Banner Health.

Credentialing Verification Services (CVS)
PHONE: (602) 640-3500
FAX: (602) 640-3535

DATE: ______________________________

INITIAL APPLICATION REQUEST FORM

I am applying for privileges/membership to: Banner Gateway Medical Center

ALL OF THE FOLLOWING INFORMATION IS REQUIRED.
(if information is pending or not applicable, please indicate)

_______Medical Staff ______Allied Health _______ Community Based Physician (no clinical privileges) (Please check one)

NAME: ____TITLE__________
FIRST MIDDLE LAST

PRIMARY OFFICE/MAILING ADDRESS: ____
STREET

____
CITY STATE ZIP

TELEPHONE: (____) ______________________________ FAX: (_______) ______________________________

E-Mail Address: ____

GROUP NAME (OR SPONSORING PHYSICIAN IF ALLIED HEALTH): ____

COVERING PHYSICIAN(S): ____

DOB: _____/______/__________ SS#__________/_______/__________ AZ LICENSE#: ____________________

UPIN#________________ NPI#___________________________ DEA#: ______________________________

MALPRACTICE INSURANCE CARRIER: ___________________________________POLICY#__________________________

Name of Insured: ____ Amount of Coverage: ____________________

Effective Date: ________________________ Expiration Date: ______________________________

Have you had or are there currently any pending claims/complaints filed against you within the last ten years? Yes No

PRIMARY SPECIALTY: ____

SPECIALTY BOARD STATUS: ___CERTIFIED ___QUALIFIED ___NOT CERTIFIED

(Primary__________________________________ & Subspecialty__________________________________
_____ ABMS _____AOA _____OTHER: __________________________________

MEDICAL SCHOOL ATTENDED (OR MEDICAL TRAINING IF ALLIED HEALTH): ____
____YEAR GRADUATED:____________________
Address City/State

POST-GRAD TRAINING:

______Internship Specialty: ____

Facility: ____

Date completed: __________/__________/____________

INITIAL APPLICATION REQUEST FORM (Continued)

______Residency Specialty: ____

Facility: ____

Date completed: ________/_________/__________

______Fellowship Specialty: ____

Facility: ____

Date completed: ________/_________/__________

PRIMARY HEALTHCARE AFFILIATION:

Facility: ____

Address: ____
Street City State Zip Code

Telephone: (_____)______________________________Fax: (_____)________________________

Date on Staff: From: ____________________________To ____________________________

Staff Category: ________________________________