Credentialing Info

Name as you want it printed on Contracts _____

Have you ever used any other names _____

Birth Date _____ Birth City _____ Birth Country_____

SS# _____ NPI _____

Home Address _____
Street Address City State Zip

Home Telephone _____ Cell Phone _____

E-Mail Address _____

State License Information - Number _____ State _____Exp _____

Number _____State _____ Exp _____

DEA Number _____ Exp _____

Medicare Number _____

Medicaid (AHCCCS) Number _____

UPIN if issued _____

Medical School Name _____

Dates Attended _____to _____ Degree Earned _____
Mo/Yr Mo/Yr

Undergraduate School Name_____

Dates Attended _____to _____ Degree Earned _____
Mo/Yr Mo/Yr

Undergraduate School Name_____

Dates Attended _____to _____ Degree Earned _____
Mo/Yr Mo/Yr

Fellowship Facility Name_____

Address _____ Phone _____
Street Address City State Zip

Dates Attended _____to _____ Type of Fellowship_____
Mo/Yr Mo/Yr

Name of Program Director_____

Did you complete the program – If not Why?_____

Residency Facility Name_____

Address _____ Phone _____
Street Address City State Zip

Dates Attended _____to _____ Type of Fellowship_____
Mo/Yr Mo/Yr

Name of Program Director_____

Did you complete the program – If not Why?_____

Residency Facility Name_____

Address _____ Phone _____
Street Address City State Zip

Dates Attended _____to _____ Type of Fellowship_____
Mo/Yr Mo/Yr

Name of Program Director_____

Did you complete the program – If not Why?_____

Physician Name _____

Are you Board Certified YES or NO –

If Yes – Which Board _____ Exp _____

If No – Do you intend to sit for exams _____ When _____

Do you have any of the following certifications:

Basic Life Support (BLS)	YES	or	NO	Exp _____
Adv. Cardiac Life Support (ACLS)	YES	or	NO	Exp _____
Adv Life Support in OB (ALSO)	YES	or	NO	Exp _____
Pediatric Adv Life Support (PALS)	YES	or	NO	Exp _____
Advanced Trauma Life Support (ATLS)	YES	or	NO	Exp _____
Neonatal Adv Life Support (NALS)	YES	or	NO	Exp _____
CPR –	YES	or	NO	Exp _____

Note- Please provide copies of certification cards if applicable

Hospital Privileges (Even if Out of State)

Name of Hospital #1_____

Address _____Phone_____
Street Address City State Zip

Staff Category _____ Date Began _____

Name of Hospital #2_____

Address _____Phone_____
Street Address City State Zip

Staff Category _____ Date Began _____

Name of Hospital #3_____

Address _____Phone_____
Street Address City State Zip

Staff Category _____ Date Began _____

Malpractice Insurance Carrier _____

Original Effective Date _____Exp Date _____

Policy # _____ Tail Coverage YES or NO

Cov Per Occurrence _____Cov per Aggregate _____

If this coverage is less than 5 years old, then I will also need previous malpractice insurance info back 5 years. Attach a separate sheet if necessary

Work History Back 15 years

Name of Facility _____From_____ to _____
Mo/yr Mo/Yr

Address _____
Street Address City State Zip

Supervisor _____E-mail _____

Phone _____Fax _____

Your Position _____

Reason for Leaving _____

Physician Name _____

Work History Back 15 years (Cont.)

Name of Facility _____From_____ to _____
Mo/yr Mo/Yr

Address _____
Street Address City State Zip

Supervisor _____E-mail _____

Phone _____Fax _____

Your Position _____

Reason for Leaving _____

Name of Facility _____From_____ to _____
Mo/yr Mo/Yr

Address _____
Street Address City State Zip

Supervisor _____E-mail _____

Phone _____Fax _____

Your Position _____

Reason for Leaving _____

Name of Facility _____From_____ to _____
Mo/yr Mo/Yr

Address _____
Street Address City State Zip

Supervisor _____E-mail _____

Phone _____Fax _____

Your Position _____

Reason for Leaving _____

References – Need 4 – 2 of the 4 must be in your specialty and if you have been in AZ for 6 months, all must be from Arizona. Must be aware of your clinical experience in the last two years, not a relative or associate.

Reference #1 Name _____DPM MD DO

Address _____
Street Address City State Zip

Phone _____ Fax _____

E-Mail Address _____

Reference #2 Name _____DPM MD DO

Address _____
Street Address City State Zip

Phone _____ Fax _____

E-Mail Address _____

Physician Name _____

Reference #3 Name _____DPM MD DO

Address _____
Street Address City State Zip

Phone _____ Fax _____

E-Mail Address _____

Reference #4 Name _____DPM MD DO

Address _____
Street Address City State Zip

Phone _____ Fax _____

E-Mail Address _____

1. Have you had a malpractice claims filed against you? Yes or No
2. Have you ever been convicted of a crime? Yes or No
3. Have you ever had any of the following revoked or suspended
    a. Medical License Yes or No
    b. Medicare Privileges Yes or No
    c. Hospital Privileges Yes or No
    d. Insurance Plan Contracts Yes or No
    e. Residency or Fellowship Program Yes or No
    f. Malpractice Insurance Yes or No
    g. Board Certifications Yes or No
    h. Any other licensures or certifications Yes or No
4. Do you use Illegal Drugs Yes or No
5. Is there any physical limitation that would affect your ability Yes or No

If any answers are Yes, please provide an explanation on a separate sheet of paper.
If there are any other issues not mentioned here that you feel should be disclosed please explain on a separate sheet of paper.

Physician Name _____

If you are applying for Hospital Privileges – the following information is also needed.

1. Name of Spouse_____
2. Have you served in the Military Yes or No
   If Yes : _____ US Military _____Reserves _____Public Health Serv.
   What Branch _____
   From _____ to _____ Type of Discharge _____
   Mo/Yr Mo/Yr
3. Please provide explanation for work History gaps of more than 3 months, on separate sheet of paper.
4. Name of your Cell Phone Carrier_____
5. If requesting privileges at any Banner Facility (Boswell, Del Webb, T-Bird, Etc
   Please complete the Abbreviations test attached and return the answer page to me.
6. List of Past and Present Hospital Privileges with the following information:
   a. Hospital Name
   b. City, State
   c. Address & Phone, and Fax if you know it
   d. Type of Privileges
   e. Start Date and End Date
   f. Copy of Surgical Privileges list
   g. Some hospitals also require the number of each procedure that you performed in the last one or two years.

Physician Name _____

Please provide me with copies of the following documents:

___State License – AZ and any other state that is current
___DEA Certificate
___Malpractice Insurance Certificate
___Undergraduate Degree(s)
___Medical School Degree
___Residency/Fellowship Certificates
___Board Certification
___Continuing Medical Education Certificates for Last 2 years
___Immunization record, Including MMR, Chicken Pox, Hepatitis B
___TB attestation documentation
___Current Curriculum Vitae
___At least 5 Wallet size photos – or a digital image can be e-mailed to me and I will print as needed.
___Copies of any Advanced Life Support Training Cards
___Copy of Privileges list from at least one hospital where you currently have priviliges

And if applicable:
___Military Release Certificate