Providence

REQUEST FOR PRACTITIONER APPLICATION / PRE-APPLICATION

Rev. 03.2023

Please complete this form, sign it, and e-mail to AKMedicalStaff@Providence.org or fax to (907) 212-4865

Degree types eligible to request application: MD, DO, DDS, DMD, DPM, CNM, ANP, PA, PhD, PsyD, CRNA, Surgical Asst, Dental Asst, Pathology Asst, Perfusionist

Facility or Facilities you wish to apply for privileges: ☐ PAMC (Anchorage) ☐ PKIMC (Kodiak Island) ☐ PSESH (St. Elias) ☐ PSMC (Seward) ☐ PVMC (Valdez)

Applicant's Name:	Degree	Applicant's Contact Phone #	Employment Type: ☐ Employed by Prov ☐ Contracted by Prov ☐ Locums ☐ Independent ☐ Fellowship Program
Applicant's E-Mail:	SSN:	Date of Birth:	Primary Practicing Specialty:
Applicant Mailing Address:	City	State	Zip Code
Anticipated Start Date:	Medical/Professional School Graduation Year	Internship/Residency Program Graduation Year:	Fellowship Program Graduation Year:
Group you will be employed by OR affiliated with in Alaska:	If **Locums**, name of company?		
Who will you share call with? (Call coverage is required to be on staff):	If **AHP**, who will be your supervising Physician?		
Credentialing Contact:	Credentialing Contact Phone #:	Credentialing Contact Email:	
Do you currently hold an active Alaska State License? ☐ **Yes** ☐ **No**	If no, have you applied for you Alaska State License? ☐ **Yes** ☐ **No**	Date licensing application was submitted:	
Have you completed a 3-year Residency Program? ☐ **Yes** ☐ **No**	☐ **N/A for AHP**	Residency Training/Specialty:	

Have you ever had Medical Staff or Allied Health Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this medical center, or health plan for reasons related to clinical competence or professional conduct? ☐ **Yes** ☐ **No**

Have you ever had your medical license revoked, restricted, or suspended by any state licensing agency? ☐ **Yes** ☐ **No**

Are you board certified in your primary specialty by a board recognized by the ABMS, AOA, or applicable AHP certifying agency? ☐ **Yes** ☐ **No**,

If NO, are you board admissible and will board certified within 5 years of training completion? ☐ **Yes** ☐ **No**

Have you ever been excluded from Medicare, Medicaid or any healthcare program as identified on the Government Services Agency "Excluded Parties Listing System" or the Health and Human Services Officer of the Inspector General "Excluded Individual Search"? ☐ **Yes** ☐ **No**

I represent that the information provided on this pre-application is accurate, complete, and fairly represents my training and current expertise. I understand and agree that any misrepresentation, misstatement, or omission from this application request whether intentional or not may constitute cause to not be provided an application as requested. I understand that in the event of discovery of such an event, or if I do not meet the minimum criteria of the facility requested, I will not be provided an application and I will not be entitled to any hearing or appeal rights that are contained in the Hospital or Medical Staff Bylaws, Policies, or other regulations. I understand that with the information I have provided above, basic steps to understand my training and background may be checked to further determine my eligibility for medical staff membership and privileges at the requested Providence Health and Services facility(ies), prior to my submitting a full application. If I currently have privileges at a facility that holds a Credentials Information Sharing Agreement with, I authorize such facility to release information covered in the Credentials Information Sharing Agreement to. I formally request an application for membership and privileges and certify that I am currently competent to perform the privileges selected above based on my training, recent experience and within the scope of my professional licensure. I agree that I am responsible to provide all necessary documentation, as deemed required by the facility(ies), in support of the application for membership and privileges I will receive. I attest to know of no health condition or inability to perform that, without reasonable accommodation that would impair my ability to competently perform the privileges I may be granted.

Signature: _____ Date: _____