INOVA CENTRALIZED CREDENTIALING
Pre-Application / Application Request Form
Email: Medicalstaffcredentialing@inova.org

INSTRUCTIONS: **PLEASE PRINT CLEARLY - Unreadable or Incomplete forms will be returned.**

Please complete the form in its entirety as all areas are required unless otherwise indicated.

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)**

Alias (Other names known) 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 /Dental 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_____

Advanced Practice Provider Virginia RN License ? (REQUIRED) ☐ YES License Number_____ ☐ NO ☐ N/A

If No, Date you applied for license_____ **If you have an RN license in a different state than Virginia - please provide a brief explanation:** _____

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 collaborating physician's name- REQUIRED for Advanced Practice Providers_____

Please Note: The collaborating physician must have clinical privileges at the APP's requested hospital(s).

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Name of Primary Practice Group (Group Joining): (REQUIRED) _____

Name provider from your group whose delineation of privilege form you need to match(Optional):
_____
(This will assist us in sending appropriate privilege form)

Primary Practice 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:** _____**(REQUIRED)**

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

Are you requesting Affiliated Staff Status (REQUIRED) ☐ YES ☐ NO

If Yes, please indicate for which Inova Hospitals – ***Ambulatory Facility does not have Affiliated Status*** : ☐ Fairfax ☐ Fair Oaks ☐ Mt. Vernon

☐ Alexandria ☐ Loudoun

DEFINITION OF AFFILIATED STAFF STATUS:

The Affiliated Physician Staff shall consist of those Physicians who restrict their clinical activities to an office-based practice. Affiliated Staff do not have clinical privileges and cannot admit or attend to patients in the Hospital.

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):**_____