



Medical Provider Resources Delegation of Credentialing Form

A) Provider Information

Provider Name
(Printed) _____

Provider Phone _____

Provider Email _____

Date Provider Started/Will Start Employment at current Employer: _____

B) Credentialing Agency Information

- I will perform my own credentialing and I authorize the use of my electronic signature within the application and on documents submitted for completion of the MPR Online Application. (Skip to section C)
- I authorize MPR to share my credentialing information with the following individual. The following individual shall be designated as my credentialing agent. I understand that the credentialing agent will be able to access, modify, and submit information through the MPR Online Application for clinical privileges and/or membership.

Delegate Name _____
First Name Last Name

Company Name _____

Address _____
Street Address

City State Zip

Contact Info. _____
Email Address

Phone Number Fax Number

C) Acknowledgement & Agreement - *MUST BE WET OR DIGITALLY VERIFIED SIGNATURE*

Provider Signature

Date

Submit signed form to Medical Provider Resources via email below as a .pdf file.