PHONE: (877) 337-7111 FAX: (800) 566-1959
WEB: www.virtuox.net

Application for initial or renewal of credentialing for Physician Interpretation panel

Physician Name _____ Physician Date of Birth ____/____/____
First Last mm dd yyyy

Physician Social Security _____ – _____ – _____ (Can be provided verbally)

Physician Email Address _____

NPI (National Practitioner Identifier) _____ FEIN (Tax ID) _____ – _____

Physician Office Address _____

City _____ State _____ Zip _____

Physician Home Address _____

City _____ State _____ Zip _____

Please provide the names of two of your peers and their contact information so we may contact them to obtain a letter of recommendation on your behalf.

Peer _____ Phone _____

Peer _____ Phone _____

	Please answer all 7 questions below to complete this application	Yes	No
1	Has your license or registration to practice ever been limited, suspended, surrendered or revoked, either voluntarily or involuntarily?	☐	☐
2	Are there any previously successful or currently pending challenges or investigations to your licensure or registration?	☐	☐
3	Have you ever voluntarily or involuntarily relinquished your license or registration?	☐	☐
4	Is your license or registration currently under investigation by any state, governmental agency or medical organization?	☐	☐
5	Do you have any physical or mental health conditions including chemical dependence/addiction, that may affect your ability to safely perform the essential functions of your practice and the clinical privileges for which you have applied?	☐	☐
6	Do you have any barriers that would prevent your ability to communicate both verbally and in writing in English in an understandable manner sufficient for the safe delivery of patient care?	☐	☐
7	Are there any other issues or concerns that the medical staff should be aware of in consideration of your application for medical staff membership and/or clinical privileges? If yes, please provide details.	☐	☐

VirtuOx will also require the following documentation to complete credentialing:

- ✓ Copy of Identification / Driver's License
- ✓ Copy of Curriculum Vitae
- ✓ Copy of Sleep Certification
- ✓ Copy of State License/s

Physician Signature _____ **Date** ____/____/____

By signing above, you certify that the information provided is truthful.