neighborcare health

# CREDENTIALING PROFILE

***FOR USE* WITH STUDENT/RESIDENT/SHORT-TERM LOCUMS/NON-PROVIDER VOLUNTEERS TO INCLUDE RNS**

(Short Term: less than 3 months)

Please submit to: Credentialing Coordinators
Administration Offices
905 Spruce Street, Suite 300
Seattle, WA 98104

Please read and sign:

- ☐ **Statement of Confidentiality**
- ☐ **Abuse Questionnaire**
- ☐ **Signature Card**
- ☐ **Release of Information**
- ☐ **WSP Criminal History Check**
- ☐ **Anti-Harassment Policy**
- ☐ **Drug Free Workplace**

Attach copies, as applicable:

- ☐ State Professional License(s)
- ☐ Wash. State Patrol Report
- ☐ DEA Certificate
- ☐ FTCA/Liability Insurance
- ☐ Immunization Records
- ☐ DOH Verification
- ☐ Diploma/Certificate

## I. RESIDENT/STUDENT INFORMATION

| Last Name: (include suffix; Jr., Sr., III) | First: | Middle: | Degree(s): |
|---|---|---|---|
| Is there any other name under which you have been known by reference, licensing and or educational institutions? | | | |
| Mailing Address: | | Telephone: | E-Mail Address: |

| Birth Date: | Birth Place (city, state, country): | Citizenship: | Social Security Number: | ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

## II. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS (as applicable)

| Washington State Professional License/Registration Number: | Issue Date: | Expiration Date: |
|---|---|---|
| Drug Enforcement Administration (DEA) Registration Number: | | Expiration Date: |
| ECFMG Number (applicable to foreign medical graduates): | | Date Issued: |

## III. RESIDENCY/INTERNSHIP

| Professional School & Program | Scheduled Program Completion: | | **Degree:** |
|---|---|---|---|
| Name of Practice / Affiliation or Clinic Name: Neighborcare Health | Clinic Site | | |
| NEIGHBORCARE HEALTH Preceptor/Clinical Supervisor | Length of Residency | Start datee: | End date: |

**EDUCATION AFFILIATION AGREEMENT has been verified by NEIGHBORCARE HEALTH as being compliant. Yes No**
If answer is no, Education Affiliation Agreement forwarded to school/program on:

**MEDICAL DIRECTOR'S CONSENT**

| | | |
|---|---|---|
| **Assistant/Site Medical/Dental Director* (if appropriate)** | Signature | Date |
| **Medical/Dental Director (if appropriate)** | Signature | Date |
| **Program/Site Manager** | Signature | Date |
| **Reviewed/Approved by QI Committee** | Signature | Date |

**Assistant Medical/Dental Director must sign for all Residents, Students, Volunteers , Shadowers & Locums*