



Dear Applicant,

Thank you for your interest in becoming a Group Medical Provider vendor with the Department of Education, Division of Vocational Rehabilitation (DVR). In our Vendor Qualification Manual, this vendor is described as a group of two or more health care providers licensed by the Department of Health legally organized as a partnership, professional corporation, or similar association. In order to be eligible for registration, potential applicants must be authorized by the VR Vendor Registration Unit.

Additionally, all potential providers must first register in MyFlorida Market Place (MFMP) and submit a substitute W-9 to the Department of Financial Services via the State of Florida Vendor website.

Please read carefully all of the instructions included in the application package and complete each item as requested. Incomplete applications will result in process delays and possible denial. If you have any questions regarding this application package or process, please contact the Vendor Registration Unit at 866-580-7438 or 850-245-3401, or via email at VRVendors@vr.fldoe.org.

Please mail or fax completed applications and all required documentation to:

Division of Vocational Rehabilitation
Vendor Registration Unit
325 West Gaines Street, Suite 1144
Tallahassee, FL 32399-0400
Fax Number: 850-245-3394

Thank you for your commitment to helping people with disabilities find and maintain employment and enhance their independence. We look forward to working with you.

Division of Vocational Rehabilitation
Vendor Registration Unit

Enclosures: Group Medical Application

Kelly Rogers, Director

Division of Vocational Rehabilitation

325 West Gaines Street, Suite 1144 • Tallahassee, FL 32399-0400
Toll Free: 1-800-451-4327 • 850-245-3399 • FAX: 850-245-3392 • www.rehabworks.org
TTY users dial 711 • VP users connect via VRS



**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR
APPLICATION**

VENDOR INFORMATION	
MYFLORIDA MARKET PLACE (Federal Tax ID) NUMBER:	
* EMPLOYER NAME:	
CONTACT PERSON'S NAME:	
* MAILING ADDRESS:	
City:	
State:	
Zip Code + Four Digits:	
* REMITTANCE ADDRESS:	
City:	
State:	
Zip Code + Four Digits:	
PRIMARY TELEPHONE NUMBER:	
FAX NUMBER:	
CONTACT NAME:	
CONTACT PHONE NUMBER:	
EMAIL ADDRESS:	

* This information should be the same reflected in MFMP and on your registration with the Department of State, Division of Corporations

**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION**

**PLEASE LIST LOCATIONS WHERE CUSTOMERS WILL BE SERVED
(Attach additional pages as necessary)**

LOCATION 1:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LOCATION 2:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

LOCATION 3:

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Is each location fully accessible to persons with disabilities? YES NO

OTHER LANGUAGES

Could you assist customers in other languages? YES NO

Please mark all applicable:

American Sign Language Spanish Creole Other (Please specify below)

**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION**

GROUP MEDICAL SPECIALTY

Provide a description of specialty licensed by the Florida Department of Health (DOH), a list, including the full name of each individual providing services to DVR clients under the Group Medical Provider, and a copy of the current Florida DOH license for each individual.

IS YOUR APPLICATION COMPLETE

- List of each individual providing services to DVR clients under the Group Medical Provider
- Copy of the current Florida DOH license, for each individual
- List of areas and counties where services will be provided

Please mail, email or fax this application and all required documents to:

Florida Department of Education
Division of Vocational Rehabilitation
Vendor Registration Unit
325 West Gaines Street, Suite 1144
Tallahassee, Florida 32399-0400
Fax Number: 850-245-3394
Email: VRVendors@vr.fldoe.org

If you have any questions that pertain to this application, please contact the Vendor Registration Unit at 866-580-7438, or 850-245-3401.

**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION**

CONFIDENTIALITY

Access to a VR customer's confidential information must be safeguarded at all times. Such information shall not be used or disclosed for any purpose not in conformity with State and Federal Laws and Regulations without written consent of the customer or their parent, guardian, or other authorized representative.

PLEASE READ AND SIGN BELOW

I hereby acknowledge I am authorized to make application on behalf of the Vendor to become an approved DVR Vendor. I further acknowledge that I have read and agree to be bound by the terms of registration outlined in this application and in section, 413.208, Florida Statutes. I acknowledge that the Provider is subject at all times to a due-diligence inquiry as to its fitness to undertake service responsibilities, and that the Provider's registration may be suspended pending such inquiry. If approved, we agree to accept and render services to customers of the Division of Vocational Rehabilitation (VR) on a non-discriminatory basis without regard to race, color, religion, sex, national origin, age, disability, political affiliation or belief.

Printed Name of Authorized Agent:

Date:

Signature:

**DEPARTMENT OF EDUCATION
DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL PROVIDER VENDOR APPLICATION**

DOE/VR AREAS & COUNTIES WHERE SERVICES WILL BE PROVIDED

Vendor Name: _____

FEIN #: _____

Name of Authorized Representative: _____

Signature: _____

*** Check all that apply:**

- | | | | | | |
|--|--|--|---|---|--|
| <input type="checkbox"/> Area One | <input type="checkbox"/> Area Two | <input type="checkbox"/> Area Three | <input type="checkbox"/> Area Four | <input type="checkbox"/> Area Five | <input type="checkbox"/> Area Six |
| <input type="checkbox"/> Escambia | <input type="checkbox"/> Columbia | <input type="checkbox"/> Lake | <input type="checkbox"/> Pinellas | <input type="checkbox"/> Charlotte | <input type="checkbox"/> Miami-Dade |
| <input type="checkbox"/> Santa Rosa | <input type="checkbox"/> Union | <input type="checkbox"/> Sumter | <input type="checkbox"/> Hillsborough | <input type="checkbox"/> Lee | <input type="checkbox"/> Monroe |
| <input type="checkbox"/> Okaloosa | <input type="checkbox"/> Gilchrist | <input type="checkbox"/> Seminole | <input type="checkbox"/> Hernando | <input type="checkbox"/> Collier | |
| <input type="checkbox"/> Walton | <input type="checkbox"/> Dixie | <input type="checkbox"/> Orange | <input type="checkbox"/> Pasco | <input type="checkbox"/> Hendry | |
| <input type="checkbox"/> Holmes | <input type="checkbox"/> Clay | <input type="checkbox"/> Osceola | | <input type="checkbox"/> Glades | <input type="checkbox"/> Area Seven |
| <input type="checkbox"/> Jackson | <input type="checkbox"/> St. Johns | <input type="checkbox"/> Brevard | | <input type="checkbox"/> Manatee | <input type="checkbox"/> Palm Beach |
| <input type="checkbox"/> Washington | <input type="checkbox"/> Nassau | <input type="checkbox"/> Polk | | <input type="checkbox"/> Sarasota | <input type="checkbox"/> Broward |
| <input type="checkbox"/> Calhoun | <input type="checkbox"/> Baker | <input type="checkbox"/> Hardee | | | |
| <input type="checkbox"/> Liberty | <input type="checkbox"/> Putnam | <input type="checkbox"/> DeSoto | | | |
| <input type="checkbox"/> Bay | <input type="checkbox"/> Duval | <input type="checkbox"/> Highlands | | | |
| <input type="checkbox"/> Gulf | <input type="checkbox"/> Alachua | <input type="checkbox"/> Indian River | | | |
| <input type="checkbox"/> Franklin | <input type="checkbox"/> Bradford | <input type="checkbox"/> St. Lucie | | | |
| <input type="checkbox"/> Gadsden | <input type="checkbox"/> Levy | <input type="checkbox"/> Martin | | | |
| <input type="checkbox"/> Leon | <input type="checkbox"/> Marion | <input type="checkbox"/> Okeechobee | | | |
| <input type="checkbox"/> Wakulla | <input type="checkbox"/> Citrus | | | | |
| <input type="checkbox"/> Jefferson | <input type="checkbox"/> Flagler | | | | |
| <input type="checkbox"/> Madison | <input type="checkbox"/> Volusia | | | | |
| <input type="checkbox"/> Hamilton | | | | | |
| <input type="checkbox"/> Taylor | | | | | |
| <input type="checkbox"/> Suwanee | | | | | |
| <input type="checkbox"/> Lafayette | | | | | |