

Credentialing / Certifications / Licenses

Certifications:

National Certification: _____ Date: _____

Certification Number: _____ Expiration Date: _____

Provider:				
<input type="checkbox"/> BLS exp. date _____	<input type="checkbox"/> ACLS exp. date _____	<input type="checkbox"/> ATLS exp. date _____	<input type="checkbox"/> PALS ex. date _____	<input type="checkbox"/> APLS exp. date _____
Instructor:				
<input type="checkbox"/> BLS exp. date _____	<input type="checkbox"/> ACLS exp. date _____	<input type="checkbox"/> ATLS exp. date _____	<input type="checkbox"/> PALS ex. date _____	<input type="checkbox"/> APLS exp. date _____

Certifications/Licensure: (Please list all certifications or licenses ever held, both active and inactive. Use separate sheet if needed.)

State	Number	Date Issued	Date Expires	Is license current, inactive or pending?

Continuing Professional Education (please list CME courses for the past five years.)

Name of Course	CME Credit Hours	Date Completed

If the answer to ANY of these questions is "Yes", please give details on separate sheet. Each answer will be judged on its merits with respect to its effect on your professional qualifications and competence.

1. Has your professional license to practice in any jurisdiction ever been surrendered, limited, suspended or revoked? Yes No
 2. Has your request for any specific clinical privilege ever been denied or granted with stated limitations? Yes No
 3. Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed? Yes No
 4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?
 5. Have you ever been subject to or are you aware of any possible professional liability case? Yes No
 6. Have you ever been denied a professional license? Yes No
 7. Are you able to perform the essential functions of the job for which you have applied? Yes No
- * If no, are you able to perform the essential functions of the job with reasonable accommodations? Yes No

Typed or Printed Name of Provider _____

Signature _____ Date _____