Child Health & Disability Prevention Program
1993 McKee Road, Building B
San José, CA 95116
Office 408.937.2250 • Fax (408) 937-2252
CHDP@phd.sccgov.org

Santa Clara County PUBLIC HEALTH

Non-Physician Medical Practitioner (NPMP) Documentation of Pediatric Training

(Physicians do not need to complete this form.)
Return completed form to the CHDP program via fax or email.

Section 1: Clinician Qualification

Clinician Name: _____

California Professional License Number: _____

Drug Enforcement Administration (DEA) Registration Number *(If appliable, attach copy)*: _____

Professional Specialty:

(If checked, complete Section 1 & 2 only and Sign)	*(If checked, complete All Sections and Sign)*
☐ Pediatric Nurse Practitioner (PNP)	☐ Physician Assistant
☐ Family Nurse Practitioner (FNP)	☐ Other Nurse Practitioner: _____
☐ Certified Nurse Midwife (CNM)	☐ Other Clinician: _____

Section 2: Work Location(s) *(Where you will provide CHDP services?)*

Facility/Site Name: _____

Facility/Site Address: _____

Work Phone: (_____)_____ Fax: (_____)_____

Additional location(s) *(If applicable)*:
1. _____
2. _____

Supervising Physician Name: _____ Specialty: _____

Section 3: History/Experience *(This section is for new enrolling CHDP clinicians only. Please also attach a copy of your curriculum vitae (CV). This section is not applicable for continuing CHDP clinicians and/or PNP, FNP and CNM.)*

Professional Specialty Institution Name: Year Graduated:

_____ _____

Describe your pediatric/adolescent experience, i.e., age group/services provided: *(Attach more paper if needed.)*

List your ***postgraduate*** work in pediatric: *(600 hours within the past three years are required. Attach more paper if needed.)*

Location Name	Year/Hours Amount	Specialty of Supervising Physician
	/	
	/	
	/	
	/	

Comments: _____

Clinician Signature: _____ Date: _____