Corewell Health
The new name for Beaumont

Corewell Health - East
Central Credentialing Services
CHEBeaumontCredentialing@corewellhealth.org
947-522-2001

Request for Application

A valid Michigan state license, liability insurance (with limits of $100K, $300K), a Michigan controlled substance license (if applicable), and DEA (if applicable) are required for all practitioners applying to Corewell Health - East.

Practitioner Name: _____ Degree: _____
Last First Middle Initial

Date of Birth: ____/____/____ Last 4 digits of Social Security: _____ NPI#_____

Practicing Specialty: _____

Do you have an active Michigan state license? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Do you have an active Michigan controlled substance license? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Do you have an active DEA? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Supervising Physician (for Advance Practice Providers ONLY): _____

Hospitals Applying To (select all that apply, along with a category)

Click here to view each hospital's bylaws, which contains the description of each category.

☐ Dearborn	(Select a Category)	☐ Taylor	(Select a Category)
☐ Farmington Hills	(Select a Category)	☐ Trenton	(Select a Category)
☐ Grosse Pointe	Category will be determined at interview	☐ Troy	Category will be determined at interview
☐ Royal Oak	Category will be determined at interview	☐ Wayne	(Select a Category)

If selecting more than one hospital, which location will be your primary? (Select from List)

Will you be employed by Corewell Health - East? Yes ☐ No ☐

If yes, please indicate anticipated start date with organization: _____

Do you need inpatient privileges once on staff? Yes ☐ No ☐

Do you plan to establish, or have you established an office near the hospital(s) applying at? Yes ☐ No ☐

Email address where to send application: _____

Primary phone number to reach you if questions: _____

Office Information

Name of Practice:_____

Primary Office Address: _____
Street City State Zip Code

Office Telephone: _____ Office Fax: _____

Anticipated Start Date with Practice: _____

Is this a: ☐ Group Practice ☐ Solo Practice ☐ Hospitalist Will you be a moonlighter/house physician: Yes ☐ No ☐

Are you in a current residency or fellowship program? Yes ☐ No ☐

If yes, what is expected date of completion?_____ If no, please indicate date program was completed:_____

Are you board certified in practicing specialty? Yes ☐ No ☐

Name of certifying board: _____

Certification date: _____ Expiration date: _____

If not board certified, what is your status in the certification process: _____

Have you ever taken and failed a certification exam? Yes ☐ No ☐

If yes, please explain: _____

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All application fees are non-refundable:

Application fees are due upon submission of application: Physician Initial Hospital fee is $350, APP Initial Hospital fee is $250. Physician/APP fee for each additional hospital is $200 to which you are applying if requested at time of initial request. Future request(s) for application(s) will be charged as outlined above. (Payment not required with this request).

I request an application for appointment to Corewell Health - East. I understand that completing this Request for Application in no way obligates the organization and/or medical staff(s) to afford me medical staff membership and/or privileges.

An application for appointment/privileges shall not be provided to a practitioner, nor will an application be accepted if the practitioner does not meet the minimum requirements for medical staff membership and/or privileges. I understand that the information requested in this document is sought to enable the organization to make an administrative decision as to whether I am eligible to receive an application. I further understand that a determination that I am eligible to receive an application does not give rise to hearing rights under the Medical Staff Bylaws.

I attest that the information provided on this Request for Application is true and accurate to the best of my knowledge and belief.

Practitioner Signature: _____ Date: _____

By typing my full name above, I acknowledge I am signing this document electronically and agree that my electronic signature has the same legal validity and effect as my handwritten signature.

Please submit your completed Request for Application via email to CHEBeaumontCredentialing@corewellhealth.org