

Division of Cardiology
CREDENTIALS AND FORMS REQUEST

(Faculty, Fellows, Physicians Assistants, Nurse Practitioners, Professionals)

***** PLEASE NOTE THAT ALL REQUESTS, MAY TAKE UP TO 2 BUSINESS DAYS TO COMPLETE *****

Full Name (Faculty, Fellow, Physicians Assistant, Nurse Practitioner, Professional):

_____ (Last name, First name)

Urgent Response Required

- Academic Transcripts
- Advanced Cardiac Life Support (ACLS) Certificate
- American Nurses Credentialing Center (ANCC) Certificate (Applicable to Nurse Practitioners)
- American Nurses Credentialing Center (ANCC) Registration (Applicable to Nurse Practitioners)
- Basic Life Support (BLS) Certificate
- Board Certificate 1. _____ 2. _____
- Board Certificate 3. _____ 4. _____
- Collaborative Practice Agreement
- Continuing Medical Education (CME) Certificates
- Current Visa or Work Permit
- Curriculum Vitae/ Résumé
- DEA Registration Certificate
- DEA Registration Certificate (Outside of NY)
- Delineation of Clinical Privileges
- Delineation of Privileges - Approvals Form
- ECFMG Certificate
- Fellowship Certificate
- Government Issued Photo ID
- HIPAA Training Certificate
- Infection Control Certificate
- Internship Certificate
- Letters of References
- License Registration (Outside of NY)
- Limited Permit
- Moderate Sedation/Analgesia for Adult Patients Certificate
- NCCPA Certificate (Applicable to Physician's Assistants)
- NCCPA Registration (Applicable to Physician's Assistants)
- New York State Child Abuse Certificate
- New York State License
- New York State License Registration 1. _____ 2. _____
- New York State License Registration 3. _____ 4. _____
- New York State Practitioner Acknowledgement State
- NYPH CVC Course
- NYPH Health Protection of Human Research (GCP) Certificate
- NYPH Physician Impairment Course
- NYPH Point of Care Course
- NYPH Risk Management
- NYPH Safety Course Certification
- Occupational Health Service (OHS) Confirmation Sheet
- Professional Liability Insurance Certificate/Malpractice Face Sheet
- Professional School Diploma
- Residency Certificate
- Signed Acknowledgement Statement
- Signed Billing Compliance Form
- Statement of Duties, Responsibilities and Scope of Clinical Activities
- Verification of Practice Protocols (Applicable to Nurse Practitioners)
- Verification of Professional Degree
- Verification of Professional School Training

FOR PERSONNEL STAFF USE ONLY:

Requestor Name: _____

Date of Request: MM/DD/YYYY Date Completed: MM/DD/YYYY

Initials: _____

*** Please forward requests to Marlene Castro via e-mail at ma2066@columbia.edu or fax at 212.342.3414/x2-3414 ***

Division of Cardiology
PERSONAL INFORMATION REQUEST FORM
(Faculty, Fellows, Physicians Assistants, Nurse Practitioners, Professionals)

***** PLEASE NOTE THAT ALL REQUESTS, MAY TAKE UP TO 2 BUSINESS DAYS TO COMPLETE *****

Full Name (Faculty, Fellow, Physicians Assistant, Nurse Practitioner, Professional):

_____ **Urgent Response Required**
(Last name, First name)

Social Security Number: _____

Hire Date(s): MM/DD/YYYY (CU)/ MM/DD/YYYY (NYPH) **Termination Date** MM/DD/YYYY

Date of Birth: MM/DD/YYYY **Country and/or Place of Birth** _____

USA Citizen? Yes No **If No, Country of Citizenship:** _____

Permanent Resident? Yes No **If Yes, A#:** _____

Marital Status: Single Married Divorced Legally Separated Widowed

Marital Status Date: MM/DD/YYYY

Ethnicity: Asian-B Black-A East Indian-J Hispanic-D
 Native American-C White-E Other-K: _____

Home Address: _____ **Home Phone:** _____

City, State, Zip: _____ **Other Phone:** _____

Email: _____ **Fax:** _____

Due Date for Requested Information (for larger projects): MM/DD/YYYY

Reason for Request:

Credentialing/Billing **Appointment/Reappointment** **Outside NYPH Privileges** **Verification Request Form**

Other: (Please explain) _____

Requests for Divisional Labels:

Attendings (F/T) **Attendings (PT)** **Fellows** **Staff** **All CU Faculty/Fellows/Staff**

Reason for Request:

FOR PERSONNEL STAFF USE ONLY:

Requestor Name: _____

Date of Request: MM/DD/YYYY **Date Completed:** MM/DD/YYYY

Initials: _____

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