

## Contra Costa Mental Health Plan PEER REFERENCE FORM

For MDs, DOs and NPs only

## SEND TO:

Behavioral Health Administration 1340 Arnold Dr., #200, Martinez, CA 94553 FAX (Provider Services): (925) 957-5217 EMAIL: Provider.Services@cchealth.org

Name Agency Date
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List three (3) professional references from your specialty area, not to include relatives, current partners or associates in practice. Include at least one individual who has directly supervised your work.

References must be from individuals who are directly familiar with your work and have observed such work for at least six months within the past year, either via direct clinical observation or through close working relations.

REFERENCE #1								
FIRST NAME	LAST NAME				TITLE			
SPECIALTY	TIME FRAME OBS	TIME FRAME OBSERVED						
	FROM				_TO	_/		
PHONE NUMBER	EMAIL ADDRESS							
FACILITY/ORGANIZATION WHERE YOU WORKED WITH THIS INDIVIDUAL	RELATIONSHIP TO	APPLICAN	Γ (COLLEAGUE/SI	JPERVISOR):				
Mailing Address								
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Сіту		STATE			ZIP			
REFERENCE #2								
	LACT NAME				TITLE			
FIRST NAME	LAST NAME				TITLE			
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FACILITY/ORGANIZATION WHERE YOU WORKED WITH THIS INDIVIDUAL	RELATIONSHIP TO APPLICANT (COLLEAGUE/SUPERVISOR):							
MAILING ADDRESS								
CITY		STATE			ZIP			
		31/112						
REFERENCE #3								
FIRST NAME	LAST NAME				TITLE			
SPECIALTY	TIME FRAME OBSERVED							
		FROM	/	/	TO	/	/	
PHONE NUMBER	EMAIL ADDRESS							
FACILITY/ORGANIZATION WHERE YOU WORKED WITH THIS INDIVIDUAL	RELATIONSHIP TO APPLICANT (COLLEAGUE/SUPERVISOR):							
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