

|  |  |
| --- | --- |
| Applicant Name: |  |



**PROFESSIONAL REFERENCES ADDENDUM**

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

**Name and Title:** Specialty:

Street Address: Email:

City, State/Province, Country and Zip Code:

Telephone Number: Facsimile:

**Name and Title:** Specialty:

Street Address: Email:

City, State/Province, Country and Zip Code:

Telephone Number: Facsimile:

**Name and Title:** Specialty:

Street Address: Email:

City, State/Province, Country and Zip Code:

Telephone Number: Facsimile:

**Name and Title:** Specialty:

Street Address: Email:

City, State/Province, Country and Zip Code:

Telephone Number: Facsimile:

**Name and Title:** Specialty:

Street Address: Email:

City, State/Province, Country and Zip Code:

Telephone Number: Facsimile:

**Please fax or e-mail this completed form to:**

Hospital Services Corporation

Credentials Verification Services

P. O. Box 92200

Albuquerque, NM 87199-2200

Telephone: (505) 346-0222

Toll Free: (866) 908-0070 x2006

Facsimile: (505) 346-0287

Email: [Credentialing@nmhsc.com](mailto:Credentialing@nmhsc.com)

