**QUAD A Current Staff Identification Form**

7500 Grand Avenue

Suite 200

Gurnee, IL 60031 ***Please list all practitioners performing any procedures in the facility***

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| **Name of Practitioner (Please Indicate Credentials – MD, DO, DDS, DMD)**    **State License # Specialty(s)**    **Certifying Board Year Certified or Year Eligible**    **Local Accredited or Licensed Acute Care Hospital Where Doctor Has Current Admitting Privileges (if applicable)**    **Department or Section**    **Has or has held unrestricted privileges in their specialty at an accredited or licensed acute care hospital within**  **30 minutes of this facility for all procedures that they perform at this facility?**   * No * Yes **List Hospital(s)** |
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