University Health

Application Request Form

Submit Clear Form

Application Request Date: _____ Anticipated Start Date: _____

Full Legal Name: _____ (First) _____ (Middle) _____ (Last Name/Suffix) _____ (Degree)

Email: _____ Cell Phone: _____

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

Primary Specialty: _____ Secondary Specialty: _____

Facility Requested:

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

Primary Facility:

If Applicant is an Allied Health Professional (AHP):

Specialty: _____ AHP/Title Role: _____

Sponsoring/Supervising Physician: _____

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: