



WE CARE OF LEE COUNTY

CONTRACT APPLICATION

Provider Name: _____ Date: _____
(Please Print) (Last) (First) (Middle)

Practice Name: _____

Address: _____
(Street) (City) (State) (Zip)

Phone Number: (____) _____ Fax Number (____) _____

Occupation: _____ Specialty: _____ FL License Number: _____

Number of new patient referrals you will accept: _____ # per month; or _____ # per quarter

Hospital affiliation(s): _____ Office contact person: _____

Individual providers applying for a We Care of Lee County contract for sovereign immunity protection that are affiliated with a Corporation, LLC, or a Professional Association (P.A.), the Florida Department of Health recommends a sovereign immunity contract be established to protect the Corporation, LLC, or P.A.

Please indicate if you would like a contract for the P.A. you're affiliated with: YES _____ NO _____
Or (already under contract) Not Applicable _____

Name of Professional Association: _____

FEI or Document Number: _____

Name and Title of Corporate Officer/Director with Contract Authority: _____

Business Address: _____
(Street) (City) (State) (Zip)

Phone Number: (____) _____

Signature: _____ Date: _____

TO PROTECT CLIENTS, A ROUTINE CHECK OF THE CORPORATION NAME AND PROVIDER'S PROFESSIONAL LICENSE WILL BE MADE THROUGH THE FLORIDA DIVISION OF CORPORATIONS AND THE FLORIDA DOH DIVISION OF MEDICAL QUALITY ASSURANCE.

(For DOH Use Only) License/Corporation Verification
Individual
Current Florida Health Professional License? Yes _____ No _____
License Status "Clear and Active"? Yes _____ No _____
Corporation
Active Florida Professional Association? Yes _____ No _____ N/A _____
Verification Completed By: _____ Signature of VHCPP Regional Coordinator _____ Date _____

Rev: 8/25/09