



HOSPITAL PRIVILEGES / INPATIENT SERVICES

The intent of this form is to gather information about each individual practitioner. A separate form should be completed and submitted for each practitioner within your practice.

Practitioner: _____ Specialty: _____

Group Name: _____ Tax ID: _____

Tell us about your practice services:

- I do not have privileges at any area hospital, my practice is limited to office services only.
- I do not practice in an office setting, my practice is limited to inpatient services only.

Tell us which area hospitals you have inpatient privileges at:

Area Hospitals

- | | |
|---|---|
| <input type="checkbox"/> Boulder City Hospital | <input type="checkbox"/> North Vista Hospital |
| <input type="checkbox"/> Centennial Hills Hospital Medical Center | <input type="checkbox"/> Southern Hills Hospital and Medical Center |
| <input type="checkbox"/> Complex Care Hospital | <input type="checkbox"/> Spring Mountain Sahara |
| <input type="checkbox"/> Desert Spring Hospital | <input type="checkbox"/> Spring Valley Hospital Medical Center |
| <input type="checkbox"/> Desert View Regional Medical Center | <input type="checkbox"/> St. Rose Dominican Hospital – Rose de Lima |
| <input type="checkbox"/> HealthSouth Rehabilitation Hospital of Las Vegas | <input type="checkbox"/> St. Rose Dominican Hospital – San Martin |
| <input type="checkbox"/> Horizon Specialty Hospital | <input type="checkbox"/> St. Rose Dominican Hospital – Siena |
| <input type="checkbox"/> Kindred Hospital – Flamingo | <input type="checkbox"/> Summerlin Hospital Medical Center |
| <input type="checkbox"/> Kindred Hospital – Sahara | <input type="checkbox"/> Sunrise Hospital and Medical Center |
| <input type="checkbox"/> Kindred Hospital – St. Rose de Lima campus | <input type="checkbox"/> University Medical Center |
| <input type="checkbox"/> Mesa View Regional Hospital | <input type="checkbox"/> Valley Hospital Medical Center |
| <input type="checkbox"/> Mountain View Hospital | |

Completed by: _____ Title: _____

Phone Number: _____ Date form Completed: _____