Number of pages including this sheet: _____ Date of Request: (mm/dd/yyyy)

From (MTF): UIC:
Requestor:
E-mail:
Phone #: Ext. Fax:

Request for Verification / Query

Provider's CCQAS record must contain data in order for request to be processed.

****** Current signed release (or release page from privilege application, dated within the last year must be provided with this request ******

PROVIDER INFORMATION:
Provider's Full Name:
Last Four SSN#: DOB: (mm/dd/yyyy)
Type of Provider ☐

Other Name(s) used:

Specify if more than one request:

☐	Qualifying Degree:
☐	Other Degree:
☐	Internship:
☐	Residency:
☐	Fellowship:
☐	ECFMG certificate:
☐	CGFNS certificate:
☐	Flight Medicine Course:
☐	License:
☐	National Registration:
☐	National Certification:
☐	Board Certification:
☐	NPDB
☐	FSMB
☐	DHHS/OIG Sanction Query
☐	Employment/Work History

Other:

Comments: