CREDENTIALING APPLICATION REQUEST FORM

Please complete this form in its entirety to obtain an application.

- All applicants should complete Sections 1,2, 4, and 5.
- APPs should also complete Section 3.
- This form applies to physicians (MD/DO), PhD/PsyD, and APPs (APRN, PA) for hospital membership, privileges, and/or **health plan enrollment.**
- This form applies to these specialties (AuD, LADC, LCSW, LD, LGC, LMFT, LPC, OT, PT, and SLP) for clinic privileges and health plan enrollment. **These specialties are not applying for medical staff privileges**.

Once completed, send this form and your CV/resume to the Medical Staff Services Department at credentialing@ouhealth.com. Within three (3) business days of receipt, you will be sent a link to complete your application and supporting documents. **Please note: The credentialing process may take up to 100 days to complete after receipt of a completed application.**

SECTION 1: DEMOGRAPHICS

Practitioner Name_____
First Middle Initial Last

Degree_____ **Primary Specialty**_____

Sub-specialty_____

NPI _____ **Date of Birth** _____ **SSN**_____

Cell Phone_____ **E-mail Address**_____

SECTION 2: EMPLOYMENT AND PRACTICE INFORMATION

Anticipated Start Date_____ **Currently in a training program?** ☐ Yes ☐ No

Training Program Name_____ **Completion Date**_____

Employer: ☐ OU Health/OU Health Partners, Inc. ☐ OUHSC ☐ OU Health/OUHSC (dual)
☐ Other (define type) - ☐ Contract ☐ Locum ☐ Private Practitioner

Employer/Locum Agency Name:_____

Employer/Locum Agency Contact Name & E-mail_____

Practice Location (select all that apply): ☐ Hospital ☐ Clinic

Primary OU Health Hospital Location _____

Primary OU Health Clinic Location_____

Secondary OU Health Clinic Location_____

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Medical Staff Category Requested (select one)

- ☐ Active – Regularly and routinely practices in the hospital; can vote.
- ☐ Courtesy – Not actively involved in medical staff affairs; unable to vote and hold office.
- ☐ Ambulatory – Refer and follow; no privileges.
- ☐ Privileges without Membership – APP, Locum, or Telemedicine

SECTION 3: ADVANCED PRACTICE PROFESSIONALS (APPs)

Sponsoring Physician_____

Certification Board_____

Certification Type_____ ☐ Acute Care ☐ Non-acute care

☐ Yes ☐ No Are you requesting privileges to work in the inpatient hospital setting?
☐ Yes ☐ No Are you providing consultative care under your supervising physician?

SECTION 4: CONTACT AND DELEGATE INFORMATION

☐ Yes ☐ No I want to select a delegate who may respond to requests for credentialing information. If yes, complete the authorization below. If no, requests for information will be sent to you, the applicant.

I hereby authorize_____ (hereinafter, individually referred to as 'delegate') to access the online web portal to enter data and submit documents for initial and reappointment requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before the delegate or I submit them via the online application portal.

Credentialing Contact/Delegate Name_____

Phone_____ **E-mail**_____

SECTION 5: ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understood the Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ _____

Provider Signature Name (Print)

_____

Date

Send this form and your CV/resume to credentialing@ouhealth.com. The full application cannot be sent until this request is received. If you do not receive the e-mail containing the application link within three (3) business days of submitting this form, please contact the Medical Staff Services Office directly at the e-mail above.