DEPENDENT HEALTH PRACTITIONER APPLICATION

PLEASE SUBMIT ALL INFORMATION TO THE MEDICAL STAFF/CREDENTIALING OFFICE

Office (405) 271-3741 Fax (405) 271-3602

oumscredentialing@oumedicine.com

Practitioner Name:____

(First) (Middle) (Last) (Suffix)

Degree Type: ____________________

Date of Birth:________________ **SS#:**______________________ **NPI Number:** ____________________

Required **Required** **if applicable**

Primary Campus?:______**OU Downtown** _____**OU Edmond**

Job Title:____________________________**[Example: Scrub Tech, Ultrasound Tech, Research Coordinator, etc.]**

Sponsoring Physician:____________________________

Will you have Hospital/Clinic Patient interaction? _____ **Yes** ______ **No**

If Yes, Clinic/Hospital Location: __________________________

Office Address:________________________________**City:**________________**State:**_____**Zip:**_______

Phone:__________________**Fax:**_________________**Email:** __________________________________

Home Address:________________________________**City:**________________**State:**_____**Zip:**_______

Phone:__________________**Cell:**_________________**Email:** __________________________________

PLEASE ATTACH A CURRENT CV