

**VA HEALTHCARE NETWORK UPSTATE NEW YORK at ALBANY
VETPRO ENROLLMENT INFORMATION
Licensed, Registered and Certified Providers**

The following information is needed to be enrolled in the VETPRO system.

Please complete this form & return it to: Michele Kieszkiel, Dependent VETPRO Coordinator

Room: 1B 121 Phone: 518-626-6945 Fax: 518-626-6953 **(DO NOT send via E-mail)**

Title: Dr. Mr. Mrs. Ms. Miss Social Security Number: _____ - _____ - _____

First Name: _____ Middle Name: _____ Last Name: _____

Gender: Male Female Birth Date: ____/____/____ (mm/dd/yyyy)

Birth City: _____ Birth State: _____ Birth Country: _____

Licensed in State of: _____

Occupation: (check one)

- | | | |
|---|---|--|
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Nuclear Med Tech | <input type="checkbox"/> RRT / CRTT |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Social Worker (Lic) |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Social Worker (Other) |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Dietician | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Therapeutic Radiology |
| <input type="checkbox"/> Graduate Nurse (RNL) | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Vocational Rehab |
| <input type="checkbox"/> Kinesiotherapist | <input type="checkbox"/> Recreation/Creative | |
| <input type="checkbox"/> LPN / LVN | <input type="checkbox"/> Registered Nurse | |

CARE LINE: BVAC D&T GEC MVAC R&D OTHER _____

Service Product Line: (check one)

- | | | |
|---|---|---|
| <input type="checkbox"/> Acute/Medicine | <input type="checkbox"/> Geriatrics/Extended | <input type="checkbox"/> Pathology/Laboratory |
| <input type="checkbox"/> Acute/Surgery | <input type="checkbox"/> Imaging/Radiology | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Ambulatory/Primary | <input type="checkbox"/> Mental/Behavioral Health | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Neurology | <input type="checkbox"/> Research |
| <input type="checkbox"/> CBOC/OPC | <input type="checkbox"/> Nursing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Optometry/Ophthalmology | |

Type of Appointment: (check one)

- | | | |
|------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Full Time | <input type="checkbox"/> Consultant | <input type="checkbox"/> Sharing Agreement |
| <input type="checkbox"/> Part Time | <input type="checkbox"/> Contract | <input type="checkbox"/> Telemedicine |
| <input type="checkbox"/> WOC | <input type="checkbox"/> Fee-Basis | <input type="checkbox"/> Other |

Preferred Address: (check one): Business Home

Address (1): _____

Address (2): _____

City: _____ State: _____ Zip Code: _____ Country: _____

Phone: _____ Email: _____

Secondary Address: (check one): Business Home

Address (1): _____

Address (2): _____

City: _____ State: _____ Zip Code: _____ Country: _____

Phone: _____ Email: _____

Submitted by: _____ Date: _____