

Individual Therapist Employment Termination Verification

*****When therapists leave employment with your group, please complete & sign the sections below for each therapist; so that we may update our systems accordingly.**

The following Therapists are no longer employed by this Facility:

Facility Name: _____

Address: _____ **City** _____ **State** _____

*****Requested By: (Please complete/sign below – before submitting to OrthoNet) :**

Print Name	Title	Date
<u>Therapist Name</u>		<u>Last Date of Employment with Group listed above Month/Year</u>
[] _____		_____
[] _____		_____
[] _____		_____
[] _____		_____
[] _____		_____
[] _____		_____
[] _____		_____

If you have additional therapists that need to be credentialed with OrthoNet, please submit the CAQH notification form accordingly for each therapist.

Please fax this form to 914-323-9307 for processing.