

**Quality Care Partners  
Ancillary Application Request Form**

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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*Please provide the following information:*

- List all previous work history within the past five years in chronological order. (Please use the back of this form for additional information.)

Facility	Address	Dates

- Please attach a copy of your current state license.
- Please attach a copy of your professional liability insurance policy showing the limits of coverage and coverage effective dates.
- Do you plan to establish or have you established an office/employment or residence within the area serviced by Quality Care Partners?  Yes  No
- Have you or do you plan on applying for hospital privileges at Genesis HealthCare System? If yes, please specify date applied or date medical staff privileges granted with Genesis HealthCare System. (If applicable) \_\_\_\_\_

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*I request an application form for panel appointment with Quality Care Partners.*

Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_