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| **Figure 3.18** | **Notice of Receipt of Incomplete Application** |
| [Date]  Dear [Name]:  For physicians: We have received your application to provide services at [Hospital name] as a physician in the [specialty/subspecialty/discipline of ].  For APPs: We have received your application to provide services at [Hospital name] as a practitioner in the [specialty/subspecialty/discipline of ], employed by [name of employed/supervising physician].  Our initial review of your application shows that certain necessary information is missing or clarification is required: [specify information needing clarification or missing information here].  Without this information, we cannot begin the process of verifying your credentials. The verification process normally takes [60–90] days and must be completed before your application can be forwarded to our medical staff for consideration. Difficulty in gathering or verifying the information will delay this process. At your earliest convenience, please supply the following:  [specify information needing clarification or missing information here]  Thank you for your interest in [Hospital name]. If you have any questions regarding the application process, please do not hesitate to contact us.  Sincerely,  [Name and title]  [Telephone number and email address] | |