ALL PRACTITIONERS
CHECKLIST FOR REAPPOINTMENT
(Required Every Two Years Following Initial Appointment)

Name of Applicant: ________________________ Date Received: __________
Department: ________________________ Specialty: __________
Place of Birth: ________________________ Date of Birth: __________
SS#: __________

	Received	Verification Completed
Application completed: To Applicant ________	________	________
Consent Statement completed: To Applicant ________	________	________
NPDB check: negative information report	________	________
OIG background check: negative information report	________	________
PA License:# Exp.__________	________	________
DEA Certificate (w/PA Address, as applicable)Exp. ________	________	________
Board Certified (as applicable) YES ___ NO ___ Board Name: ________________	________	________
Malpractice Insurance YES ___ NO ___		________
CME credits (meets licensing & Board requirements) YES ___ NO ___	________	________
Medicare Accepted (Physicians, Mid-Levels) YES ___ NO ___	________	________
Medicaid Accepted (Physicians, Dentists) YES ___ NO ___	________	________
(Social Workers, Dieticians, Hygienists do not require either medicare or medicaid)		
KHC Clinical Privileges Application: To Applicant ________	________	________
References (Competency to Perform Privileges)	________	________
Satisfactory Performance Evaluations Since Appointment/Reappointment YES ___ NO ___		________

I have reviewed the complete credentials file of the above applicant for reappointment and Clinical Privileges at Health Center. ___ I recommend OR ___ I do not recommend approval.

________________ ________________ ________________

Clinical Manager Signature **Department** **Date**