



Bradley Hospital
Lifespan. Delivering health with care.®

PediPRN Enrollment Form

Practice Information

Practice Name: _____

Practice Type: (Pediatrician, Family Practitioner, APRN, PA) _____

Practice Address: _____

Practice Phone: (back office preferred) _____

Medical Director: _____

Office Manager: _____

Estimated total number of children as patients: _____

Additional Sites:

Site 1 _____

Site 2 _____

Site 3 _____

Agreement Information

1. We agree to participate in PediPRN.
2. We agree to complete periodic satisfaction surveys.
3. We agree to continue to manage behavioral health care of appropriate cases for the primary care setting following case-based consultation with the team.
4. We understand that the PediPRN psychiatric consultant will not be prescribing medications.

Signed: _____ Date: _____

Title: _____

Please list all providers within your practice including doctors, physician assistants, and nurse practitioners.

Provider Name	Email Address	Full-time or Part-time

continued on back

Provider Name	Email Address	Full-time or Part-time