Form #3

State of Nevada - Board of Osteopathic Medicine
Hospital Privileges Verification

(Copy this form for multiple Hospitals)

Applicant Instructions: Complete Section 1 and Section 2 of this form then send this form to **each and every Hospital you currently hold Medical Staff Privileges**.

Section 1: Applicant Information

Last Name:_____ First Name:_____ Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number:_____ Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize this hospital or medical center listed below to provide any and all information pertaining to my medical staff privileges at your institution to the State of Nevada - Board of Osteopathic Medicine.

_____ _____

Applicant's Signature Date

Section 2: INSTRUCTIONS TO THE CHIEF OF MEDICAL STAFF OR DESIGNATED OFFICIAL OF THE MEDICAL STAFF

Please complete Section 3 of this form and attach a LETTER OF GOOD STANDING FROM THE CHIEF OF STAFF OR OFFICIAL and forward this information directly to this Board to the following address:

Board Name:_____

Address_____

City_____ State_____ Zip Code_____

Section 3: HOSPITAL VERIFICATION

Institution Name:_____

Institution Address: _____

Street City State Zip Code

Affiliated Medical School Name:_____

Type of Privileges/Specialty:_____

From Date: ____/_____/_____ To Date: ____/_____/_____

Current Status of Medical Privileges: _____

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Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her staff privileges?	☐Yes	☐No
Were this individual's privileges ever suspended for reasons other than failure to complete medical records?	☐Yes	☐No
Was this individual ever disciplined or placed under investigation?	☐Yes	☐No
Were any negative reports ever filed by colleagues, allied health professionals or patients?	☐Yes	☐No
Were any limitations or special requirements placed upon this individual because of questions of medical incompetence, disciplinary problems or any other reason?	☐Yes	☐No

Please explain any "Yes" response from above (attach additional pages if necessary):_____

_____

_____

_____

_____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name:_____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized)

Title:_____

Date:_____

Phone number:_____ Fax:_____

E-mail: _____

Return to:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147
702-732-2079 (fax)
Toll Free: (877) 325-7828