Minnesota Uniform Credentialing Application
Initial
Physician/Dentist/Allied Health Professional

Application is submitted by:

Name: ____
Last First Middle Suffix Title

PRIMARY PRACTICE LOCATION CREDENTIALING CONTACT NAME

Name ______________________ **Phone Number** ______________________
Address ______________________ **Fax Number** ______________________
______________________ **E-mail** ______________________
____

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A.

Checklist (please complete)
Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- ☐ Drug Enforcement Administration Registration with correct address (if applicable)
- ☐ Diploma and ECFMG certificate (if educated outside of U.S. or Canada)
- ☐ Malpractice Litigation and Professional Complaints Form (if applicable)
- ☐ Malpractice liability insurance documentation (as defined on page 8)
- ☐ Curriculum Vitae (all application items must be completed)
- ☐ Allied Health Professionals: License/registration and/or certification (if applicable)

In addition, please verify that you have:

- ☐ Provided complete street addresses wherever indicated, including past employment, hospital affiliations and references
- ☐ Designated dates by month and year time frames
- ☐ Explained all gaps of greater than three months in chronology (Page 6)
- ☐ Answered all of the Disclosure Questions on Pages 10 and 11 and enclosed explanations for affirmative answers
- ☐ Signed and dated the Attestation Signature and Date statement (Page 11)
- ☐ Signed and dated the Authorization and Release (Page 13)

This Box to be Completed by Allied Health Professionals Only

Profession/Title______________________________________

Sponsoring/Collaborative Physician ______________________
(If applicable)

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Personal Data

Name: ____
Last First Middle Suffix Title

Maiden/Former/Other Name(s):_______________________ Spouse Name (optional):___________________

Marital Status (optional): ☐ Married ☐ Single ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Date of Birth:_____/_____/_____ Birthplace (city/state/country):_______________________ U.S. Citizen: ☐Yes ☐No

Social Security Number: _______________________ UPIN or NPI:_______________________

Medicaid Number: ____________________ State ________ Medicare Number:__________________ State _________

Current Home Address:____
Street City/State/Country Zip Code

Local Home Address
(if different from above):____
Street City/State/Country Zip Code

Preferred Mailing Address: ☐ Office ☐ Home E-mail address: _______________________

Pager Number: _______________________ Home Phone Number:_______________________

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages: ____

____

Primary or Pending Practice Location

Primary Practice Location:____

Address:____
Street City/State/Country Zip Code

Office Phone Number: _______________________ Fax Number: _______________________

Federal Tax ID Number: _______________________ E-mail Address:_______________________

Credentialing Contact:_______________________ Phone Number:_______________________

Expected Start Date:_______________________ Do you intend to practice as: ☐ Primary Care ☐ Specialist ☐ Urgent Care

Is over 50 percent of your practice primary care? ☐ Yes ☐ No

Primary Specialty:_______________________ Subspecialty:_______________________

Specialty/Subspecialty in which care will be provided:____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

____

____

____

Billing Information

Billing Name:_______________________ Contact Person _______________________

Address:____
Street City/State/Country Zip Code

Office Phone Number: _______________________ Fax Number: _______________________

Additional Practice Location(s)

Practice Name:____ Phone Number:____________________

Address: ____
Street   City/State/Country   Zip Code

Credentialing Contact: ________________________________ Phone Number:____________________

Currently practicing at this location? ☐ Yes ☐ No Start Date:______________________________

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment:____________________

Specialty/Subspecialty in which care will be provided: __________________________________

Other Practice Name:____ Phone Number:____________________

Address: ____
Street   City/State/Country   Zip Code

E-mail Address:____________________________ Fax Number:______________________________

Federal Tax ID Number (if different from primary):______________________________________

Credentialing Contact: ________________________________ Phone Number:____________________

Currently practicing at this location? ☐ Yes ☐ No Start Date:______________________________

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment:____________________

Specialty/Subspecialty in which care will be provided: __________________________________

Other Practice Name:____ Phone Number:____________________

Address: ____
Street   City/State/Country   Zip Code

E-mail Address:____________________________ Fax Number:______________________________

Federal Tax ID Number (if different from primary):______________________________________

Credentialing Contact: ________________________________ Phone Number:____________________

Currently practicing at this location? ☐ Yes ☐ No Start Date:______________________________

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment:____________________

Specialty/Subspecialty in which care will be provided: __________________________________

Other Practice Name:____ Phone Number:____________________

Address:____
Street   City/State/Country   Zip Code

E-mail Address:____________________________ Fax Number:______________________________

Federal Tax ID Number (if different from primary):______________________________________

Credentialing Contact: ________________________________ Phone Number:____________________

Currently practicing at this location? ☐ Yes ☐ No Start Date:______________________________

If yes, will you continue to practice at this location? ☐ Yes ☐ No If no, last date of employment:____________________

Specialty/Subspecialty in which care will be provided: __________________________________

Medical/Graduate/Professional Education

From _____/_____/_____ Institution Name:______________________________

To _____/_____/_____ Degree Received: ☐ MD ☐ DO ☐ DDS ☐ DC ☐ DPM ☐ Ph.D Other:______________

Address:______________________________
Street City/State/Country Zip Code

Phone Number (if known):______________ Fax Number (if known):______________

From _____/_____/_____ Institution Name:______________________________

To _____/_____/_____ Degree Received: ☐ MD ☐ DO ☐ DDS ☐ DC ☐ DPM ☐ Ph.D Other:______________

Address:______________________________
Street City/State/Country Zip Code

Phone Number (if known):______________ Fax Number (if known):______________

ECFMG - Applicable to International Medical Graduates

ECFMG Number:______________ Date Issued:______________ (mo/yr) Valid Through:______________ (mo/yr)

Internship/Post-Graduate/Professional Training (If applicable)

From: _____/_____/_____ Institution Name:______________________________

To: _____/_____/_____ Internship Type/Specialty (transitional, rotating, 5th pathway, etc.):______________

Completed Training: ☐ Yes ☐ No If no, expected completion date:______________

If not successfully completed, explain:______________________________

Program Director:______________________________

Address:______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known):______________

Residency/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)

From: _____/_____/_____ Institution Name:______________________________

To: _____/_____/_____ Type of Program/Specialty______________________________

Completed Training: ☐ Yes ☐ No If no, expected completion date:______________

If not successfully completed, explain:______________________________

Program Director:______________________________

Address:______________________________
Street City/State/Country Zip Code

Phone Number (if known): ______________ Fax Number (if known):______________

Residency/Post-Graduate/Professional Training - continued

From: _____/_____/_____ Institution Name:____

To: _____/_____/_____ Type of Program/Specialty____

Completed Training: ☐ Yes ☐ No If no, expected completion date:_____________________

If not successfully completed, explain:____

Program Director:____

Address:____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known):______________________

Fellowship/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)

From: _____/_____/_____ Institution Name:____

To: _____/_____/_____ Type of Program/Specialty____

Completed Training: ☐ Yes ☐ No If no, expected completion date:_____________________

If not successfully completed, explain:____

Program Director:____

Address:____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known):______________________

Professional and Academic/Faculty Affiliations

From:_____/____/_____ Institution Name:____

To: _____/_____/_____ Appointment Held/Position:____

Address:____
Street City/State/Country Zip Code

Phone Number (if known):______________________ Fax Number (if known): ______________________

From:_____/____/_____ Institution Name:____

To: _____/_____/_____ Appointment Held/Position:____

Address:____
Street City/State/Country Zip Code

Phone Number (if known):______________________ Fax Number (if known): ______________________

From:_____/____/_____ Institution Name:____

To: _____/_____/_____ Appointment Held/Position:____

Address:____
Street City/State/Country Zip Code

Phone Number (if known):______________________ Fax Number (if known): ______________________

Chronological Employment/Practice History

Chronological listing [month/year] of employment/practice history **since completion of your post-graduate training.** List all experience, including armed service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. LEAVE NO GAPS IN CHRONOLOGY. If additional space is required, attach a separate sheet.

From: _____/_____/_____ Organization Name/Activity: ____________________

To: _____/_____/_____ Reason for Leaving: ____________________

Contact Name ____________________

	If no, attach sheet listing address and phone number of someone who can verify your

Address: ____________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known): ____________________

From: _____/_____/_____ Organization Name/Activity: ____________________

To: _____/_____/_____ Reason for Leaving: ____________________

Contact Name ____________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your

Address: ____________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known): ____________________

From: _____/_____/_____ Organization Name/Activity: ____________________

To: _____/_____/_____ Reason for Leaving: ____________________

Contact Name ____________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your

Address: ____________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known): ____________________

From: _____/_____/_____ Organization Name/Activity: ____________________

To: _____/_____/_____ Reason for Leaving: ____________________

Contact Name ____________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your

Address: ____________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known): ____________________

Explain gaps/interruptions of greater than three (3) months to practice of medicine/professional practice (if additional space is required, attach a separate sheet):

From: _____/_____/_____ Explain : ____________________

To: _____/_____/_____ ____________________

____

From: _____/_____/_____ Explain : ____________________

To: _____/_____/_____ ____________________

____

Primary Hospital Affiliation (pertinent to Primary or Pending Practice Location listed on page 2)

If no hospital privileges, describe method/coverage for continuity of care. Please provide covering physician's name, if applicable.

____

____

From: _____/_____/_____ Facility Name:______________________________

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):______________________________

Application Pending Department Name:______________________________

Department Chairperson: ______________________________

Address______________________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known)____________________

Other Hospital Affiliations - Present and past affiliations beginning with most recent.

(Additional space is provided on the Hospital Affiliation Addendum, page 15. You may make extra copies of page 15 or attach a separate sheet for additional affiliations.)

From: _____/_____/_____ Facility Name:______________________________

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):______________________________

Department Name:______________________________

Department Chairperson: ______________________________

Address______________________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known)____________________

From: _____/_____/_____ Facility Name:______________________________

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):______________________________

Department Name:______________________________

Department Chairperson: ______________________________

Address______________________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known)____________________

From: _____/_____/_____ Facility Name:______________________________

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):______________________________

Department Name:______________________________

Department Chairperson: ______________________________

Address______________________________
Street City/State/Country Zip Code

Phone Number (if known): ____________________ Fax Number (if known)____________________

Specialty/Subspecialty Certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date
______________________________	_______________________	_____/_____/_____	_____/_____/_____	_____/_____/_____
______________________________	_______________________	_____/_____/_____	_____/_____/_____	_____/_____/_____
______________________________	_______________________	_____/_____/_____	_____/_____/_____	_____/_____/_____
______________________________	_______________________	_____/_____/_____	_____/_____/_____	_____/_____/_____

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any. ____

____

Licensure - List all past, current and pending professional licenses.

State	License Number	Date Issued	Expiration Date	License Status
__________	_____________________________________	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive
__________	_____________________________________	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive
__________	_____________________________________	_____/_____/_____	_____/_____/_____	☐ Active ☐ Inactive

Drug Enforcement Administration Registration

DEA Number:______________________________________ State:____________________________ Expiration Date: _____/_____/_____

Approved for all schedules? ☐Yes ☐ No, please explain ____

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice ☐ DEA certificate pending. Date application submitted to DEA: _____ /_____/_____

☐ Other ____

State Controlled Substance Certification/Registration (If applicable - not applicable to AZ, FL, MN, WI).

Issued By:__________________________________ Number:_________________________________ Expiration Date: _____ /_____/_____

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

Coverage dates:

From: _____/_____/_____ Insurance Carrier Name:____

To: _____/_____/_____ Address ____

Street City/State/Country Zip Code

Name in which policy issued:____

Policy number:____ Expiration Date: _____/_____/______

Amount of coverage (per occurrence/aggregate):____

Professional/Peer References

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgement, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.) Limit to one **(1) current office associate. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name:____ Title:______________________________

Facility Name:____

Address:____
Street City/State/Country Zip Code

Phone Number:________________________________ Fax Number:____________________________

E-Mail Address:____

Name:____ Title:______________________________

Facility Name:____

Address:____
Street City/State/Country Zip Code

Phone Number:________________________________ Fax Number:____________________________

E-Mail Address:____

Name:____ Title:______________________________

Facility Name:____

Address:____
Street City/State/Country Zip Code

Phone Number:________________________________ Fax Number:____________________________

E-Mail Address:____

Life Support Certification

Do you have any current life support certifications (BLS, CPR, ACLS, ATLS, etc.)? ☐ Yes ☐ No

If Yes: Type of Certification Expiration Date(s)

____ _____/_____/_____

____ _____/_____/_____

____ _____/_____/_____

____ _____/_____/_____

Disclosure Questions for Initial Credentialing

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

1. ☐ Yes ☐ No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. ☐ Yes ☐ No Has your **professional license or registration** ever been investigated or is it currently being investigated and, if so, what were the results?

3. ☐ Yes ☐ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. ☐ Yes ☐ No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. ☐ Yes ☐ No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. ☐ Yes ☐ No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. ☐ Yes ☐ No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

9. ☐ Yes ☐ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. ☐ Yes ☐ No Are there any **charges pending or are you currently charged** with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

11. ☐ Yes ☐ No Have you ever been found liable, guilty or responsible for **sexual impropriety** or misconduct or sexual harassment \ with a patient, co-worker, or other?

____

____

12. ☐ Yes ☐ No Have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgements? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.** You may be asked for additional information by individual organizations.

____

____

13 ☐ Yes ☐ No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

____

____

14. ☐ Yes ☐ No Have you ever practiced within your profession without **professional liability insurance?**

____

____

15. ☐ Yes ☐ No Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

____

____

16. ☐ Yes ☐ No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

____

____

17. ☐ Yes ☐ No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

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____

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

Signature ______________________________ Date ____________________

Name ______________________________
(please print or type)

The signature blocks below are to be signed ONLY if a previous completed application is being reviewed and updated.

Application Update

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign one of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date _________________________

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date _________________________

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date _________________________

Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership and/or participation status (hereinafter, referred to as "Participation") at Clinical Resource Group, Inc. (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.

3. **Release from Liability.** I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand and agree that the Entity may communicate with me via e-mail over the Internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release.

A photocopy of this Authorization and Release shall be as effective as the original.

Signature ______________________________ **Date** ______________________

Name (please print or type____

Application Addendum
To Initial and Reappointment Applications

Medicare/Champus Penalty Statement: This statement is required by Medicare/Champus

Penalty statement according to the Federal Register dated August 31, 1984 and effective October 1, 1984.

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/CHAMPUS PAYMENTS"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

Signature:____ Date:______________________________

Name:____
(please print or type)

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet the licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

Signature:____ Date:______________________________

Name:____
(please print or type)

Signature/DEA Verification

Pharmacies are required to maintain signatures and DEA numbers on file for all practitioners who prescribe.

Signature:____ Date:_________________________________

Name:____ DEA Number:__________________________
(please print or type)

Office Address:____ Specialty:______________________________

____

Phone Number:____

Malpractice Litigation and Professional Complaints

Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. If is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Name(s) of plaintiff(s) or complainants(s)

____

____

Month/Year of incident

____

____

Where incident occurred

____

____

Describe the nature of incident (Complaint, Allegation)

____

____

____

____

Provide a narrative description of your participation/level of care

____

____

Outcome of incident

☐ Pending ☐ Dropped/Settled/Closed - no payment ☐ Date Closed ___/___/___ ☐ Verdict for you - no payment

☐ Dropped/Settled/Closed with payment, amount: ______________________ ☐ Dismissed with prejudice

☐ Verdict for plaintiff, amount: ________________________________ ☐ Dismissed without prejudice

Represented by Legal Counsel for this claim/malpractice lawsuit? ☐ Yes ☐ No If yes, give the name and address of counsel.

Name:______________________________

Address:______________________________

Phone Number:______________________________

Insurance company that provided coverage for this claim:

Name:______________________________

Address: ______________________________

Phone Number:__________________________ Policy Number:__________________________

Signature__________________________ **Date** __________________________

Print Name__________________________ **Phone Number**__________________________

Hospital Affiliation Addendum

(Please make as many extra copies as necessary.)

From: _____/_____/_____ Facility Name:____

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):_______________________

Department Name:____

Department Chairperson: ____

Address____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known)______________________

From: _____/_____/_____ Facility Name:____

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):_______________________

Department Name:____

Department Chairperson: ____

Address____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known)______________________

From: _____/_____/_____ Facility Name:____

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):_______________________

Department Name:____

Department Chairperson: ____

Address____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known)______________________

From: _____/_____/_____ Facility Name:____

To: _____/_____/_____ Type/category of privilege/affiliation (active, courtesy, etc.):_______________________

Department Name:____

Department Chairperson: ____

Address____
Street City/State/Country Zip Code

Phone Number (if known): ______________________ Fax Number (if known)______________________