



Application request form for physicians and APPs

All applicants must meet the minimum qualifications to apply.

Date: _____

Select all categories that apply

<input type="checkbox"/> HonorHealth employee or PSA	<input type="checkbox"/> Affiliate status – No hospital privileges requested	<input type="checkbox"/> ICP member	<input type="checkbox"/> Community physician or APP
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HonorHealth medical center and facility privileges (Select all that apply)

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

Primary medical center (Select one)

<input type="checkbox"/> HonorHealth Deer Valley Medical Center	<input type="checkbox"/> HonorHealth Four Peaks Medical Center	<input type="checkbox"/> HonorHealth John C. Lincoln Medical Center
<input type="checkbox"/> HonorHealth Scottsdale Osborn Medical Center	<input type="checkbox"/> HonorHealth Scottsdale Shea Medical Center	<input type="checkbox"/> HonorHealth Sonoran Crossing Medical Center
<input type="checkbox"/> HonorHealth Tempe Medical Center	<input type="checkbox"/> 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:

<input type="checkbox"/>	Application Request Form (ARF)
<input type="checkbox"/>	Board certificate Board eligibility notice and/or board exam confirmation are also accepted.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.

Application fee and dues notice

HonorHealth requires two non-refundable fees as part of the application process. Fees must be paid by credit card using the secure payment link emailed to you after completing your application:

- **Initial application fee:** \$250 per facility
- **Biennial dues:** \$400 per facility

Important: Your application will not be reviewed until both the initial application fee and biennial dues have been paid in full.

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.