

SECTION 4 — Education & Training

Medical School

Facility / School Name

Address

Degree Earned

From (MM/YY)

To (MM/YY)

Internship

Facility / School Name

Address

Specialty

From (MM/YY)

To (MM/YY)

Residency

Facility / School Name

Address

Specialty

From (MM/YY)

To (MM/YY)

Fellowship (if applicable)

Facility / School Name

Address

Specialty

From (MM/YY)

To (MM/YY)

Explain any gaps > 30 days in training or employment:

SECTION 5 — Board Certification

Certifying Board Name

Specialty

Certificate Number

Initial Cert. Date (MM/YY)

Current Status

Active

Inactive

Expired

MOC Participation: Yes No

SECTION 6 — Employment & Hospital Privilege History

Employment History (since completing training):

Employer / Facility	City/State	Position	Dates	Reason for Leaving

Hospital Privileges (current and prior):

Hospital Name	City/State	Privilege Type	Dates	Status

SECTION 7 — Clinical Privileges Requested

List procedures or privilege categories requested:

1.

2.

3.

Supporting documentation (case logs, training certificates) may be required.

SECTION 8 — Professional Liability (Malpractice)

Current Carrier Name

Policy Number

Coverage Type

Claims-made

Occurrence

Limits: \$

/ \$

Effective From (MM/YY)

To (MM/YY)

Face sheet:

Attached

Malpractice Claim History — Have you ever had a professional liability claim?

No

Yes (attach explanation: allegation, dates, outcome)

SECTION 9 — Disclosure Questions

Have you ever experienced any of the following? (Check Yes or No)

Question	Yes	No
License suspension, restriction, or investigation	<input type="checkbox"/>	<input type="checkbox"/>
DEA or controlled substance registration issues	<input type="checkbox"/>	<input type="checkbox"/>
Denied or restricted hospital privileges	<input type="checkbox"/>	<input type="checkbox"/>
Criminal charges or convictions	<input type="checkbox"/>	<input type="checkbox"/>
Medicare/Medicaid sanctions or exclusions	<input type="checkbox"/>	<input type="checkbox"/>
Substance use treatment or impairment concerns	<input type="checkbox"/>	<input type="checkbox"/>

If any answer is 'Yes,' provide full explanation below:

SECTION 10 — Health Status

I attest that I am physically and mentally able to perform the essential duties of my specialty:

Yes No (attach explanation)

Immunization records provided: Yes No

SECTION 11 — References (same specialty; not family members)

Provide three peer references who can speak to your clinical competence.

Reference 1

Name

Specialty

Institution / Practice

Phone

Reference 2

Name

Specialty

Institution / Practice

Phone

Reference 3

Name

Specialty

Institution / Practice

Phone

SECTION 12 — Attestation & Signature

I attest that all information provided in this application is accurate, current, and complete to the best of my knowledge. I authorize the verification of all information submitted. I understand that misrepresentation may result in denial or termination of credentialing.

Physician Signature _____

Date (MM/DD/YYYY)

Printed Name