6470 East Johns Crossing
Suite 170
Duluth, GA 30097
Phone: 800-669-8682
Fax: 888-774-0456

CHIROPRACTIC NETWORK

I accept your invitation to participate in the Comprehensive Health Group (CHG) Chiropractic Network. I understand separate credentialing is required for each Doctor. (All fees for joining have been waived).

PROVIDER PROFILE:

First Name   Middle Initial   Last Name

Clinic Name   Years in Practice

Clinic Address   City, State, Zip

Telephone   Fax   Email

Please answer all questions, submit copies of the requested documents, and sign and date the release. If you answer "yes" to any of the following questions, please provide a full explanation and include a copy of the official ruling and any other pertinent data. HAVE ANY OF THE FOLLOWING EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, PLACED ON PROBATION OR NOT RENEWED? (please circle Yes or No).

License in any state	Yes	No
Other Professional registration/license	Yes	No
Do you have any Malpractice suits pending against you?	Yes	No
Have you had any other type of professional sanction?	Yes	No
Have you had an action against you which was resolved by monetary settlement?	Yes	No
Have there been any felony criminal charges brought against you?	Yes	No
Do you presently have a physical or mental health condition, including alcohol or drug dependence, that can affect or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately?	Yes	No

I have enclosed copies of the required documents:

1. **Current State Chiropractic License**
2. **Copy of current Malpractice Declarations Page showing limits of $1million/$3million**

*Please list other office locations, tax ids, etc. on a separate sheet when applicable. Duplicate as necessary.

I certify that all information given by me to the foregoing questions and statements in this application is true and correct without omissions of any kind. I consent to and authorize the release, by any person to CHG, of all information relevant to the evaluation of my education, professional qualifications, competence, character and ethics. Thank you.

Doctor's Signature   Date   Fed ID (TIN)/SS #

Fax to 888-774-0456