

**DO NOT SEND THIS FORM TO CAMERON AND ASSOCIATES, INC. PLEASE SEND TO THE COLLEGE OR UNIVERSITY FOR VERIFICATION.**

**Please note completion of this form is required for all nurse practitioners seeking CAI network affiliation.**

To Whom It May Concern:

The following provider of behavioral health care services has applied for credentialing or re-credentialing with Cameron and Associates, Inc. (CAI) Please verify the providers advanced degree/certification program in the section below, and return to:

**CAMERON AND ASSOCIATES, INC.**

**Attn. Provider Relations**

6100 Lake Forrest Drive

Suite 550

Atlanta, Georgia 30328

Student Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

College or University: \_\_\_\_\_

Address of College or University: \_\_\_\_\_

Date of Matriculation: \_\_\_\_\_ Degree Received: \_\_\_\_\_

---

*Permission to release information:*

I, \_\_\_\_\_, hereby give permission for an appropriate representative of \_\_\_\_\_ (College or University), to release information concerning my Completion of the aforementioned degree program.

---

**For School Completion Only**

Date of Matriculation: \_\_\_\_\_ Field of study: \_\_\_\_\_ Degree: \_\_\_\_\_

Date Degree earned: \_\_\_\_\_

Concentration in which degree was awarded (if any): \_\_\_\_\_

Name/Title of person verifying degree: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date