

## Quality Care Partners Membership Application Request Form

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*Please provide the following information:*

- List all hospitals at which you have held clinical privileges within the past five years in chronological order. (Please use the back of this form for additional information.)

Hospital	Address	Dates

- Please attach a copy of your certification card from your specialty board or a copy of your letter indicating your admissibility to take the board's examination.
- Please attach a copy of your current state license.
- Please attach a copy of your current Drug Enforcement Administration (DEA) certificate.
- Please attach a copy of your professional liability insurance policy showing the limits of coverage and coverage effective dates.
- Do you plan to establish or have you established an office or residence within the area serviced by Quality Care Partners?     Yes    No
- Have you or do you plan on applying for hospital privileges at Genesis HealthCare System? If yes, please specify date applied or date medical staff privileges granted with Genesis HealthCare System. \_\_\_\_\_

*I request an application form for membership with Quality Care Partners.*

Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_