**Current Staff Identification Form**

***Please list all practitioners performing any procedures in the facility***

|  |
| --- |
| **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)** |
|  |

|  |
| --- |
| **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)** |

|  |
| --- |
| **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)** |
|  |

|  |
| --- |
| **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)** |