STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

CREDENTIALS VERIFICATION DISCLOSURE FORM

The purpose of this questionnaire is to verify that an applicant's credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank and other associations before an authorized approval and hiring determination is made.

All licensed independent practitioner applicants who are applying for the positions listed below, or the equivalent of those positions, must complete this form prior to the hiring interview. **Fax the form, along with your CURRENT Curriculum Vitae, to the California Department of Corrections and Rehabilitation (CDCR) Credential Coordinator at (916) 322-3208.** If you have any questions, the agent may be reached at (916) 327-3336.

PLEASE PRINT LEGIBLY AND PROVIDE ALL REQUESTED INFORMATION.
THIS WILL PREVENT UNNECESSARY DELAYS.

Position applying for: ☐ Physician & Surgeon ☐ Chief Medical Officer ☐ Nurse Practitioner
☐ Chief Physician & Surgeon ☐ Chief Deputy, Clinical Services ☐ Physician Assistant

Name: Last: _____ First: _____ Middle: _____

Other Names Used: _____ Gender: ☐ Female ☐ Male

Full Social Security Number: _____ Date of Birth: _____

Home Address: _____
Street Address City State Zip Code

Contact Information: _____
e-mail address phone numbers

Professional school(s) (nursing or medical degrees):

_____
Name Degree Year Graduated

_____
Name Degree Year Graduated

Professional license(s)/certifications/registrations (medical, nurse practitioner, physician assistant):

License number: _____ State: _____ License number: _____ State: _____

License number: _____ State: _____ License number: _____ State: _____

Name of Specialty Residency _____

Board eligible: ☐ Yes ☐ No If Yes, name of Board: _____

Board certified: ☐ Yes ☐ No If Yes, Board: _____

Most recent year certified/recertified: _____

DEA Number: _____ Expiration Date: _____

RELEASE OF INFORMATION

I hereby authorize the CDCR, its medical staff and their representatives to query the appropriate licensing board, National Practitioner Data Bank and other medical associations, and to consult with administrators and members of medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, ethics and other qualifications.

I hereby release from liability all individuals and organizations that provide said information to the hospital, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is not a commitment to hire, just a request to obtain additional information. Please Note: This authorization shall expire upon separation from the Department or within six months of the below date in the event that no employment is offered and accepted.

_____ _____
Signature of Applicant Date