Hospital Privileges and Malpractice Attestation

EmblemHealth®

Please complete this form and return via fax to **212-510-5268** or via email to **credrecredprocess@emblemhealth.com**

Hospital Affiliation

Specialty:
License:
Primary Hospital:
All Current Hospital Affiliations:

Is the status of your hospital privileges Active or Admitting?	☐ Yes	☐ No ☐ Other
Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced, or nonrenewed?	☐ Yes	☐ No
Have you ever voluntarily relinquished or voluntarily limited any hospital privileges?	☐ Yes	☐ No
Have any disciplinary proceedings ever been instituted against you or any disciplinary actions now pending in respect to your hospital privileges or licenses?	☐ Yes	☐ No
If any of the above questions are answered "yes", please explain.		
I attest that the information as corrected above is complete and correct to the best of my knowledge and understand that the falsification of this information is grounds for revocation of approval.		

Print Name:	
Signature:	Date:

Malpractice Coverage

Insurer:	
Policy Number:	Start Date:
Coverage Amounts:	End Date:
I certify that the information as corrected above is complete and correct to the best of my knowledge and understand that the falsification of this information is grounds for revocation of approval. I agree to maintain the types and amounts of malpractice insurance required by EmblemHealth.	

Print Name:	
Signature:	Date:

RESET PRINT SUBMIT