APPLICATION FOR MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

Dear Applicant:

Thank you for your interest in medical staff membership and clinical privileges at Jackson Health System which includes Jackson Memorial Hospital, Jackson North Medical Center, Jackson South Medical Center, Jackson West Medical Center, Holtz Children's and Women's Hospital, Jackson Behavioral Health Hospital, Jackson Rehabilitation Hospital, and our affiliated community health services.

The Corporate Credentialing Department is the centralized office that handles application requests and the processing for all of the Jackson Health System facilities. We look forward to working with you and answering any questions you may have in order to facilitate a smooth process.

To begin the credentialing process:

1. Complete the enclosed initial application request form.
2. Non-refundable application fee: **$500 MD/$300 AHP**

Application and membership fees are due upon receipt of the application. Failure to submit ***required fees*** within 10 business days will result in the application being considered incomplete and/or a voluntary withdraw or resignation as appropriate. Please note applications will not be processed without full payment of ***all required fees.***

Fee Assessment Schedule		
	Medical Staff	**AHPs**
Application Fee	**$500.00**	**$300.00**
Service Fee (if check bounces)	**$ 50.00**	**$ 50.00**

Preferred/faster method:

Bank ACH and Wire Information
Wells Fargo Bank, NA
420 Montgomery Street
San Francisco, CA 94104
(888) 384-8400
Account Information
Account Name: Public Health Trust of Miami-Dade County, Florida
Account TIN: 59-1713947
Account Number: 4947420592
Account Type: Checking
Account Address: 1500 NW 12th Ave Ste 1002 Miami, FL 33136
Routing/Transit Number for ACH/Wires: 121000248

(OR) ***Check made payable to:*** Jackson Memorial Hospital
Cost Center: 695.09
Account #: **460180 Revenue-Med Staff Applications & Renewals**

Mail check to:
Jackson Memorial Hospital
1500 NW 12th Avenue
Jackson Medical Towers, West Building, Suite 1451
Miami, FL 33136

Upon receipt of the initial request form and payment, you will receive an email with instructions on how to apply online.

Jackson HEALTH SYSTEM
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Request for Initial Credentialing Application

Please provide us with the information indicated below:

Applicant's First Name:	Middle Name:	Last Name:

Degree (MD, DO, ARNP, CNM, CRNA, etc.):

Hired by: (*You must indicate who is hiring you. Please check one that applies*)

- ☐ Jackson Employee
- ☐ JMG
- ☐ UMMG
- ☐ FIU
- ☐ Leon Medical Center
- ☐ JHS HOSPITALIST
- ☐ STAT Hospitalist
- ☐ Maxim
- ☐ Sheridan
- ☐ CHI
- ☐ Schumacher Group
- ☐ Appexx Radiology
- ☐ VRAD
- ☐ Independent Provider
- ☐ Other: __________________

(Jackson employee) Name of Recruiter & email address:____

The following information is required (Do not leave blank):

Department:____**Division:**_________________________________

Supervisor's Name (Who is your direct report):______________________________

***You must indicate your primary facility*. (*Where you will operate regularly*)**

☐ ***JMH*** ☐ ***North*** ☐ ***South*** ☐ ***West*** ☐ ***OTHER:***___________________________________

Select Facility Designation – indicate the order where you would be primary, secondary etc, enter the name in each square. Example if Jackson north is primary enter North in box 1 & so on..

Primary 1:	*Secondary 2:*	*Tertiary 3:*	*Quaternary 4:*

☐ Urgent Care Center: ○ Country Walk ○ Arch Creek ○ South Beach ○ Clock Tower/Cutler Bay

- ☐ Corrections Miami
- ☐ Penalver Clinic
- ☐ North Dade
- ☐ PET Center
- ☐ JHS Breast Center
- ☐ Transitional TB Clinic
- ☐ Downtown Medical Center
- ☐ So Dade Homeless Shelter
- ☐ Jefferson Reeves
- ☐ Rosie Lee Wesley Health Center
- ☐ Miami Hope Homeless Shelter
- ☐ Other: __________________

(Complete all boxes below. Indicate with NA if it does not apply/* Required information)

Field	
*Allied Health Professional indicate sponsoring/supervising physician	
*Specialty/ Sub Specialty:	
*Social Security Number:	
*NPI Number: (required)	
*Date Of Birth:	
*Office Address, Phone Number & Fax number: (Primary Practice Location) Cannot be a home address	
*Home Address and Phone Number:	
*Personal cell phone number:	
*Personal email address: (You must have a personal email address. You cannot use a group email.)	

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*Board Certification(s):	*Please circle which applies Board Certified?* Yes No Residency Completion Date:__________________
Credentialing Address if different from Office address	

Provider's Authorization for Delegate

Step 1

Contact information for the practitioner being credentialed: PLEASE PRINT

Provider Name:	
Provider phone number:	
Provider email address (required)	

NOTE: Provider's *email must be unique to the provider*; it **cannot** be the same address as the delegate.

Step 2

The delegate listed below is my delegate: (PLEASE PRINT)

I HERE BY AUTHORIZE: DELEGATE:

Name:	
Email address:	
Phone (with area code):	***ext:***

(Hereinafter, individually referred to as "Delegate") to enter data and submit documents for appointment/re-appointment on my behalf. I understand that I will need to review the data and documents for accuracy before submission to Jackson Health System.

I acknowledge that I have voluntarily provided the above information and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this authorization shall be as effective as the original.

PROVIDER SIGNATURE

NAME

SOCIAL SECURTIY NUMBER or NPI

DATE (MM/DD/YYYY)

Step3

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to email below
2. Faxed to the attention of the Corporate Credentialing Office at the fax below OR
3. U.S. mail to the address below

Jackson Health System – Corporate Credentialing Office
1500 NW 12th Avenue, Suite 1451
Jackson Medical Towers (West)
Miami, FL 33136
Phone 305-585-7725 - Fax 305-585-8971 - corporatecredentialing@jhsmiami.org