Provider Credentials Checklist of Supporting Documents

Provider: ______________________________ **Department:** **KTHFS** ___________________

DOCUMENT	REQUESTED	RECEIVED	EXPIRATION DATE
APPLICATION & ATTACHMENTS:			
Medical Staff Application for Appointment and/or Privileges (completed and signed)			
Copy of Govt. Issued Photo ID (Requested on Pg. 1)			
Immunizations w/supporting evidence (Page 13)			
Signed Stmnt. Of Understanding/Release (Page 14)			
Health Statement (Page 15) – two signatures required			
Signed Malpractice Claims Info Report (Page 17-18)			
Written explanation if "Yes" to 1-26, pgs. 9-11			

REQUEST FOR PRIVILEGES:			
Clinical Privileges (Delineation Sheet)			

LICENSE:			
Copy of (all) License Certificate(s)			
License Verification			
Other License Verification(s)			
OSBN (Oregon State Board of Nursing)			
Current Federal DEA Certificate – exp date			
Copy of Board Certification(s) – exp date			
Verification of Board Certification(s) – exp date			
Internship Certificate			
Verification from Internship			
Residency Certificate			
Verification from Residency			
Fellowship Certificate			
Verification from Fellowship			

DOCUMENT	REQUESTED	RECEIVED	EXPIRATION DATE
EDUCATION:			
Professional School Diploma(s)			
Continuing Medical Education (CME) Summary			

OTHER CERTIFICATIONS:			
Current BLS certificate – exp date Basic Life Support			
Current ACLS certificate – exp date Advanced Cardiac Life Support			
Current ATLS certificate – exp date Advanced Trauma Life Support			
Current PALS certificate – exp date Pediatric Advanced Life Support			