OU Medicine

OU Medical Center | The Children's Hospital | OU Medical Center Edmond | Breast Health Network

REQUEST FOR APPLICATION

Practitioner Name: _____ **Male** ☐ **Female** ☐
(First) (Middle) (Last)

Cell Phone: _____ **Email Address:** _____

Degree Type: **MD** ☐ **DO** ☐ **DDS** ☐ **DMD** ☐ **DPM** ☐ **PA-C** ☐ **APRN** ☐ **CRNA** ☐ **PhD** ☐

Date of Birth: _____/_____/_____ **Social Security #:** _____ **NPI Number:** _____

Malpractice Insurance Carrier: ****Insurance must be $1mil/$3mil ****

- ☐ **APIC (OU Physicians/OUHSC)**
- ☐ **Are you contracted with or employed by OU Medicine?**
- ☐ **Other, please specify:** _____

Primary Campus (please select one of the three campus designations below):

☐ **OU Medical Center Downtown Campus** ☐ **OU Medical Center Women's & Children's Campus** ☐ **OU Medical Center Edmond Campus**

- ☐ **OUCOM/OUHSC Clinical Faculty or OUMI Employee or OUMI Contractor**
- ☐ **Member of OU Physicians or OU Physicians Affiliate**
- ☐ **Other (supported by separate signed consent by OU Physicians)**
- ☐ **If none apply:**
  - ☐ **Remote Location: Clinical Privileges at Edmond Campus and Limited Clinical Privileges at OU Medical Center and The Children's Hospital at OU Medical Center**

If Edmond Campus selected as primary – Please provide the following information:

- ☐ **Call ED Coverage (must have call agreement in place)**
- ☐ **Primary Practice Location**
- ☐ **Call Coverage for Partner / Partner's Name:** _____
- ☐ **Other (specify):** _____

Is the Provider a current Resident/Fellow: **No** ☐ **Yes** ☐

If yes: Expected completion date: _____/_____/_____ **Anticipated Hospital Start Date:** _____/_____/_____

Requested Medical Staff Category:

- ☐ **Active: Regularly & routinely practice in Hospital – Can vote**
- ☐ **Courtesy: Not actively involved in Medical Staff affairs and unable to vote or hold office**
- ☐ **Ambulatory: Refer & Follow – No privileges**
- ☐ **Advanced Practice Professional: APRN** ☐ **PA-C** ☐ **CNM** ☐ **CNS** ☐ **CRNA** ☐ **PhD** ☐ **PsyD** ☐
  - **APP Sponsoring Physician on Staff:** _____
  - **Hospital Practice Location?:** _____ **Certification:** _____
- ☐ **Locum Tenens: Intermittent or Substitute Practitioner (Complete Page 2)**
  - **Locum Company Name:** _____
  - **Oklahoma Medicaid Provider #:** _____

Specialty: _____ **Subspecialty:** _____

Credentialing Contact and/or Delegate: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____ **Email:** _____

*****PLEASE SUBMIT REQUEST FOR APPLICATION FORM, CV & DELEGATE FORM TO THE MEDICAL STAFF SUPPORT SERVICES DEPARTMENT*****

Office: (405) 271-3741 / Fax (405) 271-3602 oumscredentialing@oumedicine.com

Hospital Use only:
Completed by CC: _____ Date: _____ Time: _____

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LOCUM PROVIDERS MUST COMPLETE AND SUBMIT INFORMATION BELOW:

Name: _____

NPI #: _____

Cell: _____

E-mail: _____

Specialty: _____

Locums Company: _____

OK Medicaid Provider ID: _____

Please submit this form to:

Patricia.Bradley@oumedicine.com

Lucille.Jones@oumedicine.com

Fax: (405) 271-5006

Phone: (405) 271-8132