Children's Wisconsin

Kids deserve the best.

I am requesting an application for: (Check all that apply)

☐ CW- Milwaukee ☐ CW-Surgicenter (Milwaukee) ☐ CW - Fox Valley (Neenah)

Name: Last _____First _____MI _____

Applicant's Email Address: _____ Cell number _____

License type _____(MD, DO, APNP, PA etc.) NPI #_____

Specialty Acupuncture

What is the anticipated start date at Children's Wisconsin? _____

Who will be your employer at the time privileges/membership is granted?

_____

Employer's Address _____

City _____ State _____ Zip code_____

Office Phone_____ Office Fax _____

Credentialing Contact: _____

Credentialing Contact's E-mail: _____

Physicians, Dentists & Podiatrists

Did you complete Residency training? YES ☐ NO ☐ Program Name _____

Facility Name _____ Date Completed _____

Did you complete Fellowship training? YES ☐ NO ☐ Program Name _____

Facility Name _____ Date Completed _____

Are you Board Certified? YES ☐ NO ☐ Date Certified _____

Are you Board Eligible? YES ☐ NO ☐ Board Specialty _____

When do you plan to sit for the board?_____

If no, please explain _____.

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Other Providers – Professional Healthcare Providers (PA, APNP, DA, etc.)

Are you certified? YES ☐ NO ☐ Date _____ Specialty _____

Who is your Sponsoring / Collaborating Physician Member and Department?

_____

Please return this form, your current CV, and a form of identification (ID, passport, DL) to Medical Staff Services by email: medstaff@childrenswi.org.

Save this form 'with changes' and attach all required documents.

Date: _____