



Community Health Services

Credentialing Checklist

Provider Name: _____ Date: _____

- ___ **Ohio License** (verified from website)
- ___ **Board Certification** (if applicable)
- ___ **DEA Certificate** (verified from website)
- ___ **Copy of Degree/s**
- ___ **Curriculum Vitae**
- ___ **CHS Application with Information Release form**
- ___ **Criminal background check** (Corporate Intelligence)
- ___ **National Practitioner Data Bank Query Report** (ordered by Human Resources)
- ___ **American Medical Association Report** (ordered and verified by website)
- ___ **Privileging Form**
- ___ **Photo ID/Driver's License** (Copy made by Human Resources)
- ___ **Malpractice Insurance** (Locum Providers only)
- ___ **1 reference letter from hospital of most recent affiliation** (Program Director)
- ___ **2 other reference letters**
- ___ **Documentation of physical examination**

Credentialing checklist completed by: _____