

RediStaff, LLC

Locum Tenens Credentialing

Dear Physician,

Please fill out the enclosed form and return to us either by mail, fax, or email.

Below is a list of documents that we would also need to process your hospital credentialing. It would be best if you could drop by the Administrative Office so we can scan the documents, but mailing or faxing good copies would be fine.

- Driver's License
- Social Security Card or Passport
- ACLS, ALSO, PALS, other certifications
- Curriculum Vitae
- Physician Permit
- Previous Licenses or Certifications
- DEA
- DPS
- Diplomas (medical school, residency, fellowship, etc)
- Board certificate or letter of board eligibility
- ECFMG, if applicable
- Military documents, if applicable
- Previous and current malpractice insurance information
- Any malpractice claim/suit information
- Hospital appointment letters, if applicable
- Continuing Medical Education (CME) certificates
- 5 passport-sized photos

RediStaff, LLC
Mailing address: 5858 Westheimer Rd. Suite 306
Houston, TX 77057
Phone: (832) 295-0921
Fax: (713) 334-2528
Email: redistaff.houston@mdreliance.com

Should you have any questions, please feel free to contact me.
Thank you,

Amanda J. Wendenburg
Director of Staffing
RediStaff, LLC

RediStaff, LLC
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Personal Information:

Full Name: _____

Degree: _____

Maiden Name and Years Associated with Maiden Name: _____

Other Name Used and Years Associated with Other Name: _____

Home Address: _____

Home Phone #: () _____ - _____ Fax #: () _____ - _____

Mobile #: () _____ - _____ Pager #: () _____ - _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Place of Birth: _____

Citizenship: _____

If not US, Visa Number and Status: _____

Referred by: _____

Name of Spouse: _____

Have you ever been in the US Military Service? Yes or No

Dates of Service: _____

Last Location: _____

Branch of Service: _____

Active or Reserve? _____

Emergency Contact:

Emergency Contact Name: _____

Relationship: _____

Primary Phone #: () _____ - _____

Secondary Phone #: () _____ - _____

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Education Information:

Medical School: _____

Full Address: _____

Degree: _____

Attendance Dates (Month and Year): _____ / _____ to _____ / _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Internship:

Institution: _____

Specialty: _____

Program Director: _____

Full Address: _____

Attendance Dates (Month and Year): _____ / _____ to _____ / _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Residency:

Institution: _____

Specialty: _____

Program Director: _____

Full Address: _____

Attendance Dates (Month and Year): _____ / _____ to _____ / _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Fellowship:

Institution: _____

Specialty: _____

Program Director: _____

Full Address: _____

Attendance Dates (Month and Year): _____ / _____ to _____ / _____

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Phone #: () _____ - _____

Fax #: () _____ - _____

Licenses and Certificates Information:

Physician License Number: _____

Original Date of Issue: _____ / _____ / _____

Expiration Date: _____ / _____ / _____

DEA Number: _____

Original Date of Issue: _____ / _____ / _____

Expiration Date: _____ / _____ / _____

DPS Number: _____

Original Date of Issue: _____ / _____ / _____

Expiration Date: _____ / _____ / _____

ECFMG (if applicable):

Certification Number: _____

Certification Dates: _____

UPIN: _____

NPI: _____

Medicare #: _____

Medicaid #: _____

Board Certification:

Specialty 1: _____

Board: _____

Certification Number: _____

Date Initially Certified: _____ / _____ / _____

Date Expires: _____ / _____ / _____

Renewal Date: _____ / _____ / _____

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Specialty 2: _____

Board: _____

Certification Number: _____

Date Initially Certified: _____ / _____ / _____

Date Expires: _____ / _____ / _____

Renewal Date: _____ / _____ / _____

If not Board Certified, Indicate any of the following:

- I have taken exam, results pending for: _____
- I have taken part 1 and am eligible for part 2 of the: _____
- I am intending to sit for the Board on: _____
- I am not planning to take Boards.

Hospital Affiliations:

Hospital Affiliations

1. Institution: _____

Full Address: _____

Start Date: _____ / _____ / _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Type of Privileges: _____

2. Institution: _____

Full Address: _____

Start Date: _____ / _____ / _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Type of Privileges: _____

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3. Institution: _____
Full Address: _____
Start Date: _____ / _____ / _____
Phone #: () _____ - _____
Fax #: () _____ - _____
Type of Privileges: _____

Work History (since Medical School):

Current Employer: _____
Full Address: _____
Employment Dates (Month and Year): _____ / _____ to _____ / _____
Phone #: () _____ - _____ Fax #: () _____ - _____
Position: _____

Previous Employer: _____
Full Address: _____
Employment Dates (Month and Year): _____ / _____ to _____ / _____
Phone #: () _____ - _____ Fax #: () _____ - _____
Position: _____
Reason for discontinuance: _____

Employer: _____
Full Address: _____
Employment Dates (Month and Year): _____ / _____ to _____ / _____
Phone #: () _____ - _____ Fax #: () _____ - _____
Position: _____
Reason for discontinuance: _____

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Professional References:

Please list 5, and include their address, phone number, and one other mode of contact (ie: fax, email).
If you are a recent graduate, please also include your residency program director and your faculty advisor.

1. Reference Name: _____

Full Address: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Email: _____

2. Reference Name: _____

Full Address: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Email: _____

3. Reference Name: _____

Full Address: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Email: _____

4. Reference Name: _____

Full Address: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Email: _____

5. Reference Name: _____

Full Address: _____

Phone #: () _____ - _____

Fax #: () _____ - _____

Email: _____

**RediStaff, LLC
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Professional Memberships, Societies and/or Associations:

I Dr. _____ authorize RediStaff, LLC Credentialing department to verify all the information that I provided.

Signed:

Signature:

Initials: