**CAPP Provider Interest Form**

1. **Initial Requirements**

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| **Name:** | Click or tap here to enter text. |
| **Degree** | **Click or tap here to enter text.** |
| **Clinical License and Number:** | Click or tap here to enter text. |
| **Good standing?**  | **Yes** [ ]  **No** [ ]  |

1. **Clinical Experience**

|  |  |
| --- | --- |
| **Do you have 2 years of working with adults in a treatment setting?**  | **Yes** [ ]  **No** [ ]  |
| **Describe:**  | Click or tap here to enter text. |

1. **Preferred Contact Information**

|  |  |
| --- | --- |
| **Phone**  | Click or tap here to enter text. |
| **Email** | Click or tap here to enter text. |

1. **Practice Location and Information (if applicable)**

|  |  |
| --- | --- |
| **County of Practice Location** | Click or tap here to enter text. |
| **Practice Name** | Click or tap here to enter text. |
| **Service Address** | Click or tap here to enter text. |
| **Service Phone Number** | Click or tap here to enter text. |

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| *Please email your completed form to:* |
|  |
| *CMEP\_CAPP@med.unc.edu*Thank you for your interest in rostering as a CAPP Provider with the NC Child Medical Evaluation Program!We will be contacting you about upcoming CAPP Provider trainings.  |
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