Healthcare Professional Liability Verification Request Form

To: UF Self-Insurance Program
Insurance Services
352-273-7006

From: UF Health
Medical Staff Office

EMAIL COMPLETED FORM TO: **ufisosip@mail.ufl.edu**

Date of Request

MSO Requester (Phone/Email Contact)

Date Verification due

Date of Credentialing Meeting

HEALTHCARE PROVIDER INFORMATION

Provider (name and clinical degree)

Medical License #

UFID #

Provider is: Select Provider's Status

If "New Hire" or "Current Resident to be hired as Faculty" selected above, what is the anticipated start date?

If "Other" selected above, please explain:

Which UF College AND Department -or- UF Hospital/Facility employs or will employ this new hire?

This verification is needed for which UFH facility/facilities?

___ UFH Shands
___ UFH St. Johns
___ UFH Rehabilitation GNV
___ UFH Jacksonville
___ UFH Leesburg
___ Select Specialty Hospital (LTACH)
___ UFH Spanish Plaines
___ Other

If "Other" selected above, please explain

Provide name and email/phone # for the department/service contact/lead for this provider:

Name

Email/Phone

Optional: Comments