PHONE: (877) 337-7111 FAX: (800) 566-1959
WEB: www.virtuox.net

Application for initial or renewal of credentialing for Physician Interpretation panel

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission and is utilized by VirtuOx for the verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration (if applicable).

Physician Name _____ (First) _____ (Last) Physician Date of Birth ____/____/____ (mm dd yyyy)

Physician Social Security _____ – _____ – _____ (Can be provided verbally)

Physician Email Address _____

NPI (National Practitioner Identifier) _____ FEIN (Tax ID) _____ – _____

Physician Office Address _____

City _____ State _____ Zip _____

Physician Home Address _____

City _____ State _____ Zip _____

Please provide the names of two of your peers and their contact information so we may contact them to obtain a letter of recommendation on your behalf. This is a requirement from the Joint Commission upon your initial credentialing and at renewal.

Peer _____ Phone _____

Peer _____ Phone _____

	Please answer all 7 questions below to complete this application	Yes	No
1	Has your license or registration to practice ever been limited, suspended, surrendered or revoked, either voluntarily or involuntarily?	☐	☐
2	Are there any previously successful or currently pending challenges or investigations to your licensure or registration?	☐	☐
3	Have you ever voluntarily or involuntarily relinquished your license or registration?	☐	☐
4	Is your license or registration currently under investigation by any state, governmental agency or medical organization?	☐	☐
5	Do you have any physical or mental health conditions including chemical dependence/addiction, that may affect your ability to safely perform the essential functions of your practice and the clinical privileges for which you have applied?	☐	☐
6	Do you have any barriers that would prevent your ability to communicate both verbally and in writing in English in an understandable manner sufficient for the safe delivery of patient care?	☐	☐
7	Are there any other issues or concerns that the medical staff should be aware of in consideration of your application for medical staff membership and/or clinical privileges? If yes, please provide details.	☐	☐

VirtuOx will also require the following documentation to complete credentialing:

- ✓ Copy of Identification / Driver's License
- ✓ Copy of Curriculum Vitae
- ✓ Copy of Specialty Certification
- ✓ Copy of State License(s)

I hereby certify that, to the best of my knowledge, the information provided is true and accurate.

Physician Signature _____ **Date** ____/____/____

Please send the completed form duly signed and dated to credentialing@virtuox.net.