PHYSICIAN

CHECKLIST FOR INITIAL APPOINTMENT

(***Bold Italics: Minimum Requirements for Temporary Appointment***)

Name of Applicant: _____ Date Received: _____

Department: _____ Specialty: _____

Place of Birth: _____ Date of Birth: _____

SS#: _____

		Verification	
		Received	**Completed**
Application: To Applicant _____		_____	_____
Consent Statement completed: To Applicant _____		_____	_____
NPDB check: negative information report		_____	_____
OIG check: negative information report		_____	_____
PA Medical License #: _____	Exp. _____	_____	_____
PA License application required	YES ___ NO ___		
Application Submitted & Fee Paid	YES ___ NO ___		
DEA Certificate (w/PA state address)	Exp. _____	_____	_____
Board Certified	YES ___ NO ___	_____	_____
Board Eligible	YES ___ NO ___	_____	_____
Board Name: _____			
Malpractice Insurance	YES ___ NO ___		_____
Relevant Education:			
Medical School _____			_____
Internship _____			_____
Residency _____			_____
Other (Name) _____			_____
Relevant prior 5 years employment history confirmed		_____	_____
Competency References			
1. _____		_____	_____
2. _____		_____	_____
3. _____		_____	_____
4. _____		_____	_____
Medicare Accepted	YES ___ NO ___	_____	_____
Medicaid Accepted	YES ___ NO ___	_____	_____
Clinical Privileges Application: To Applicant _____		_____	_____

I have reviewed the complete credentials file of the above applicant for appointment and Clinical Privileges at Health Center. ___ I recommend OR ___ I do not recommend approval.

_____ _____ _____

Clinical Manager Signature Department Date