Bridge Way Credentialing, LLC.

DEMOGRAPHIC FORM

GENERAL INFORMATION			
Degree: ☐ MD ☐ DO ☐ DPM ☐ DC ☐ DDS ☐ DMD ☐ Other			
Practitioner Name:			
DOB:	Social Security#		Gender ☐ M ☐ F
Place of Birth:	Citizenship:		Visa status:
Alien registration # and Expiration Date:			
Marital Status:	Spouse's name:		
Home address:			Home Phone:
Cell Phone:	Email Address:		
Practice Name:			
Practice Address:		Practice Phone: Fax:	
Practice TAX ID#		Business type: Sole, LLC, PSC, Corp Etc.	
Office Hours			Group NPI#
Individual NPI #	NPPES Username		NPPES Password
UPIN#	Medicaid#		Medicare #
CAQH #	CAQH User ID		CAQH Password
CLIA Cert#	BUS. LIC#		MISC CERT#
DEA# State obtained-	Issue Date-		FCVS ID#
U.S. MILITARY SERVICE ☐Yes ☐No			
Branch	**Rank**	**Dates of service:** **Discharge status:** **Date of Discharge:**	

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MEDICAL LICENSES

List all states where you hold or have held a license to practice medicine, regardless of status.

State	Type	License #	Issue Date	Exp. Date	Status

EDUCATION INFORMATION

List schools in chronological order, colleges and universities attended, whether or not complete.

Name	City/State	Month/Yr From - To	Major/Degree

POST GRADUATE TRAINING

List all internship, residency and fellowship training in chronological order

Name	City/State	MM/YR From – To	Program Type/Dept/Supervisor

INTERNATIONAL GRADUATES

Did you attend a fifth pathway program? ☐ Yes ☐ No

Did you complete clinical clerkships in a country other than where your medical school is located? ☐ Yes ☐ No

ECFMG Number		**Issue Date:**
Billing address:	Billing Contact:	Billing Phone:
Do you utilize Electronic Medical Records?	EMR Vendor name:	

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SPECIALTY BOARD CERTIFICATION		
Are you board certified? ☐Yes ☐No If not are you eligible to sit for exam? ☐Yes ☐No		
Specialty Board Name	Specialty/subspecialty	Date Certified/Recertified

MEDICAL EXAMINATION

Indicate which licensing examination you took. SBME, FLEX, USMLE, NBME, COMLEX

Examination	Part/Step	Date of Exam	State	# of Attempts

If applicable how many years to complete the USMLE exam sequence?

ADVERSE ACTIONS

Has a claim for malpractice ever been made against you, regardless of outcome?
☐Yes ☐No * Complete malpractice forms for each case*

Have any adverse actions ever been taken against you by a school, employer, hospital, medical board, etc? ☐Yes ☐No

Have you ever been arrested, charged or convicted of a violation of any local, state or federal statue? ☐Yes ☐No *If yes please provide details*

Note: Failure to report such events could result in processing delays, fines or denial of participation or license!

REFERENCES

Name: ☐Colleague ☐ Friend	Address:
Phone#	Email Address:
Name: ☐Colleague ☐ Friend	Address:
Phone#	Email Address:
Name: ☐Colleague ☐ Friend	Address:
Phone#	Email Address:

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Name: ☐Colleague ☐ Friend	Address:
Phone#	Email Address:

COVERING PHYSICIAN INFO

Name:	Address:
Title:	Phone#:
Name:	Address:
Title:	Phone#:
Name:	Address:
Title:	Phone#:
Name:	Address:
Title:	Phone#:

HOSPITAL PRIVILEGES

Name of Facility: City/State:	
Status: ☐ Active ☐ Inactive ☐ Other	To: From:

Name of Facility: City/State:	
Status: ☐ Active ☐ Inactive ☐ Other	To: From:
Name of Facility: City/State:	
Status: ☐ Active ☐ Inactive ☐ Other	To: From:

Name of Facility: City/State:	
Status: ☐ Active ☐ Inactive ☐ Other	To: From:

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CONFIDENTIAL