Request for Consideration

Please attach your current CV/Resume

All information on this form must be provided to consider this a completed request

Date:	**Printed Name, Title:**		
Hospitals where you would like to be considered for membership and/or privileges.	☐ Brandon Regional	☐ Largo Medical Ctr.	☐ Reg. Med. Ctr. Bayonet Pt.
	☐ Blake Medical Ctr.	☐ Medical Ctr. Trinity	☐ St. Petersburg Gen.
	☐ Citrus Memorial	☐ Memorial Hospital Tampa	☐ South Bay
	☐ Doctor's Hospital	☐ Northside	☐ Tampa Community
	☐ Englewood Community	☐ Oak Hill	
	☐ Fawcett Memorial	☐ Palms of Pasadena	

Category of Staff Membership (check one) ☐Active ☐Courtesy ☐Consulting ☐Locum Tenens ☐ Telemedicine ☐ Ambulatory (Membership only) ☐APP

Credentials (check):	☐MD ☐DO ☐DPM ☐DDS ☐DMD ☐PhD/PsyD ☐CRNA ☐CNM ☐ARNP ☐PA Privilege						
Primary Specialty:		***2nd Specialty:**					
Anticipated Start Date:		**For mid-level practitioners, primary sponsor**					
Home Address:							
Home Phone:		**Cell Phone:**					
FAX:		**Email address:**					
Alternate Contact:		**Phone Number:**					
Date of Birth:		**Social Security Number**					
NPI Number		**Joining Existing Practice:**	**Yes**		**No**		
		Recruited by HCA:	**Yes**		**No**		
Name of Practice:							
Practice Address:							
Practice Phone:		**Practice Fax:**					

Yes	**No**	**Board Certified?**	**Which Board?**	**Date:**
Yes	**No**	**Board Qualified**	**Which Board?**	
Signature:			**Date:**	

Return this fully completed form, delegate form, and your CV via email or fax to:

Originating Hospital Name _____
Medical Staff Office Address _____
City, State, Zip _____
Phone: _____ **Fax:** _____
MSO e-mail address _____

HCA Credentialing Online – Provider's Authorization for Delegate

Step 1 Please provide your contact information and email below:

Provider Name: _____

Provider Phone: _____

Provider Email (required): _____

NOTE: Provider email MUST BE UNIQUE to the provider; it cannot be the same address as a delegate.

Step 2 Please select your preference for delegate:

☐ I do not want to select any delegates at this time. I will personally provide credentialing information.
_____ INITIALS

☐ I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities. The delegate listed below is my primary delegate for HCA access.

☐ The delegate listed below is my delegate for all entities.

☐ I hereby authorize: **Delegate:**

name:	
email:	
phone:	- ext.

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to HCA via the HCA Credentialing Online web portal.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ _____

PROVIDER SIGNATURE PRINTED NAME

_____ _____

SOCIAL SECURITY NUMBER or NPI DATE (MM/DD/YYYY)

Step 3

Please complete, sign and date. The form may be returned via:
1. Scanned and e-mailed to the appropriate facility contact listed on page 2.
2. Faxed to the attention of appropriate facility contact as listed on page 2.