**Current Staff Identification Form**

***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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