oneHealth™

This form should be completed only if applicable

DESIGNATION OF CREDENTIALING AGENT

I, _____, the undersigned, do hereby authorize _____ _____ as my designated Credentialing Agent. Therefore, I give permission for OneHealth to receive, provide and communicate with _____ on my behalf regarding all aspects of my credentialing and/or recredentialing for OneHealth. I have provided contact information for _____ below.

Organization: _____

Designee: _____

Phone: _____

Address: _____

_____

I understand that as an applicant in the OneHealth credentialing/recredentialing process, I have the sole burden of providing adequate and accurate information for proper evaluation of my professional competence, character, ethics an other qualifications, and for resolving any doubt about such qualifications or the ability to practice in a safe and effective manner. I also understand that my designee has been appointed to merely help coordinate and communicate this information on my behalf.

I further understand that this designation will remain effective, with no expiration, until such time as I submit a written retraction/cancellation of such designation.

_____ _____

Provider Signature Date

8930 W. Sunset Rd., #200 Las Vegas, NV 89148

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