LAS PALMAS DEL SOL HEALTHCARE

FACULTY OF RECORD/COORDINATOR CREDENTIALING FORM

This form is to be completed and submitted with the "Pre-Clinical Clearance Form" in compliance with Joint Commission requirements every semester.

Directions: *Please print or type the requested information into the spaces provided.*

Faculty of Record's/Coordinator's Name and ID Number:	Home:	Cell:
Email Address:	Office:	Beeper:
Credentials:		
License # /State/Expiration Date:		
Primary Source (Organization's Name) Verified:	CPR Status (if applicable/ will be required for on-site faculty/coordinator) Verified:	
Institution/School:		
Title/Position:		
Date of Employment:		
Briefly describe the qualifications/experience(s) that qualify this person as being competent to serve as a Faculty of record: ***(Attach copy of the Pre-Clinical Clearance Form)***		
I hereby verify that the above information is current and accurate:		
Faculty of record signature:	Date	
Immediate Supervisor's Signature:	Date	
(FOR HOSPITAL/FACILITY USE ONLY) License and CPR (CPR if applicable) status verified by:	Date	