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Phone: (505) 346-0222
Toll Free: (866) 908-0070 x2006
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www.nmhsc.com
www.lacredentials.com

WORK HISTORY VERIFICATION

Re: SSN: Year of birth:
From:

1. Evaluation based on: ☐ Observation of Applicant ☐ Review of Credentialing/Personnel File
2. Category/Position Held: (Active, Associate, Consulting, Ancillary, etc.)________________________________
If privileges held are Consulting or Courtesy, do they allow this practitioner to admit patients to your facility? No_____ Yes_____ If yes, please provide details on a separate attached sheet.
3. Specialty or Department: ____
4. Status: (Temporary, Permanent, Provisional) ____
5. Dates of Membership/Employment as Reported by Practitioner: From: ____________ *To: ____________
*In the event the To date is blank, it is assumed this date to be current.
If these dates are not correct, please provide the correct dates: From: ____________ To: ____________
6. Termination: ☐ Voluntary ☐ Involuntary If involuntary, provide details on a separate sheet.
7. Do you know of any reason why the privileges or panel membership requested by the referenced practitioner should not be granted, including any mental or physical reason, or do you have any reservations related to this practitioner's patient care, medical/clinical knowledge, use of current medical knowledge in his or her practice, interpersonal and communication skills, professionalism, or adherence to applicable bylaws, standards, policies or similar requirements? (A privilege request form may not be enclosed if this verification is being requested on behalf of a managed care organization.) No_____ Yes_____ Please provide details on a separate attached sheet.
8. Have this practitioner's clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished? No_____ Yes_____ Please provide details on a separate attached sheet.
9. Has your Executive Committee for any reason ever disciplined this practitioner? No_____ Yes_____ Please provide details on a separate attached sheet.
10. Has this practitioner been a member in good standing on your staff? No_____ Yes_____ Please provide details on a separate attached sheet.
11. Have any quality of care issues or trends been identified during this practitioner's on-going professional performance evaluation (OPPE) process? Not available_____ No_____ Yes_____ Please provide details on a separate attached sheet.
12. Please provide the following information related to this practitioner for the past 24 months:

Number of Admits to your Hospital:	______	Number of Consults Performed:	______
Number of Preocedures Performed:	______	Morbidity / Mortality Data:	______
Average Length of Stay:	______	Average Complication Rate:	______
The above information is not available:	______		

☐ Would Recomment ☐ Would Not Recommend Current Staff: ☐ Yes ☐ No

Comments: ____

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Print Name Title

Please return this information to the address above or email to: credentialing@nmhsc.com

Revised: October, 2015