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

PLEASE PRINT CLEARLY: **Please Note: Unreadable or Incomplete forms will be returned**

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)**

Applicant's Email :____________________________________**(REQUIRED) Cell:** ___________________ **(REQUIRED)**

Credentialing Contact Email:____ **(REQUIRED)**

National Provider Identifier (NPI): ☐ YES_____________________ ☐ NO If No, Date you applied for _______________

Virginia Medical 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________

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 supervising physician's name- REQUIRED for Advanced Practice Providers____________________________________

Name of 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)

Office 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

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):**__________________________________