

Temporary Privileges Application Checklist – SAMPLE

Name: _____

Name of Attending/Admitting Physician: _____

Date Application Received: _____

Credentialing Item	Exp. Date	Date Requested	Date Received	Verified (phone/letter)
Complete application	NA			
Current state license to practice				
DEA registration				
Current or previously successful challenge to either licensure or registration				License Y__N__ Registration Y__N__
Professional liability insurance limits				
Relevant training and experience				
NPDB report and evaluation	NA			
Current competence				
Professional references: (no fewer than three)	NA			Currently competent:
Attest to current competence				Y__N__
Attest to ability to perform the privileges requested (privileges reviewed)				Currently able: Y__N__
Attest to health status				Currently healthy: Y__N__
Active healthcare affiliation(s):	NA			Privileges in good standing
				Y__N__
				Membership in good standing
				Y__N__
Subject to involuntary termination of medical staff membership at another organization	NA			Y__N__
Subject to involuntary limitation, reduction, denial or loss of clinical privileges	NA			Y__N__
Other: (criteria required by medical staff bylaws)	NA			

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Sufficient documentation has been received that shows the applicant is licensed by [*insert name of state*] and the information available supports a favorable determination regarding his/her qualifications, ability, and judgment to exercise the privileges requested.

Effective dates of temporary privileges: From: _____ To: _____

Privileges granted: _____

Specific conditions, if any, regarding the exercise of clinical privileges:

Signature of Service/Department Chairperson

Date

Signature of Chief of Staff

Date

Signature of CEO

Date

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