



Harmony Health Clinic

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www.HarmonyClinicAR.org

Facsimile Cover Sheet

Sending To	Sending From
Attention: Volunteer Coordinator	From:
Fax: (501) 375-4401	Date:
Phone: (501) 375-4400 EXT: n/a	Phone: () EXT:
Comment:	Fax: ()
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Notes:

Harmony Health Clinic
CREDENTIALING FORM



NAME:
DEGREES:
CURRENT AFFILIATION (HOSPITALS WHERE YOU HAVE ACTIVE PRIVILEGES):

SEX:
DATE OF BIRTH:
ADDRESS (OFFICE):

ADDRESS (HOME):

TELEPHONE: OFFICE: HOME: CELL:
FAX:
E-MAIL:

MEDICAL SCHOOL:

DATE OF GRADUATION:

INTERNSHIP:

RESIDENCY:

FELLOWSHIP:

ARKANSAS LICENSE NUMBER:

DATE OF EXPIRY:

DEA NUMBER:

NATIONAL PROVIDER NUMBER:

MALPRACTICE INSURANCE PROVIDER AND POLICY NUMBER:

PROFESSIONAL REFERENCES: 1. _____

2. _____



Harmony Health Clinic

Authorization and Release Form

I hereby authorize the Harmony Health Clinic Credentialing Committee to contact the following agencies for records, recommendations, and other inquiry regarding my eligibility to volunteer at Harmony Health Clinic: (Please check all that apply)

- Arkansas State Medical Board
- Arkansas State Board of Nursing
- Arkansas State Board of Pharmacy
- Arkansas State Board of Dental Examiners
- Arkansas Social Work Licensing Board
- Current employer (Contact Person): _____
(Address/email: _____)

- Previous employer(s):
(Please list: name of hospital/company, employment dates, contact person, address/email)
- _____
- _____
- _____
- _____
- _____

I release from liability all representatives of Harmony Clinic for acts performed to verify my eligibility and credentials to volunteer and all individuals and/or organizations who provide information concerning my qualifications.

Signature of volunteer

Date