MultiCare

Institute for Research & Innovation

Application for Research Credentialing

Applicant Information	
First and Last Name	**Email**
Degree (e.g. MD, PA-C, ARNP, RPh)	**Phone**
Employed by MHS? ☐ Yes ☐ No	**If not MHS employed, provide employer name**
Mailing Address	**City, State, Zip**

Documents	
Professional License	☐ Attached ☐ Yes ☐ No ☐ N/A
Curriculum Vitae or Resume, signed / dated on the first page (update required every 2 years)	☐ Attached ☐ Yes ☐ No ☐ N/A
Training:	
Human Subjects Protection (CITI Biomedical Researchers Certification)*	☐ Attached ☐ Yes ☐ No ☐ N/A
Good Clinical Practice (required for New Investigators / Researchers)*	☐ Attached ☐ Yes ☐ No ☐ N/A
Conflict of Interest in Research (COIR)	☐ Attached ☐ Yes ☐ No ☐ N/A
Signed Research Practice Agreement	☐ Attached ☐ Yes ☐ No ☐ N/A
HIPAA Training Certification (required for non-MultiCare Health System employees)	☐ Attached ☐ Yes ☐ No ☐ N/A
Optional: Professional Certification(s)	☐ Attached ☐ Yes ☐ No ☐ N/A

Applicant Signature	
I certify that the information provided in this application is complete and correct.	
Applicant Signature	**Date**

* Completion of Human Subject Protection training through a different affiliation may be reviewed on a case by case basis; request for review must be accompanied by a certificate of completion, dated within the past 3 years, and description of course(s) taken.

For Completion by MHS Research Staff	
I certify that the information provided in this application is complete and correct.	
Receipt of all required documents	☐ Yes ☐ No
Notify MHS Compliance of FCOI training and request disclosure be sent.	☐ Yes ☐ No ☐ N/A
Completion of HHS / FDA Check ***Date:*** _____	☐ Yes ☐ No ☐ N/A
☐ Full privileges granted	
Authorized Signature	**Date**

After completion of this form, send with all appropriate attachments to: research@multicare.org