BOTSFORD
HOSPITAL

# REQUEST FOR APPLICATION

**<u>PHYSICIANS</u>: The applicant's Curriculum Vitae must accompany this form**

Practitioner Name: ______________________________________________ Title: ________________

Office Name: __________________________________________________________________________

Practitioner Address: ___________________________________________________________________

___________________________________________________________________

Telephone: _______________ Fax: _______________ Specialty: ____________________________

Board Certified/Eligible: Yes ________ No: ________

AMBS: ________ AOA: ________ Other: ____________________________

Is the applicant in a current residency program? Y ___ N ___
Will the applicant be employed by Botsford Hospital? Y ___ N ___
Does the applicant hold a current State of Michigan license? Y ___ N ___
Does the applicant hold a current Controlled Substance License? Y ___ N ___ NA ___
Does the applicant hold a current DEA? Y ___ N ___ NA ___
Does the applicant have current Professional Liability Insurance? Y ___ N ___

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**<u>ALLIED HEALTH PRACTITIONERS</u>: The applicant's Curriculum Vitae must accompany this form**

Practitioner Name: ______________________________________________ Degree: ________________

Office Name: __________________________________________________________________________

Practitioner Address: ___________________________________________________________________

___________________________________________________________________

Telephone: _______________ Fax: _______________ Specialty: ____________________________

Does the applicant hold any certifications? Y _____ N _____

NCCPA ____ ANCC_____ AANA _____ Other_____

Sponsoring Physician Name: ____________________________________________________________

Who is providing Professional Liability Insurance? Hospital: ________ Physician: _______

Does the applicant hold a current State of Michigan License/Registration? Y ___ N ___
Does the applicant hold a current Specialty License? Y ___ N ___
Does the applicant hold a current DEA certificate? Y ___ N ___

**Return Request Form and CV by mail or fax (248) 471-8837**
**Maral Meyers, Credentialing Coordinator • Medical Administration • 28050 Grand River Ave • Farmington Hills, MI 48336**
**(248) 471-8820**