INOVA CENTRAL VERIFICATION OFFICE
Pre-Application / Application Request Form
8110 Gatehouse Road, 610W
Falls Church, VA 22042
P:703-204-3370 F: 703-289-8650 Email: Medicalstaffcredentialing@inova.org

Please Note: Credentialing process take 60 – 90 days to complete from receipt of completed application.

PLEASE PRINT CLEARLY: **Please Note: Unreadable or Incomplete forms will be returned**

Last Name: ____________________________**First Name:** _____________________ **Middle Name:** ____________ **(REQUIRED)**
Current name as listed on your VA Medical License (Please note- Your name must match your Medical License and all other certifications, including your malpractice insurance, NPPES (NPI) , Government Photo ID, Federal DEA and Board Certification)

Male Female (**REQUIRED) Date of Birth:** ___________ **(REQUIRED) Social Security Number** ____________**(REQUIRED)**

Applicant's Email :___________________________________**(REQUIRED) Cell:** ___________________ **(REQUIRED)**

Credentialing Contact Email____ **(REQUIRED)**

National Provider Identifier (NPI): YES____________________ NO If No, Date you applied for _______________

Virginia Medical License (REQUIRED) YES License Number_________________ NO N/A

If No, Date you applied for _________

Advanced Practice Provider Virginia License? (REQUIRED) YES License Number________________________ NO N/A

If No, Date you applied for license________

Virginia Drug Enforcement Administration (DEA) Number?(REQUIRED) YES Registration Number__________

NO If No, Date you applied for registration________

Professional Degree (REQUIRED) **MD** **DMD*** **DDS** **NP++** **FNP** **DNP, NP** **DNP, FNP** **PA** **CRNA**
DO **DPM**** **OD** **CNM** **DNP, CNM** **CCP** **PhD/PsyD**
(**OD –can only apply at Mt. Vernon Hospital**)
***DMDs MUST have a license in Dentistry in Virginia. ** Podiatrists (DPMs) MUST have 24 months of foot and ankle surgery trainings.**

Please include supervising physician's name- REQUIRED for Advanced Practice Providers____________________________________

Name of Group Joining: (REQUIRED) ____

Office Address of Group Joining (Required) Street**:** ____

Suite/Dept. : ________________ City: ___________________State: _________ Zip Code: :____________

Work Phone Number :(**REQUIRED)** _________________ Work Fax Number**:(REQUIRED)** _____________________

Specialty: :(REQUIRED) _______________________ **Subspecialty: :(REQUIRED)** _________________________

Board Status(REQUIRED For Both Physicians and Advanced Practice Providers (ABMS or AOA for Physicians):
Certified **Eligible (Qualified to sit for the exam)**

If Eligible, Date of eligibility expiration:________________ **Name of Board:** ______________________________________

INOVA Hospital(s) Requested: (REQUIRED) Fairfax – If applying for Fairfax Please indicate if you need Pediatric Privileges Yes **No**

Fair Oaks Mt. Vernon Alexandria Loudoun Ambulatory (Inova Employed PCP)

Please Indicate Your Primary Facility(REQUIRED) Fairfax Fair Oaks Mt. Vernon Alexandria Loudoun Ambulatory

Telemedicine Physician? (REQUIRED) Yes No Approved By: __________________

Hospitalist Physician (REQUIRED) Yes No Approved By: __________________

eICU **Medical Surg** **Pediatric** **Psychiatry** **OB**

Intensivists? (REQUIRED) Yes No Approved By: __________________

Cardiac **Medical – Surgical** **Neonatal** **Neurology** **Pediatric**

Name of Person that Completed the Request Form (Please Print) ____ **REQUIRED)**

Phone Number (REQUIRED):_______________________ **Email Address REQUIRED):**__________________________________