Logo, company name

Description automatically generated

**Medical Staff Services Credentialing** [**credentialing@stcharleshealthcare.org**](mailto:credentialing@stcharleshealthcare.org)

* Please complete the information below and return to [credentialing@stcharleshealthcare.org](mailto:credentialing@stcharleshealthcare.org).
* Attach a copy of your CV with includes dates (month/year)
* Once reviewed the credentialing team will send an online link to complete the online application form.
* Tips to complete the online application is attached.

**Last Name**:Click or tap here to enter text. **First Name**:Click or tap here to enter text. **MI**: Click or tap here to enter text.

**Degree (MD, DO, MSN, MPAS**:Click or tap here to enter text.

**DOB:** Click or tap to enter a date. **NPI**: Click or tap here to enter text.

**Cell:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Specialty**: Click or tap here to enter text.

**Oregon Medical License No**: Click or tap here to enter text.

(Please enter pending if you currently do not have and OR Medical License)

**Oregon DEA Number:** Click or tap here to enter text.

(If applicable)

**CAQH Application: Only for SCMG Employed or Contracted**

User Name: Click or tap here to enter text. Password: Click or tap here to enter text.

**Please select all of the St. Charles Locations in which you are applying for.**

**Bend**  **Prineville**  **SCMG Outpatient Only**

**Madras**   **Redmond**

**Status:**

Locum Provider If yes, Agency Name Click or tap here to enter text.

Independent Provider (non-employed)

St. Charles Employed Provider

**Please provide the office address in which you will be providing patient care services:**

**Name**: Click or tap here to enter text.

**Address**: Click or tap here to enter text.

**City**: Click or tap here to enter text. State: Click or tap here to enter text. Zip: Click or tap here to enter text.

**Phone**: Click or tap here to enter text. Fax: Click or tap here to enter text.

**Office Manager:**

**Name**: Click or tap here to enter text.

**Email Address**: Click or tap here to enter text. Phone: Click or tap here to enter text.

**Credentialing Contact** (If applicable)

**Name**: Click or tap here to enter text.

**Email Address**: Click or tap here to enter text. Phone: Click or tap here to enter text.

**Phone number in which you would like to be set up for Whistle Secure messaging (required):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: (Apple, Android) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Application Fees: Upon request of a practitioner, the medical staff credentialing team will send the practitioner a link to complete the online initial application.**

**Initial Application Processing Fee are as follows:**

* **St. Charles (Bend/Redmond) (Primary Facility) -$500**
* **SC Madras or SC Prineville (Primary Facility) - $200**
* **Additional Facility - $100**

**Please send a check to:**

**St. Charles Healthcare System**

**Attn: Medical Staff Credentialing**

**2500 NE Neff Rd**

**Bend OR 97701**