



DENTAL CREDENTIALS VERIFICATION

INSTRUCTIONS: This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

PRACTITIONER/PRACTICE INFORMATION					
NAME (LAST)		(FIRST)		(MIDDLE)	
SOCIAL SECURITY NO. (SSN)		PERSONAL NPI NUMBER		PRACTICE NPI NUMBER	
TAXPAYER IDENTIFICATION NUMBER USED: <input type="checkbox"/> SSN or <input type="checkbox"/> EIN (EMPLOYER IDENTIFICATION NUMBER)		List # _____		DOES YOUR OFFICE COMPLY WITH OSHA/CDC STANDARDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PRACTICE NAME					
PRIMARY OFFICE STREET ADDRESS			CITY		STATE
TELEPHONE NUMBER		OFFICE FAX NUMBER		EMAIL	
DENTAL LICENSURE			BOARD CERTIFICATION		
STATE OF _____		LICENSE NUMBER / EXP. DATE		SPECIALTY	DATE CERTIFIED/RE-CERTIFIED
OTHER CERTIFICATIONS (ATTACH CERTIFICATE IF APPLICABLE) Examples Include: ACLS, BLS, ATLS, PALS, NRP, E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.					
TYPE(S):		NUMBER(S):		EXP. DATE(S):	
CURRENT HOSPITAL & OTHER INSTITUTIONAL AFFILIATIONS					
FACILITY NAME:			ACTIVE <input type="checkbox"/> COURTESY <input type="checkbox"/>		STAFF PRIVILEGES YES <input type="checkbox"/> NO <input type="checkbox"/>
PROFESSIONAL LIABILITY					
NAME OF CARRIER			POLICY NUMBER		
ODS requires a one million minimum per claim and a three million minimum aggregate amount LIST YOUR LIMIT PER CLAIM / AGGREGATE AMT:				EFFECTIVE DATE	EXPIRATION DATE
PROFESSIONAL STATUS					
If you answer "yes" to any of the following questions, please give full details on a separate sheet of paper.					
1. Have you had any malpractice claims or suits filed against you?				YES	NO
If yes, did any of these result in a settlement?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____					
2. To your knowledge, are you the subject of an investigation or disciplinary action by any licensing board or hospital as of the date of this application?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____					
3. Have you had any professional liability denied, canceled or not renewed?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____					
4. Have you had any certificate/license by any Board or agency revoked, suspended, voluntarily surrendered, limited or otherwise sanctioned?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____					
5. Have you been denied a DEA registration number or been issued a restricted DEA registration?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____					

I acknowledge that information relating to this application may be investigated and verified by ODS and/or its Representatives and agree that all information contained herein is true and complete, including my NPI which is a component of the credentialing/recredentialing process.

SIGNATURE _____

DATE _____

ODS REVIEW: _____

REVIEW DATE: _____