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| **Figure 3.5** | **Initial Appointment Application Instructions** |
| Return to: [Hospital]  Medical Staff Services Department Address  City, state, ZIP  Email  Telephone number(s): or Fax number:  **General instructions**  All information requested in this application is necessary to complete the credentialing process. This infor- mation is based on the standards for physician credentialing established by [CMS/Hospital accreditor] and [Hospital]’s medical staff bylaws.  Failure to provide the specific requested information and documentation will result in delays in verification and/or approval of your credentialing file.  Prior to completing this application, please read and observe the following:  » Print legibly or type your responses.  » Modification to the wording or format of this form or the privilege forms will invalidate both.  » All questions must be answered fully and truthfully. If more space is needed, attach additional sheets.  » Make reference to the question being answered.  » “See CV or résumé” is not an acceptable answer.  » If a particular section does not apply to you, write “N/A” in that section.  » Mail or hand-deliver the completed, signed application form to the medical staff services department, along with all of the requested documentation, completed forms, and any application processing fees.  » Make a copy of the application to retain in your files and/or computer for future use and reference.  You must update the medical staff services department promptly if any information on this form changes once it has been submitted. | |