(Practice Name)

PHYSICIAN CREDENTIALING INFORMATION

Last Name	First Name	MI	Suffix
Any other name under which you have been know			
Date of Birth	SS #	Gender	
Home Address			
City	State	Phone	Email
Citizenship	City/State of Birth	Country of Birth	
Marital Status	Spouse Last Name	Spouse First Name	
Degree(s)	UPIN #		
License #	State	Initial Effective Date	Expiration
DEA #	State	Initial Effective Date	Expiration
Medicare #	Medicaid #		
Other State Licenses			
Pager/Beeper/Cell #			
Basic Life Support: Type	Expiration		
Date of Last Physical Exam	Physician		
Date of Last TB test			
Board Certified Specialty	Certifying Board		

Date Certified	Expiration Date	
Secondary Specialty		
College	From	To
Address		
Degree Obtained	Course of Study/Major	
Medical School	From	To
Address		
Degree		
Internship	From	To
Address		
Specialty	Program Director	
Residency	From	To
Address		
Specialty	Program Director	
Fellowship/Other	From	To
Address		
Specialty		
Professional Associations		
CME hours		

Hospital Affiliation	Type Privileges	Appointment Date
Address		
Hospital Affiliation	Type Privileges	Appointment Date
Address		
Work History (last 5 yrs.)		
Practice	From	To
Address		
Phone	Contact Person	
Practice	From	To
Address		
Phone	Contact Person	
Practice	From	To
Address		
Phone	Contact Person	
Professional Reference Name		Phone
Address		
Specialty	Start Date of Association	End Date of Association
Professional Reference Name		Phone
Address		

Specialty	Start Date of Association	End Date of Association
Professional Reference Name		Phone
Address		
Specialty	Start Date of Association	End Date of Association
Malpractice Carrier (last 5 yrs.)	Effective Date	Expiration Date
Address		
Phone	Contact Person	Policy #
Amount Coverage	Type Coverage	Retroactive Date
Malpractice Carrier	Effective Date	Expiration Date
Address		
Phone	Contact Person	Policy #
Amount Coverage	Type Coverage	Retroactive Date
Malpractice Carrier	Effective Date	Expiration Date
Address		
Phone	Contact Person	Policy #
Amount Coverage	Type Coverage	Retroactive Date
Any certifications, privileges, licenses revoked, limited, suspended, involuntarily or voluntarily relinquished?		
Any reprimands or reviews for such?		
Has professional liability insurance been denied?		

Do you have physical or mental conditions that may affect your ability to practice?	
Have you ever been the subject of an investigation or adverse action?	
Do you now or have you ever had any pending malpractice claims?	
Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?	
Are any criminal charges pending against you?	
Have you ever been arrested or charged with a crime involving children?	
Have you ever been arrested or charged with a crime involving moral turpitude?	
Are you currently using illegal drugs or legal drugs in an illegal manner?	
Needed copies	Medical License DEA License Driver's License Board Certification Diplomas: College, Medical School, Internship, Residency CME CV (if available)