INOVA CREDENTIALING REQUEST FORM

Please return form to: Medicalstaffcredentialing@inova.org

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

Applicant's name as it appears on the Virginia License:

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

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)

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

☐ 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:** _____