African-American □ Black - African □ Black - Caribbean □ Hispanic or Latino □ White □ Asian □ Other	Marital status □ Single □ Married □ Domestic partnership
Best contact method: □ Phone □ E-mail □ Social Media (facebook)	Best contact time: □ Morning □ Noon □ Evening	
Potential Volunteer Areas (mark all that apply): □ New parent group □ Plan events □ Speak to donors □ Community ambassadors	Potential Workshops (mark all that apply): □ High School application □ College application □ Cyber bullying □ DOE Evaluation □ Sexual education □ Parenting Journey □ Other	
Proficient in English: □ Yes □ No	Highest level of education completed: □ No High School □ High School Diploma □ GED □ Some College □ College □ Advanced Degree	Employment Status: □ Full-Time □ Part-Time □ Self-employed □ Unemployed
Employer: Work Address:		
City	State	Zip Code

Has custody of participant: □ Yes □ No If no, address:		
City	State	Zip Code

EMERGENCY CONTACTS- PLEASE LIST THREE

Name:	Phone number: Can pick up youth: ☐ Yes ☐ No
Name:	Phone number: Can pick up youth: ☐ Yes ☐ No
Name:	Phone number: Can pick up youth: ☐ Yes ☐ No

PLEASE FILL OUT IF PARTICIPANT IS IN KINDERGARTEN - 8th GRADE

PICK UP LIST- Non Parent/Guardian that can pick up the youth from program

Name:	Phone number:
Name:	Phone number:
Name:	Phone number:

CAN NOT PICK UP LIST- People who cannot pick up the youth from program

Name:	Order of protection: ☐ Yes ☐ No
Name:	Order of Protection: ☐ Yes ☐ No
Name:	Order of Protection: ☐ Yes ☐ No

ACADEMIC RELEASE

I hereby give permission for Harlem RBI Incorporated, doing business as DREAM, and henceforth in this application referred to as DREAM, to have access to my child's school records, including information about enrollment, grades, citywide and statewide test scores, and attendance. I give DREAM permission to collect OSIS numbers from school administrators and to conduct survey and/or interviews with parents and children. All collected information will be kept private and reported in aggregate form. Your child's name will not be published.

_____	_____	_____
Parent/Guardian's Name	Parent/Guardian's Signature	Date

WAIVER OF ALL CLAIMS/CONSENT FORM

I hereby give my child permission to try out for and to participate in any and all programs associated with DREAM, including but not limited to DREAM's baseball, softball, educational and mentoring programs and field trips related thereto ("Activities"). I understand that (i) despite the efforts of DREAM to instill a "safety first philosophy" within the organization, my child may be exposed to certain risks and hazards incidental to his/her participation in the Activities, including, but not limited to, physical injury and (ii) the permission that I give hereby means that I am agreeing to assume on his/her behalf all risks and hazards incidental to his/her participation in such Activities, including, but not limited to, physical injury. With respect to such risks of physical injury, I further understand that the permission I hereby grant means that I am agreeing to assume on his/her behalf all risk and hazards incidental to the sport of baseball and all warm-ups, practices and competitions associated with baseball, including specifically (but not exclusively) the danger of being injured by thrown bats, fragments thereof, and thrown or batted balls.

I understand that DREAM program staff members are required to report any suspected abuse or neglect of a child. The staff and volunteers are trained to respond if a child discloses/alleges abuse and a report will be filed with authorities. If I have any further questions, or would like more information on violence prevention, I will ask DREAM staff for additional resources.

In consideration of DREAM permitting my child to participate in the Activities, I hereby release, discharge and agree to indemnify and hold harmless DREAM, its directors, organizers, sponsors, coaches, staff, volunteers and agents from any and all claims, liabilities or causes of action arising out of my child's participation in the Activities, including but not limited to physical injury to my child, whether the result of negligence or any other cause.

WARNING: Protective equipment cannot prevent all injuries that a youth player may sustain while playing baseball or softball.

_____	_____	_____
Parent/Guardian's Name	Parent/Guardian's Signature	Date

EMERGENCY MEDICAL TREATMENT CONSENT FORM

I hereby give my permission to DREAM to give consent on my behalf in the event of the need for the emergency administration of medical treatment which DREAM, in its sole discretion, believes to be necessary and appropriate, including, without limitation, treatment by trained First Aid personnel, EMTs, First Responders, Paramedics and Emergency Room Physicians. I understand that DREAM staff may administer a topical over-the-counter spray or lotion such as sunblock or insect repellant to my child during summer programming. In consideration of DREAM permitting my child to participate in DREAM activities and programs, I hereby release, discharge and agree to indemnify and hold harmless DREAM, its directors, organizers, sponsors, coaches, staff, volunteers and agents from any and all claims, liabilities or caused of action arising out of such treatment and with respect to the exercise of its judgment in this regard. I further attest that I have disclosed all vital and important health information (allergies, medications and medical limitations on activities) which would be necessary for the proper care of my child.

I agree to pay, and to assume responsibility, for all medical and dental expenses incurred in the treatment of my child.

WARNING: Protective equipment cannot prevent all injuries that a youth player may sustain while playing baseball or softball

_____	_____	_____
Parent/Guardian's Name	Parent/Guardian's Signature	Date

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CONSENT TO PARTICIPATE IN EVALUATION/RESEARCH

I hereby give my child permission to try out for and to participate in any and all evaluations associated with DREAM. DREAM regularly evaluates the outcomes for youth in youth programs. While your child is enrolled, we are likely to be studying our programs to see what kinds of things young people like about them and how they affect participants. We also want to know how the youth are changing as they mature and if and how things they do in the program contribute to those changes. We are especially interested in understanding more about academic outcomes, life skills, and rick-behaviors.

During our regular course of operations, your child's group may be the subject of some data collection and program observations, and your child may be asked to respond to surveys or interviews. All of his/her information, individual responses and specific observation notes will be kept strictly confidential, and you are free to inquire more directly about any evaluation activities that become scheduled for your child's group. By signing below, you are saying that your child can participate in any standard evaluation activities or studies that are conducted during regular program operations.

_____ has my consent to take part in any standard data collection/evaluation of DREAM.
(Youth's Name)

_____ _____ _____
Parent/Guardian's Name Parent/Guardian's Signature Date

PARENTAL PERMISSION TO USE DREAM TRANSPORTATION

DREAM frequently utilizes vans and/or buses to transport the children to practices, games and other events. At present, your permission is requested below for your child to play in these practices, games and tournaments and to be transported either (i) with the entire team to these events in the vans and/or buses used by DREAM for transportation to these events or (ii) in the event that vans and/or buses do not have the capacity to transport all the children, with one of our Volunteer Coaches in a private automobile.

With my signature below, I hereby give my permission to have my child participate in the various practices, games, and tournaments in which DREAM routinely participates throughout New York City, Newark, and surrounding areas and to be transported to such events via the vans and/or buses used by DREAM for such purposes or via the private automobile of a Volunteer Coach, it being my understanding that the Van/Bus Policy established by DREAM shall govern all such trips requiring the use of a van or bus and that the Volunteer Coaches' Automobile Policy shall govern all such trips requiring, as supplementary transportation to the regular vans and/or buses, the use of an automobile. Furthermore, I understand and agree that, players are expected to ride in DREAM arranged transportation to and from all games unless I give 24 hours' prior notice to my child's Coach of the details of alternative transportation arrangements that my child will use, including, but not limited to, (i) travel in my own automobile and (ii) public transportation, which transportation I have determined to be appropriate for my child. I further agree that by furnishing my permission for my child to utilize such alternative transportation arrangements, I will assume on my child's behalf all risks and hazards incidental to such alternative transportation, including, but not limited to, physical injury.

_____ _____ _____
Parent/Guardian's Name Parent/Guardian's Signature Date

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MEDIA PERMISSION AND RELEASE

I, the undersigned, acknowledge that the various activities, including but not limited to sports, education, plays skits and interviews, that my child may participate in from time to time as a participant in DREAM, a nonprofit organization, may be videotaped, audio taped, filmed, photographed and/or transcribed and I hereby grant permission and a non-exclusive, perpetual, irrevocable, royalty-free, worldwide license to DREAM and any of its successors and assigns ("Licensee") to use and include in these records and recordings, my child's voice, name, likeness, and image (together, the "Recorded Activities") and to reproduce, translate, transcribe, distribute, prepare derivative works, broadcast, exhibit, display and perform any portion, in whole or in part, of my child's Recorded Activities publicly for any use, including advertising and publicity for DREAM, in whole or in part, in any manner or any form of media (whether now known or hereafter existing), including but not limited to television (network, cable, syndication, satellite), film, Internet, and video, throughout the world in perpetuity. DREAM shall have the right to license, sub-license or assign any of its rights without prior consent of myself or my child, and this release shall inure to the benefit of the Licensee. Moreover, as a result of my child's participation in programming, DREAM may collect or obtain data which will be used for statistical or research purposes only, and I understand that compliance with requests for additional information is not mandatory.

I hereby release and discharge Licensee from any and all liability arising out of or in connection with claims of violations of my child's rights of privacy or publicity, libel or slander, or violation of any other personal, intellectual or other proprietary rights. I understand and acknowledge that my child will not be compensated for the Recorded Activities or for the future use of the Recorded Activities as set forth above.

This release shall be construed, interpreted, and my rights will be determined, in accordance with the laws of the sate of New York without reference to its choice of law provisions.

_____ _____ _____

Parent/Guardian's Name Parent/Guardian's Signature Date

CLINICAL RELEASE FORM

If your child is in counseling or has been in the past; please complete this form by writing the person's name & complete address, and then sign the form.

Counselor/Therapist/Social Worker Name: _____

Phone Number : _____

Address: _____

City, State: _____ Zip Code:_____

Email address: _____

I hereby authorize the above stated person to release pertinent information to DREAM concerning my child. I understand that this information is being requested in order to help DREAM determine in what way they can be of service to my family and me. I also understand that any and all information shared will be treated with professional discretion and confidentiality.

Child's Name: _____

_____ _____ _____

Parent/Guardian's Name Parent/Guardian's Signature Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | **First Name** | **Middle Name** | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other _____

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** | **District** __ __ **Number** __ __ __ | **Phone Numbers** Home _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** | **Email**

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____/____/____	_____ µg/dL
	____/____/____	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____/____/____	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	____/____/____	_____ g/dL _____ %

Hearing

	Date Done	*Results*
< 4 years: gross hearing	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	____/____/____	☐*Nl* ☐*Abnl* ☐*Referred*

Vision

	Date Done	*Results*
<3 years: Vision appears:	____/____/____	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	____/____/____	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	

Tdap	___/___/___	___/___/___	___/___/___	___/___/___					
MMR	___/___/___	___/___/___	___/___/___						
Varicella	___/___/___	___/___/___	___/___/___						
Mening ACWY	___/___/___	___/___/___	___/___/___						
Hep A	___/___/___	___/___/___	___/___/___						
Rotavirus	___/___/___	___/___/___	___/___/___						
Mening B	___/___/___	___/___/___	___/___/___						
Other _____	___/___/___	___/___/___	___/___/___						

	IgG Titers	Date
Hepatitis B		___/___/___
Measles		___/___/___
Mumps		___/___/___
Rubella		___/___/___
Varicella		___/___/___
Polio 1		___/___/___
Polio 2		___/___/___
Polio 3		___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Telephone | Fax | Email

FORM ID#