

Holy Cross Health Maryland

Center for Practitioner Information (CPI) Application Request Form

E-mail completed form to: MedStaffOffice@Holycrosshealth.org

Red fields are required.

Practitioner's Name: First:	Middle:	Last:	Degree:
Date of Birth (Required - mm/dd/yyyy format):			
Practitioner's e-mail address (Required):			
Indicate if the provider will be employed by: ___ Employed Medical Grp ___ Hospital (not med grp) ___ Contracted Service			
Specialty for Find-A-Provider:			
Is practitioner still in residency? <input type="checkbox"/> Yes <input type="checkbox"/> No —————> Anticipated Grad Date: <i>*Applications for June graduates will be released in March.</i>			
Is the practitioner board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Maryland License #:		If not licensed, has an application been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated start date (date of admission/case):		Is this a "hot" file? (MSO use only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Application request sent to the CPI by:			
Credentialing Contact (will get unique portal login; name and email required):			
Copy To (will be notified when portal sent; email required):			
Office Information: Joining an existing practice? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of another practitioner whose office can be copied:			
Primary office name:			
Office address (include city & ZIP):			
Office phone:			
Portal/Process: <input type="checkbox"/> AHP/APP <input type="checkbox"/> Physician			
<input type="checkbox"/> Full Initial Appointment/Credentialing (with or without clinical privileges)			
<input type="checkbox"/> Add/Mid-Cycle Privileges (already on staff at the hospital). If a peer reference is required, provide name & email below			
<input type="checkbox"/> Add Facility (portal within last 6m and launch "Add Facility" portal). If a reference is required, provide name and email below.			
Professional Reference Name (for Add Privileges/Add Facility):			
Professional Reference Email:			

To which facility(ies) is the practitioner applying? *Indicate which privilege forms on page 2.*

<input type="checkbox"/> Holy Cross Hospital (MD)	<input type="checkbox"/> Holy Cross Germantown Hospital	<input type="checkbox"/> Professional Services of Holy Cross <small>CPI: Add THMGCV too, only if the provider is employed by THMG</small>
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<u>Holy Cross Hospital, Silver Spring DOP's</u>		
<input type="checkbox"/> Academic Staff	<input type="checkbox"/> Hematology Oncology	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Advance Hand Surgery	<input type="checkbox"/> Holy Cross Health Center	<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Medicine	<input type="checkbox"/> Podiatry
<input type="checkbox"/> APP – Certified Registered Nurse Anesthetist	<input type="checkbox"/> Neuromonitoring	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> APP – Nurse Midwife	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Psychology
<input type="checkbox"/> APP – Nurse Practitioner	<input type="checkbox"/> Obstetrics & Gynecology	<input type="checkbox"/> Radiation Oncology
<input type="checkbox"/> APP – Physician Assistant	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Radiology
<input type="checkbox"/> APP – Psychology	<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Surgery
<input type="checkbox"/> Critical Care Medicine	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Surgical House Officer
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Palliative Medicine	<input type="checkbox"/> Thoracic and Cardiovascular Surgery
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Pathology	<input type="checkbox"/> Urology
<u>Holy Cross Germantown Hospital DOP's</u>		
<input type="checkbox"/> Academic Staff	<input type="checkbox"/> Holy Cross Health Center	<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Advanced Hand Surgery	<input type="checkbox"/> Medicine	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Neuromonitoring	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> APP – Certified Registered Nurse Anesthetist	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Radiation
<input type="checkbox"/> APP – Nurse Midwife	<input type="checkbox"/> Obstetrics & Gynecology	<input type="checkbox"/> Radiation Oncology
<input type="checkbox"/> APP – Nurse Practitioner	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Radiology
<input type="checkbox"/> APP – Physician Assistant	<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Remote Monitoring
<input type="checkbox"/> Critical Care Medicine	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Surgery
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Surgical House Officer
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Palliative Medicine	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Pathology	<input type="checkbox"/> Thoracic and Cardiovascular Surgery
<input type="checkbox"/> Hematology Oncology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Urology