Print

Reset Form

CONTRA COSTA HEALTH SERVICES

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_____

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 Observed FROM _____/_____/_____ TO _____/_____/_____	
Phone Number	Email Address	
Facility/Organization where you worked with this individual:	Relationship to Applicant (Colleague/Supervisor):	
Mailing Address		
City	State	Zip

REFERENCE #2		
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):	
Mailing Address		
City	State	Zip

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):	
Mailing Address		
City	State	Zip