

Hospital Affiliation Verification Request

All Things Credentialing · Your one-stop shop for credentialing, privileging & enrollment

Letter and response form for a hospital, surgery center or other facility's medical staff or credentialing office. Attach the practitioner's signed authorization and release.

GENERAL TEMPLATE — NOT LEGAL ADVICE. This document is a generic starting point from All Things Credentialing. It is not tied to any specific accreditor's standards, state law or payer contract. Adapt it to your bylaws, policies, current accreditation standards and applicable law, and have it reviewed by your compliance team or counsel before use.

Date of request	
To (Medical Staff Office / Credentialing)	
Address / fax / secure email or portal	
From (organization)	
Contact name, title	
Phone / email for response	
Our reference #	
Please respond by (date)	

The practitioner named below has applied for appointment, privileges or participation with our organization and has listed your facility as a current or past affiliation. A signed authorization and release is attached. Please complete and return it to the contact above, or tell us how to use your verification portal.

Information you provide will be kept confidential and used only for credentialing and peer review purposes, as permitted by applicable law and our policies.

Part 1 — Practitioner (completed by requesting organization)

Full name	
Other / former names	
Degree	
Specialty	
NPI	
Date of birth (if your policy permits)	
Affiliation dates reported by practitioner (MM/YY - MM/YY)	

Part 2 — Affiliation details (completed by facility)

Appointment start date (MM/YY)	
Appointment end date (MM/YY) or "current"	
Staff category / status (e.g., active, courtesy, provisional, locum, telemedicine)	
Department / section	
Privileges held (attach delineation if available)	
Reason affiliation ended (if applicable)	

Part 3 — Standing and adverse actions

Question	Yes	No / details
Is / was the practitioner in good standing throughout the affiliation?	☐	☐
Were privileges ever denied, reduced, restricted, suspended, revoked or not renewed?	☐	☐
Was the practitioner ever placed on probation, required proctoring/FPPE for cause, or other conditions?	☐	☐
Did the practitioner resign or relinquish privileges while under investigation, or to avoid investigation?	☐	☐
Is any investigation or corrective action currently pending?	☐	☐
Were any reports made to the NPDB or a state licensing board about this practitioner?	☐	☐

If you answered "No" to the first question or "Yes" to any other, please explain or tell us whom to contact.

Explanation / whom to contact	
-------------------------------	--

Completed by (responding organization)

Name	
Title	
Organization / department	
Phone / email	
Signature	
Date completed	
Source used (e.g., official records, database)	

Please return this form with your organization's letterhead or official seal if that is your normal practice. Thank you for your assistance.