

Return to: Computer Science Corporation
PO Box 4610
Rensselaer NY 12144-4610

**EMPLOYMENT CERTIFICATION FOR
CERTIFIED ASTHMA EDUCATOR**

This Form Must Be Completed and Signed by Each Employer

1. Employer Name: _____
2. Employer License Number (if practitioner): _____
3. Employer National Provider Identifier (NPI): _____
Employer Medicaid Provider # _____
4. Employer Telephone Number: _____
5. Employer Current Service Address: _____

6. Will the Certified Asthma Educator practice at the same service location(s) at which you practice?
 Yes No
If no is checked, list locations where the Certified Asthma Educator will practice.

CERTIFICATION STATEMENT

I swear that the information that I have provided is true and accurate to the best of my knowledge. I agree to notify, in writing, the Department of Health (DOH), Division of Provider Relations and Utilization Management if for any reason the National Certification of this educator is no longer active.

Employer Signature _____

Print Name _____

Date _____