University Health

**Application Request Form**

Submit Form  Clear Form

Application Request Date: _____ Anticipated Start Date: _____

Full Legal Name: _____ (First) _____ (Middle) _____ (Last)

Degree: _____

Facility Requested:

- ☐ University Hospital / Babcock Specialty Hospital
- ☐ University Health Retama Hospital
- ☐ University Health Palo Alto
- ☐ ASC-RBG Surgery Center
- ☐ ASC-MC Surgery Center
- ☐ Multi-Assistance Center at Morgan Wonderland (MAC)

Primary Facility: _____

Applicants:

Cell Phone: _____ Email: _____ Date of Birth: _____

Social Security #: _____ TX License #: _____ NPI #: _____

If Allied Health Professional (AHP):

Specialty: _____ AHP/Title Role: _____

Sponsoring/Supervising Physician: _____

Primary Specialty: _____

Secondary Specialty: _____

Influenza Vaccine Attached? (**Required from October – March**): ☐ Yes ☐ No

Completed an ACGME Residency: ☐ Yes ☐ No

Completed an ACGME Fellowship: ☐ Yes ☐ No

Staff Status requested (please see attached University Health Bylaws)

| | | | |
|---|---|---|---|
| ☐ | Active - Academic | ☐ | Active - Community |
| ☐ | Courtesy - Academic | ☐ | Courtesy - Community |
| ☐ | Affiliate - Academic | ☐ | Affiliate - Community |
| ☐ | Associate | ☐ | Allied Health |

***ATTACH A COPY OF CV/RESUME***

Group Name: _____

Address: _____

Office Manager Name: _____

Phone: _____ Email: _____

Credentials Primary Contact Name: _____

Credentials Primary Email: _____

Credentials Primary Phone: _____

Notes/Relevant Information: