



INOVA CREDENTIALING REQUEST FORM

Please return form to: MedicalStaffCredentialing@inova.org

All information below is required for an application to be sent.

Applicant's legal name:

Last: _____ **First:** _____ **Middle:** _____

Your name must be the same on all of the following: VA Medical License, Board Certifications, Malpractice Insurance, NPI, Government Photo ID, and Federal DEA

Applicant's Email: _____ **Applicant's Cell:** _____ **Date of Birth:** _____

Credentialing Contact's Name: _____

Credentialing Contact's Email: _____

National Provider Identifier (NPI): _____

Board Specialty (for delineation of privileges form): _____

Collaborative Physician (Must have privileges at the APP/AHPs requested hospitals): _____

Primary Group: _____

Anticipated Start Date: _____

Professional Degree:

- MD DMD* DDS NP FNP DNP, NP PA CRNA
- DO DPM** OD*** PHD/PSY CNM DNP, CNM CCP
- Surgical Assistant Registered Nurse First Assistant

**DMD must have license in Dentistry in Virginia*

***Podiatrists (DPM) must have 24 months of foot and ankle surgery training and be qualified through the American Board of Foot & Ankle Surgery*

****OD- Can only request Inova Mount Vernon*

Inova Hospital(s) Requesting:

Fairfax --- If applying to Fairfax, do you require pediatric privileges Yes No

Fair Oaks Alexandria Mt Vernon Loudoun

Please note: Private Surgical Assistants/RNFAs not available at IAH or IMVH

Please Indicate Your Primary Facility. Mark only one.

Fairfax Fair Oaks Alexandria Mt Vernon Loudoun

I will not see patients in the hospital and am requesting membership only and no clinical privileges.

Name of Person that Completed the Request Form (Please Print): _____

Phone Number: _____ **Email Address:** _____