Application request form for physicians and APPs

All applicants must meet the minimum qualifications to apply.

Date: _____

Select all categories that apply

☐ HonorHealth employee or PSA	☐ Affiliate status – No hospital privileges requested	☐ ICP member	☐ Community physician or APP

HonorHealth medical center and facility privileges (Select all that apply)

☐ HonorHealth Deer Valley Medical Center	☐ HonorHealth John C. Lincoln Medical Center - Complete Care – Surprise (Prasada)
☐ HonorHealth Four Peaks Medical Center - HonorHealth Florence Medical Center - Mesa Emergency Department	☐ HonorHealth Scottsdale Osborn Medical Center - HonorHealth Greenbaum Specialty Surgical Hospital
☐ HonorHealth Scottsdale Shea Medical Center - HonorHealth Piper Surgery Center - Complete Care – Paradise Valley	☐ HonorHealth Sonoran Crossing Medical Center - Complete Care – Lake Pleasant
☐ HonorHealth Tempe Medical Center	☐ HonorHealth Scottsdale Thompson Peak Medical Center

Primary medical center (Select one)

◯ HonorHealth Deer Valley Medical Center	◯ HonorHealth Four Peaks Medical Center	◯ HonorHealth John C. Lincoln Medical Center
◯ HonorHealth Scottsdale Osborn Medical Center	◯ HonorHealth Scottsdale Shea Medical Center	◯ HonorHealth Sonoran Crossing Medical Center
◯ HonorHealth Tempe Medical Center	◯ HonorHealth Scottsdale Thompson Peak Medical Center	

Applicant information

Applicant's full name: _____
(Name as listed on board certificate, DEA, medical license, etc.)

National Provider Identifier (NPI): _____

Title (MD, DO, NP, etc): _____ **Specialty:** _____

Personal email: _____ **Phone:** _____

Date of birth: _____/_____/_____ **Social Security Number:** _____ - _____ - _____

Gender: ☐ Male ☐ Female

Certifying board name: _____ **Certificate number:** _____

Practice information

Office/group name: _____ **Phone:** _____

Designated contact: _____ **Email:** _____
Note: The applicant and designated contact are the only individuals authorized to receive communications regarding this application.

Covering physician(s): _____
(N/A for Allied Health or Affiliate. Covering physician must be the same specialty and have the same active privileges at all HonorHealth facilities being requested)

Sponsoring physician(s) (For APP/Allied Health applicants only): _____

Required documents

Email the completed form and the following required documents to HonorHealthCVO@HonorHealth.com:

☐	Application Request Form (ARF)
☐	Board certificate Board eligibility notice and/or board exam confirmation are also accepted.
☐	Curriculum Vitae (CV) in PDF format Format CV by month/year and include education, training, employment, affiliations and gaps from medical or professional school to present. Nurses must include everything from completion of school to present.
☐	Professional photo in JPG format Professional, full-color headshot (from shoulders up) with light gray or white background. Photo will be used for ID badge and online profile.

Next steps

After receiving the completed application request form and required documents, an online application link will be emailed to the applicant and designated credentialing contact within 24 hours.

Please note that the online application link is valid for 30 days and will be automatically withdrawn if not submitted within that timeframe.

Thank you for your interest in HonorHealth. We look forward to working with you.