CONNECTICUT VALLEY HOSPITAL
DEPARTMENT OF MENTAL HEALTH-ADDICTION SERVICES
P.O. BOX 351
MIDDLETOWN, CONNECTICUT 06457
(Application for Credentialing - Form 1)

Applicant Name:

Address:

Phone #: Home:
Work:

☐ I am applying for credentialing in the following areas:

☐ Individual Psychotherapy ☐ Group Psychotherapy
☐ Family Psychotherapy ☐ Prescriptive Authority & Treatments
☐ Supervision/Administration

☐ I have attached my Curriculum Vitae to this application.

☐ I have attached a copy of my current certification from ANCC as a Clinical Specialist, Nurse Practitioner or Psychiatric Nurse Practitioner.

☐ I have attached a copy of my current APRN License if applicable.

☐ I have attached a coy of my current Drug Enforcement Agency Registration if applicable.

☐ I have attached a current copy of my current Connecticut Controlled Narcotics Certificate if applicable.

☐ I have provided current proof of malpractice liability insurance for the amount specified per Connecticut General Statutes if applicable.

☐ I have requested and/or attached two (2) letters of reference, one is from a practitioner who is familiar with my work in those areas credential review is requested.

_____ _____
Name Name

_____ _____
Address Address

☐ I received a _____ from _____
Graduate Degree School

in _____ _____
(Month/Year) Address

In submitting this request for credentialing, I am declaring my intention to abide by all standards and ethics for the profession of Nursing as defined by the American Nursing Association and to practice within Connecticut State Law.

I further confirm that all information on this form is true and give permission to CVH to verify the facts as I have presented them.

_____
Signature of Applicant/Date

CONNECTICUT VALLEY HOSPITAL
DEPARTMENT OF MENTAL HEALTH-ADDICTION SERVICES
P.O. BOX 351
MIDDLETOWN, CONNECTICUT 06457
(Application for Credentialing - Form 2)

Date:

Re:

Dear Sir/Madam:

The above named Advance Practice Nurse has applied for credentialing at Connecticut Valley Hospital. It is the responsibility of our hospital to verify advanced degrees of nurses employed here. The above-named individual states that he/she received a graduate degree from your school in _____ (year). Would you please assist us by completing and returning the form below in the enclosed stamped, self-addressed envelope at your earliest convenience.

Thank you.

Sincerely,

Director of Patient Care Services

I authorize and consent to Hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consent to their inspecting all records and documents that may be material to evaluation of said qualifications and competence.

_____ _____
Signature Date

_____
Print Name

_____ has received _____
Name of Applicant Degree(s)

from _____, on _____, 20___.
School Date

_____
Name of Person Verifying

_____
Title

_____
Date of Verification

CONNECTICUT VALLEY HOSPITAL
(Credentialing - Form 3)

Division:

The application for Credentialing of:

_____ _____
(name) (title)

to provide the following services has been evaluated and approved by the reviewers listed below:

(Please √)

Clinical Function	Requested	Approved
Individual Psychotherapy		
Group Psychotherapy		
Family Therapy		
Prescriptive Authority and Treatments		
Supervisor/Administrator		

□ Recommended to the Nursing Executive Committee by Director of Patient Care Services

_____ Date

□ Granted by the Nursing Executive Committee _____ Date

□ Not approved by the Nursing Executive Committee _____ Date

Reason for Disapproval _____

Signed _____
Director of Patient Care Services