

Washington Standardized Delegated Practitioner Profile

All practitioner data elements are required, (as applicable), however the format is optional, i.e. this form or a spreadsheet.

Delegated Group Name _____

Practitioner Name & Title _____
Last Name First Name MI Title

Social Security Number _____ DOB _____ Male Female

Languages Spoken _____ Effective Date with Group _____

Medical School/Training Program _____ Completion Date _____

Residency Program _____ Completion Date _____

List Specialty(s)

1) _____
Specialty Board Certification Date Board Eligibility Date

2) _____
Sub-Specialty Board Certification Date Board Eligibility Date

Specialist PCP Provides OB services? Yes No Accepting New Patients? Open Established Closed

Gender Restrictions? No Yes Specify: _____ Age Restrictions? No Yes Specify: _____

Advertise in Directory? Yes No Advertise for Women's HealthCare? Yes No

State License Number _____ State _____ Expiration Date _____

State License Number _____ State _____ Expiration Date _____

DEA Certification Number _____ Expiration Date _____

Medicare Number _____ Medicaid Number _____ UPIN Number _____

Primary Clinic Name _____

Primary Physical Address _____ Ste _____ City _____ State _____

Zip _____ County _____ Tax ID _____ Office Hours _____

Day Phone _____ Fax _____ After Hours Phone _____

Services Available _____
(i.e. wheelchair accessible/interpretive services, etc.)

Mailing Address _____ Ste _____

City _____ State _____ Zip _____ County _____

Payment Address for this clinic _____ Ste _____

City _____ State _____ Zip _____ County _____

Secondary Clinic Name _____

Secondary Physical Address _____ Ste _____ City _____ State _____

Zip _____ County _____ Tax ID _____ Office Hours _____

Day Phone _____ Fax _____ After Hours Phone _____

Services Available _____
(i.e. wheelchair accessible/interpretive services, etc.)

List hospital affiliations and privileges granted to practitioner

_____ Active Temporary Provisional Inpatient Coverage Argmt N/A

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Date Approved by Peer Review/Credentialing Committee _____

Form Completed By _____ Date _____

(For additional practice locations, attach a separate page)