MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit

SUBSCRIPTION SERVICE REQUEST – CREDENTIALING SERVICES

Subscription Service Request is: (Check one)	**New** ☐ **Cancellation** ☐	**Cancellations enter your facility password:**
Name of Organization		
Mailing Address:	Department:	
	Street Address:	
	City/State/Zip:	
Contact Person:	Name:	Title:
	Telephone:	FAX:
	E-mail Address:	

If you provide credentialing services for a health care facility licensed by the Department of Public Health (DPH), any health care service plan or medical care foundation licensed by the Department of Managed Health Care (DMHC), a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an accredited outpatient surgery setting which requires access to the 805 report information, **please complete the client listing information on Page 2 of this form**.

Pursuant to Business and Professions Code section 805.5, prior to granting or renewing staff privileges to any physician, any health care facility licensed by DPH or health care services plan or medical care foundation or the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an accredited outpatient surgery setting shall request a report from the Medical Board as to whether the applying physician has been denied staff privileges or had those privileges removed or restricted. This is not considered public information and cannot be disclosed to clients other than those legally entitled to request that information.

If access to 805 report information is granted, it shall be the responsibility of the credentialing service to confirm that their client is legally authorized to obtain this information before disclosing any 805 report information obtained through the License Verification System. Failure to fully comply with these policies and requirements will result in the denial of access to 805 report information.

The Organization and Responsible User agree to comply with this Security Agreement as a condition for accessing the Board's License Verification System or associated systems and are legally bound by this document. Failure to fully comply with these policies and requirements will result in the denial of access. The Organization and Responsible User understand that any illegal use of the Board's License Verification System or associated systems is punishable as a public offense under California Penal Code Section 502.

Signature of the Responsible User to this document and the Manager of the Organization under the laws of the State of California certify under penalty of perjury that they have read, understand and agree to the above statements and that the information provided is true and correct.

_____	_____	_____
Manager of Organization (Printed Name)	Signature	Date
_____	_____	_____
Responsible User (Printed Name)	Signature	Date

Return completed form to:

Medical Board of California
License Verification System
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
ATTENTION: MARCO ARMAS

Revised 12/2015

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Client Information – Page 2

Client 1	
Name:	Telephone Number:
Street Address:	CDPH License Number: *
	DMHC License Number: *
City/State/Zip:	Accreditation or Medicare Certification Number: *

Client 2	
Name:	Telephone Number:
Street Address:	CDPH License Number: *
	DMHC License Number: *
City/State/Zip:	Accreditation or Medicare Certification Number: *

Client 3	
Name:	Telephone Number:
Street Address:	CDPH License Number: *
	DMHC License Number: *
City/State/Zip:	Accreditation or Medicare Certification Number: *

Client 4	
Name:	Telephone Number:
Street Address:	CDPH License Number: *
	DMHC License Number*:
City/State/Zip:	Accreditation or Medicare Certification Number: *

If access to 805 report information is granted, it shall be the responsibility of the credentialing service to confirm that their client is legally authorized to obtain this information before disclosing any 805 report information obtained through LVS. Failure to fully comply with these policies and requirements will result in the denial of access to 805 report information.

Name of Credentialing Service:	Date:
Contact Person:	Telephone Number:

LVS Password:

*** Provide a copy of the CDPH License, DMHC License, Medicare certification, accreditation number or proof of accreditation for each facility for which you are providing services.**