Beaumont

BEAUMONT HEALTH
CREDENTIALING SERVICES
BEAUMONT SERVICE CENTER – 3D
26901 BEAUMONT BOULEVARD SOUTHFIELD, MICHIGAN 48033
(947) 522-2003
Website address: www.beaumont.org/emailapps
Email address: **BeaumontCredentialing@Beaumont.org**

INITIAL APPLICATION REQUEST FORM

Thank you for your interest in medical staff membership and/or clinical privileges at Beaumont Health hospitals. Please complete the initial application request form and return to the Central Verification Office (CVO) via email. Your application request will be reviewed by CVO personnel. An email will be sent to notify you if you are qualified to receive an application. If it is determined that you meet the applications requirements, application will be mailed to you at the mailing address you identify below.

******Please check here if you wish the application to be scanned to you via email ☐

Hospitals/Staff Status You Are Applying To (check all that apply)
(**NOTE: $250 non-refundable application fee will be charged per site**)

☐ Beaumont Hospital, Wayne ☐ Beaumont Hospital, Taylor ☐ Beaumont Hospital, Dearborn ☐ Beaumont Hospital, Trenton

☐ Active	☐ Active	☐ Active	☐ Active
☐ Courtesy	☐ Courtesy	☐ Courtesy	☐ Courtesy
☐ Consulting	☐ Consulting	☐ Consulting	☐ Consulting
☐ Ambulatory	☐ Ambulatory	☐ Ambulatory	☐ Visiting
☐ Visiting	☐ Affiliate	☐ Visiting	☐ Affiliate
☐ Affiliate		☐ Affiliate	

Last Name	First	Middle:	Degree
Primary Office Address	City		
	State	Zip	
Office Telephone Number	Email Address (must be provided)		
Office Fax Number			
Mailing Address (where application is to be sent)	City		
	State	Zip	

INITIAL APPLICATION REQUEST FORM

Reason for Applying to Beaumont Health

Joining an existing practice ____ Yes ____ No

Please Identify ____

Medical/Graduate School	Graduation Date (From/To)
Internship Specialty	Dates (From/To)
Residency Specialty	Dates (From/To)
Fellowship Specialty	Dates (From/To)
Practicing Specialty	If not Certified, status in the certification process

Are you board certified in your practicing Specialty? ____ Yes ____ No

Name of Board ____

Certification Date ____

Expiration ____

Have you had the opportunity to take the exam but chose not to?

Reason ____

Have you ever taken and failed a certification exam?

____ Yes ____ No

Please provide details ____

Do you currently have an unrestricted Michigan State Medical and Controlled License? ____ Yes ____ No

Do you currently hold an unrestricted Federal DEA? ____ Yes ____ No

Do you have professional liability insurance coverage with limits of at least $100/000/$300/000 which will cover your clinical activities at Beaumont Health? ____ Yes ____ No

Insurance Company Name: ____

Have you actively practiced in your specialty in the previous 24 months; or completed a residency/fellowship within the last 12 months? ____ Yes ____ No

Do you have an office in or do you plan to establish one in the Beaumont Health service area? ____ Yes ____ No

INITIAL APPLICATION REQUEST FORM

I request an application for appointment to the Medical Staff(s) of Beaumont Health. I understand that completing this Initial Application Request in no way obligates the healthcare system and/or medical staff(s) to afford me medical staff membership or privileges.

No application for appointment/privileges shall be provided to a physician, nor an application accepted from a proposed applicant if the applicant does not meet the minimum requirements for Medical Staff membership and/or privileges. I understand that a determination that I am eligible to receive an application does not give rise to hearing rights under the Medical Staff Bylaws.

I certify that the information provided in this Initial Application Request is true and accurate to the best of my knowledge and belief.

Date

Please Sign or Type Name

rev 3/12/10 online app request/cas
revise 2/22/11; revised 6/10/11; revised 10/12/11; revised 2/20/14; revised 4/29/16; revised 6/4/18; revised 11/19/18

Please email back, as an attachment, to Credentialing Verification Office at BeaumontCredentialing@Beaumont.org