**Name: Date: Due:**

**Credentialing Application Checklist**

**I. Preliminary application requirements (prior to functioning** within role in Emory entities)

\_\_\_\_ Recent photo ID

\_\_\_\_ Evidence of malpractice insurance

\_\_\_\_ Professional license/certification (if applicable for role)

\_\_\_\_ Immunization records

\_\_ \_ Seasonal flu vaccines (mandatory Oct-March)

\_\_\_\_ Signed confidentiality and non-disclosure statement\*

\_\_\_ Declaration of MD sponsor and selected sites

II. Application requirements (2 months duration - applicant functions within role with supervision)

\_\_\_\_ Application\*

\_\_\_\_ Job description \*

\_\_\_\_ Competency Review for Clinical Authorizations \*

\_\_\_\_ Letters of professional reference \* (on file)

\_\_\_\_ Current resume or curriculum vitae

\_\_\_\_ Attestation of Annual Regulatory Requirements\*

\_\_\_\_ Summary of continuing professional education.

Optional (if required for role)

\_\_\_\_ Current CPR (not required for minimal contact)

\_\_\_\_ Research informed consent\*

\_\_\_\_ OR requirements

**III. Completed Application (**applicant may **function independently in their role**)

**(**The Nursing Office of Credentialing will process application and issue a confirmation letter and authorization list. At this point, the applicant may function independently in their role)

Please return to the Nursing Credentialing Office F-213, Emory University Hospital, Box 45, 1364 Clifton Road, NE, Atlanta, GA 30322. To expedite, you may e-mail or fax first, then send all originals by mail. Confidential Fax (404) 712-4976. [myra.kitchin@emoryhealthcare.org](mailto:myra.kitchin@emoryhealthcare.org)

**For questions or assistance, please call Myra Kitchin at (404)-712-0510.**

**Credentialing Application Checklist Explanations**

**I. Preliminary application requirements (prior to functioning** within role in Emory entities)

\_\_\_\_ **Recent photo ID**=federally or state issued photo identification such as a passport or driver’s

license. Please call to schedule a time to provide a copy of this document in person for a photo

identification verification. Applicant may also supply Social Security number and official signature.

\_\_\_\_ **Evidence of malpractice insurance –** Provide copy of policy with your name listed.

Emory University paid employees/Emory Healthcare paid employees receive Clifton

malpractice insurance automatically. Please submit either an offer/invitation letter on EU

letterhead or an EU/EHC pay stub. (Check Clifton malpractice box on application page 3)

\_\_\_\_ **Professional license/certification** (if applicable for role)- submit web verification or

copy of license/certificate with identity number and expiration

\_\_\_\_ Immunization records - submit documentation to Credentialing Office for varicella

MMR, and TST (see attachment). If additional immunizations are needed you will be

instructed to contact the Emory Employee Health Representative. Emory University

verifications are accepted. Hepatitis B series must be initiated if required for role.

\_\_\_\_ Seasonal flu vaccines (October-March mandatory)- submit verification from

clinic, MD office, or pharmacy. Within Emory, submit confirmation e-mail.

\_\_\_\_Signed confidentiality and non-disclosure statement –see HIPAA attachment.

read, sign, and submit originals

\_\_\_\_ Declaration of MD sponsor and selected sites (sponsoring MD must have

active clinical privileges or clinical access at sites requested) provide with

initial contact information and confirm on application form.

II. Application requirements (2 months duration - applicant functions within role with supervision)

\_\_\_\_ **Application** – submit 5 page application form. Please complete all areas- particularly site selection,

sponsor declaration, designate supervisor (optional, but helpful in obtaining form signatures); all liability

questions (yes or no, NA not acceptable); mark Clifton if Emory University or Emory Healthcare employee;

sponsoring MD signs page 3; applicant signs page 5. Submit originals

\_\_\_\_ **Job description** – form not provided. A brief, HR type job description of basic role is

needed. Sponsor or designated supervisor and applicant must date and sign. Submit originals.

\_\_\_\_ Competency Review for Clinical Authorizations **–** list basic functions needed for

role. Sponsor or designated supervisor grades each skill, dates/signs form.

In addition to the sponsor/supervisor’s attestation of competency via grading, a validation of

skills to attest / demonstrate competencies may be required under the department's

instruction/supervision using Emory Healthcare standards. Credentialing office will provide

instruction for department. The department may require additional competency verifications.

Obtain signatures (sponsor or supervisor designated on application, applicant) Submit originals.

Submit any previous skill training documentation to support competency.

For some skills such as phlebotomy and EKG, the application must be completed before

skill can be authorized. Training information and competency verification form will be

provided for departmental training. Authorizations will be modified to include new skills.

\_\_\_\_ **Letters of professional reference** - Three written professional references (1 doctoral

level MD/PhD, 2 peer) are provided to document satisfactory critical thinking, technical

and interpersonal relationship skills. The designated sponsor or supervisor may not act as

a reference. Preferably, the references are of the same clinical designation as applicant,

have known the applicant for at least one year, and may be but are not required to be

affiliated with Emory. Applicant should not return the reference. Reference submits original

OR EU applicants may request reference attestation page-Shelly Lewis [sclewis@emory.edu](mailto:sclewis@emory.edu)

**\_\_\_\_** Current resume or curriculum vitae

\_\_\_\_ Attestation of Annual Regulatory Requirements - Open hyperlink provided in the

attached “Attestation of Annual Regulatory Requirements”. Read courses in PDF format for self

study. Initial each regulatory after completion. Sign and submit the attestation. There are no

on-line tests to submit. Complete age appropriate (adult or pediatric) as applicable.

\_\_\_\_Summary of continuing professional education. (as appropriate to role)

Optional (if required for role)

\_\_\_\_ Current CPR CPR class within the last 24 months. American Heart Association is required

(Heart Saver AED or higher) (RN/LPNs require BLS)

Required for full contact (collecting specimens, vital signs, ht/wt, phlebotomy, etc)

Not required for minimal contact (nothing more than handshake - obtaining informed consent, specimen

processing/shipping, questionnaires, etc.)

\_\_\_\_ Research informed consent- MD sponsor signs. Study IRB numbers must

be listed or attached. CITI training required- please submit verification.

\_\_\_\_ OR requirements Detailed history of experience with the surgical patient. (if applicable)

(may include school experiences) Successful completion of basic peri-operative orientation

provided by the OR educator or documentation of equivalent training (if applicable

\_\_\_\_Alternate supervising physician form – if additional supervising MDs are needed in OR

*Please feel free to contact the Credentialing Office with any questions or concerns. Thank you for your conscientiousness with credentialing.*