Please Email Completed Application to:
backgroundchecks@nihcgrp.com

Credentialing Application

Please read, complete and sign this form in the space provided. If additional space is needed, attach a separate sheet. **Your written authorization is required as a condition of your employment.**

Legal Name:
(First) (Middle) (Last)

Telephone #: ( ) - Email Address:

Date of Birth: Social Security Number: - -

Driver's License: State of Issue:

Medical License Number:

Home Address (Current)

Street:

City: State: Zip:

Practice Address (Current)

Street:

City: State: Zip:

Are you a:

Existing DC at The Joint New DC at The Joint

Please Provide for Each Provider / Practice:

____ Copy of Medical License

____ Current Copy of Malpractice Insurance (Including Declaration Page)

I hereby authorized National Integrated Healthcare Group ("NIHG") to investigate my background and qualifications for purposes of evaluating whether I am qualified for the position for which I am applying. I understand that NIHG may utilize an outside firm or firms to assist it in checking such information, and I specifically authorize such an investigation to include, but not limited , the following areas: verification of social security number; credit reports; current and previous residences; current and previous employment history; education background; professional license; malpractice claims; character references; drug testing; civil and criminal history records from any jurisdiction(s); driving records; birth records; and any other public or industry records.

The information contained in this authorization is correct to the best of my knowledge.

______________________________ ______________________

Provider Signature Date

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Credentialing Application (cont.)

Former Names / Aliases (if applicable)

Former Name (Alias) 1:

Dates Used:

Former Name (Alias) 2:

Dates Used:

Former Name (Alias) 3:

Dates Used:

Previous Home Addresses (Provide Any Addresses in the Past 5 Years)

Previous Address 1:

Dates at Address:

Previous Address 2:

Dates at Address:

Previous Address 3:

Dates at Address:

Previous Address 4:

Dates at Address:

Previous Practices Addresses (Provide Any Addresses in the Past 5 Years)

Previous Address 1:

Dates at Address:

Previous Address 2:

Dates at Address:

Previous Address 3:

Dates at Address:

Previous Address 4:

Dates at Address:

Please duplicate this page if additional addresses are required

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Credentialing Application (cont.)

Primary Joint Clinic

Provider Name:

Franchisee Name:

Clinic Name:

Clinic Contact:

Clinic Phone: ( ) - Clinic Email:

Clinic Physical Address

Street:

City: State: Zip:

Clinic Mailing Address (if different from physical address)

Street:

City: State: Zip:

Additional Joint Clinic

Provider Name:

Franchisee Name:

Clinic Name:

Clinic Contact:

Clinic Phone: ( ) - Clinic Email:

Clinic Physical Address

Street:

City: State: Zip:

Clinic Mailing Address (if different from physical address)

Street:

City: State: Zip:

Please duplicate this page if additional locations are required

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Practice Name:

Credit Card Information				
Card Type:	MasterCard	VISA	Discover	AMEX
	Other ________________________________			
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):		CVV:		
Billing Street Address:				
Billing City:		State:		
Billing Zip Code:				

I, ______________________________________, authorize NIHG Services LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

____ ____________________

Cardholder Signature Date

The above charge(s) will appear on your statement as NIHC Group

Authorization: I agree that this is a timely recurring charge that will be processed as indicated above (if applicable). I hereby agree and acknowledge that I will not dispute NIHC Group recurring billing with my credit card issuer. I guarantee and warrant that I am the legal cardholder for this credit card, and that I am legally authorized to enter into this recurring billing agreement with NIHC Group. In the event the credit card expires, or any charges are denied, I do hereby agree to provide NIHC Group with a new and valid card within 48 hours of expiration or denial. I further authorize a $35.00 service charge for denied, cancelled or terminated payments not in accordance with this Agreement.

Recurring Billing: I hereby acknowledge that there will be no advance notice of billing and authorize National Integrated HealthCare Group (NIHC Group) to process recurring payments as part of payment plan (if applicable).