# Credentialing Request Form

**APP Resident ☐**

**Signed Contract Attached?** **No ☐** **Yes ☐** **NA ☐**

Locums Agency: ____________________

Locums Credentialing Contact email: ____________________

**Contract Type:** **CCC Employed ☐** **CCH Employed ☐** **SCH Employed ☐** **Carris Employed ☐** **Independent Contractor ☐** **NA ☐**

Date Need to be Credentialed By: ____________ MM/DD/YYYY
If unsure of start date, please contact Credentialing.

If APP/AHP Supervising Physician: ____________________

***Granting of hospital privileges takes 90 days from the submission of a complete request. Payer enrollment takes 90 days from the receipt of a completed application and applicable licenses.**
(Requests submitted with a less than 60-day timeframe will be reviewed by the Credentialing Department and the submitter will be contacted to discuss a more appropriate date.)

Full Name w/Professional Designation: ____________________
*First, Middle, Last, MD, DO, CNP, etc.*

Practicing Specialty: ____________________

Email: ____________________

Phone: ____________________

**Telemedicine** Privileges ☐ No ☐ Yes

If yes, check all that apply:
☐ St. Cloud ☐ Long Prairie ☐ Melrose ☐ Monticello ☐ Paynesville ☐ *Non-CentraCare* ____________________
☐ Sauk Centre ☐ Carris – Rice Memorial ☐ Carris – Redwood Falls ____________________

**Hospital** Privileges ☐ No ☐ Yes

If yes, check all that apply:
☐ St. Cloud ☐ Long Prairie ☐ Melrose ☐ Monticello ☐ Paynesville ☐ Sauk Centre
☐ Carris – Rice Memorial ☐ Carris – Redwood Falls ☐ CentraCare Surgery Center ☐ Carris Surgery Center

**Payer** Credentialing ☐ No ☐ Yes

If Yes, complete all locations needing enrollment below:
If No, please list your primary location:

Primary Practice Location: ____________________ Additional Practice Location: ____________________
Additional Practice Location: ____________________ Additional Practice Location: ____________________
Additional Practice Location: ____________________ Additional Practice Location: ____________________

Section Director/Hiring Manager: ____________________ Date Submitted: ____________

Additional Contacts for Updates: ____________________ Dept # ____________

When complete email to: CredentialingInitialTeam@centracare.com with Signed Contract and CV