DEPARTMENT OF HEALTH & HUMAN SERVICES | Public Health Service
Indian Health Service
«FacilityName»

Address

VERIFICATION OF AFFILIATION

Date

«RS_Name»
«RS_Address»
«RS_City», «RS_State» «RS_Zip» Fax Number: «RS_Fax»

Re: «FormalNameWithDegree»

The practitioner listed above has applied for appointment/reappointment at «FacilityName» Indian Medical Center. Please verify the information requested below. «Hisher» consent for release of information is attached «Image:File_REL». Please return via secure email or fax to **Attn: «UserFullName», «UserFax»**. Thank you.

«UserFullName»
Medical Staff Professional

URGENT

Dates of Staff Membership: From _____ To _____ Observed? ____ Unobserved?____

Staff Category: _____Approximate number of patient contacts in the past year: _____

1. Has applicant's clinical privileges ever been denied, revoked, restricted, or granted with limitations? **YES*___ NO___**
2. Did «heshe» attempt procedures beyond his/her skills or training? **YES*___ NO___**
3. Has the applicant's medical staff membership or status at your hospital ever been revoked, not renewed, or subject to probationary conditions, or have proceedings begun that could result in any such action? **YES*___ NO___**
4. Are you aware of any malpractice litigation or claims involving the applicant? **YES*___ NO___**
5. Do you know of any current illegal use of drugs, quality of care problems, or other issues for which the applicant was disciplined or counseled while on staff at your facility? **YES*___ NO___**
6. Would you recommend «himher» for appointment to our medical staff? **YES___ NO*___**
7. Do you find this provider to be ethical and of high moral character? **YES___ NO*___**
8. Evaluation completed: *(**Provide explanation)*

_____ **Based on close observation and/or personal knowledge.**

_____ **Based on review of Credentials file.**

Comments:

_____

Signature: _____ Title: _____

Printed Name: _____Phone: _____Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is [####-####]. This information collection is to be used in verifying an applicant's credentials to meet agency policy, Centers for Medicare Conditions of Participation requirements, and accrediting body standards. The time required to complete this information collection is estimated to average less than 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required to determine an applicant's credentials to provide healthcare (IHS IHM 3-1.4 C. (3), CMS CoP §482.12(a)(6) and §482.22(c)(4) and [the nature and extent of confidentiality to be provided, if any (the Privacy Act, 5 U.S.C. § 552; the Privacy Rule promulgated under the Health Insurance