



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) _____		<input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Date of birth _____
Social Security no. (SSN) _____	Personal NPI no. _____	Practice NPI no. _____	
Taxpayer identification no. used: <input type="checkbox"/> SSN or <input type="checkbox"/> EIN (Employer identification no.) List no.: _____		Does your office comply with OSHA/CDC standards? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Practice name _____			
Primary office street address _____		City _____	State _____ ZIP _____
Telephone no. _____	Office fax no. _____	E-mail address _____	
Dental licensure		Board certification	
State of _____	License no. and expiration 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): _____	Expiration date(s): _____	
Current hospital and other institutional affiliations			
Facility name: _____	<input type="checkbox"/> Active <input type="checkbox"/> Courtesy	Staff privileges <input type="checkbox"/> Yes <input type="checkbox"/> No	
Professional liability			
Name of carrier _____		Policy no. _____	
ODS requires a one million minimum per claim and a three million minimum aggregate amount. List your claim/aggregate amount: _____		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? If yes, did any of these result in a settlement? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
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? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Have you had any professional liability insurance denied, canceled or not renewed? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Have you had any certificate/license by any board or agency revoked, suspended, voluntarily surrendered, limited or otherwise sanctioned? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Have you been denied a DEA registration number or been issued a restricted DEA registration? If yes, please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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 _____

