

**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.**