

Application for Research Credentialing

Applicant Information	
First and Last Name	Email
Degree (e.g. MD, PA-C, ARNP, RPh)	Phone
Employed by MHS? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not MHS employed, provide employer name
Mailing Address	City, State, Zip
Documents	
Professional License	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Curriculum Vitae or Resume, signed / dated on the first page (update required every 2 years)	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Training:	
Human Subjects Protection (CITI Biomedical Researchers Certification)*	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Good Clinical Practice (required for New Investigators / Researchers)*	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Conflict of Interest in Research (COIR)	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Signed Research Practice Agreement	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
HIPAA Training Certification (required for non-MultiCare Health System employees)	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Optional: Professional Certification(s)	<input type="checkbox"/> Attached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Applicant Signature	
I certify that the information provided in this application is complete and correct.	
Applicant Signature	Date

* Completion of Human Subject Protection training through a different affiliation may be reviewed on a case by case basis; request for review must be accompanied by a certificate of completion, dated within the past 3 years, and description of course(s) taken.

For Completion by MHS Research Staff	
I certify that the information provided in this application is complete and correct.	
Receipt of all required documents	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notify MHS Compliance of FCOI training and request disclosure be sent.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Completion of HHS / FDA Check Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Full privileges granted	
Authorized Signature	Date

After completion of this form, send with all appropriate attachments to: research@multicare.org