JACKSON HEALTH SYSTEM
CREDENTIALS UPDATE FORM

***** Once completed Fax to: 305-355-1530 or E-mail CorporateCredentialing@jhsmiami.org *****

PROVIDER DATA	
FIELD	**Corrections / Updates**
Name (Please list t as on ME Licence	
System ID Number JHS	
Degree	
Specialty / Service	
Physician Sponsor(s) *if applicable*	
Medical License Number	
PERSONAL DATA	
FIELD	**Corrections / Updates**
Birth Date	
NPI Number	
Home Address	
Home Telephone	
Cell Phone	
Home E-mail Address	
PROFESSIONAL DATA	
FIELD	**Corrections / Updates**
Office Address 1	
Office Phone/Answering Service Number	
Office Fax Number	
Pager	
Primary E-mail Address (*used for direct communications*)	
Federal DEA Number *(if applicable)*	
DEA Expiration Date	
Malpractice Insurance Policy# / Carrier Address / Telephone# / Fax#	

Failure to maintain a current credentials file may result in an automatic administrative suspension from the JHS Medical/AHP Staff (JHS Bylaws).

I fully understand that any misrepresentations or misstatements in or omissions from this form, whether intentional or not, constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted above by me in this update form, is accurate, complete and true to my best knowledge and belief. I have reviewed my submission above and request that the changes be updated in my credentials file.

Signature of Practitioner _____ Printed Name _____ Date _____

Signature of Sponsor _____ Printed Name _____ Date _____