ID# Issued: _____

Memorial Healthcare System
Application Request - Initial/Expedited/Reinstatement

PHONE: 954-844-4430 ❖ FAX: 954-965-6468

It is requested that the MEDICAL AFFAIRS CREDENTIALING DEPARTMENT provide access to an Application Packet to the following practitioner:

(*Practitioner will receive two emails with link to PHP and secure password to complete online application and privileges request)

Practitioner's Name: _____ _____ _____
First Name Middle Last Name

Gender: ☐ Male ☐ Female

Degree: ☐ MD ☐ DO ☐ DPM ☐ OTHER: _____ **Date of Birth:** _____/_____/_____
(PA, APRN, CNM) MM DD YYYY

Specialty: _____ **AHP only – Sponsoring Physician**: _____

***Practitioner's Email Address:** _____@_____

CC Email Address: _____@_____

Cell Phone: (_____)_____ **Office Phone:** (_____)_____

Other Phone: (_____)_____ **Fax Number:** (_____)_____

Request for Application Date: _____/_____/_____
Month Day Year

Is provider being employed by MHS?
Yes_____ No _____

Target/Desired Start Date (MHS employees only): _____/_____/_____
Month Day Year

Previous affiliation with MHS?
Yes_____ No _____

Application requested: ☐ Initial Appointment (with clinical privileges)
☐ Expedited (to add a facility by a current staff member)

Facilities within MHS to which practitioner is making application (please circle):

☐ **MRH** ☐ **MHW** ☐ **MHP** ☐ **MHM** ☐ **JDCH** ☐ **ASCW**

Additional Comments: _____

Requested by: _____
Name/Title/Contact Number

Xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx **OFFICE USE ONLY** xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Person completing Application Request form: _____
* SCAN COMPLETED REQUEST INTO MSOW

01/2016

NOTE - processing time:
Initial Appointment = 60 – 90 Days
Expedited (must already be on staff at another facility) = 30 – 60 Days