NATIONAL MEDICAL ASSOCIATION
CREDENTIALING APPLICATION

- ***Please type or print legibly using black or blue ink***
- ***Complete application in its entirety***
- ***Write N/A if not applicable***
- ***Use an additional sheet if more space is needed***
- ***Fax to: (310) 532-6043 * Questions: Call (800) 684-3211 or (310) 532-6614***

DEMOGRAPHIC DATA

Last Name	***First Name***	***Middle Initial***	***Title***
Office Address	***City***	***State***	***Zip***
Social Security No.	***Date of Birth***		***Gender***
Telephone Number ***( ) -***	***Fax Number*** ***( ) -***		***E-Mail Address***
Board Certification	***Specialty***		***Expiration Date***

EDUCATION AND TRAINING

Medical School (Name)	***Address***			***Graduation Year***
	City	***State***	***Zip***	***Degree***
Internship (Institution Name)	***Address***			***From:***
Specialty	***City***	***State***	***Zip***	***To:***
Residency (Institution Name)	***Address***			***From:***
Specialty	***City***	***State***	***Zip***	***To:***
Fellowship (Institution Name)	***Address***			***From:***
Specialty	***City***	***State***	***Zip***	***To:***

LICENSURE

License Number		***State of Licensure***		***Expiration Date***	
Other State License#	***State***	***Other State License #***	***State***	***Other State License#***	***State***
DEA Number		***Expiration Date***			
Malpractice Insurance Carrier:		***Policy #***		***Expiration Date***	
Mailing Address		***City***	***State***	***Zip***	

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and performance ("credentialing information") by and between the "National Medical Association" and other Healthcare organizations (e.g. hospital, medical staffs, medical groups, independent practice associations (IPA's) health maintenance organizations (HMO's) preferred provider organizations (PPO's) other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history) licensing authorities, and business and individuals acting as their agents collectively for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgments and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment peer review and credentialing on behalf of this Healthcare organization, and all persons and entities providing credentialing information to such representatives of this Healthcare organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal laws.

I hereby affirm that the information submitted in this application and any addenda thereto, including my curriculum vitae, (if attached) is true, current, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that the material omission or misrepresentations may result in denial of my application or termination of my privileges, employment or participation agreement. A photocopy of this document shall be as effective as the original.

*Print Name:*_____

*Physician Signature:*_____*Date:*_____

(Stamped Signature is not acceptable)