STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

CONFIDENTIAL **PLEASE PRINT OR TYPE**

PSYCHIATRY/PSYCHOLOGY CREDENTIALING ATTACHMENT

1. Name: _____
   First Middle Last
2. Business Address: _____
   Number Street Suite
   _____ _____ _____ _____
   City State/Country Zip Code Telephone Number
3. Place of Birth: _____ Birth Date: ____/____/____
   City State/Country Month/Day/Year
4. Are you a resident of Hawaii?
   ☐ Yes ☐ No How long: _____
5. Have you been certified or licensed to practice medicine/psychology in another State?
   ☐ Yes ☐ No If "YES," what State(s): _____
6. Have you ever been denied a certificate or license as a practicing physician/psychologist?
   ☐ Yes ☐ No If "YES," what State(s): _____
7. Has any certificate or license been suspended or revoked?
   ☐ Yes ☐ No If "YES," attach a statement of explanation: _____
   _____
8. EDUCATION (List most recent first, please include residency.)

NAME OF INSTITUTION	MAJOR COURSE OF STUDY	DATE OF GRADUATION	DEGREE CONFERRED

9. EXPERIENCE (List most recent first.)

FROM	TO	POSITION	DUTIES	NAME & ADDRESS OF EMPLOYER

10. Do you hold a diplomat certificate in good standing from the American Board of Examiners in Professional Psychiatry and Neurology? ☐ Yes ☐ No If "YES," date you were certified? _____
11. Are you a member of A.P.A.? ☐ Yes ☐ No If "YES," what type of membership:
    _____
12. Do you have any hospital privileges? ☐ Yes ☐ No Which hospital? _____
13. Are you affiliated with or employed by any clinic? ☐ Yes ☐ No
    Which clinic? _____ How many hours per week? _____
14. Are you an independent private practitioner? ☐ Yes ☐ No How many hours per week? _____

_____ _____
Signature of Provider Date Signed

DHS PSYCHIATRIC CONSULTANT REVIEW

Reviewed By: _____
Date Reviewed: _____ Approved ☐ Disapproved ☐
Reason: _____

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.