## APPLICATION GUIDELINES

**The guidelines below support the completion of the Cactus Credentialing Application.**

The following guidelines apply throughout the Application:

* Fields displayed in RED are mandatory and must be answered in order for the Application to be considered finished and ready for submitting. Note: Once finished, the Application can be forwarded for processing by clicking **Submit** (located at both the top and the bottom of the Application).
* Attachments, where applicable, can be added while completing the Application by selecting
* **Add Attachment** from the Menu drop-down, or
* **Fax or Attach Image** at the top of the document.

Note: Required attachments include the following:

* Social Security Card
* Curriculum Vitae
* Case Log/Procedure List (2 years) inclusive of patient age or date of birth
* State/Federal DEA(s)
* Malpractice Insurance Certificates (5 years)
* Nebraska Excess Fund Letter
* Visa/Work Permit (if applicable)
* Military Discharge Certificate and DD214 (if applicable)
* ECFMG (if applicable)
* APP Certifications
* Specialty Board Certificates
* Call Coverage List

### Form Specific

The following guidelines apply to specific forms/sections of the Application:

|  |  |  |  |
| --- | --- | --- | --- |
| **Page** | **Part/Section** | **Item** | **Notes** |
| 2 | General Information | NPI | NPI is calculated using NPI validation logic (Luhn formula) and erroneous entries will not be accepted |
| 4 | Office Locations | Addresses | Different address or multiple address types can be selected for a single location |
| 6 | Education | Phone,Fax, Email | Provide the phone, fax and email information for the Office of the Registrar |
| 7 | Training | Phone, Fax, Email | Provide the **current** phone, fax and email information for the department where you trained |
| 9 | Hospital & Healthcare Affiliations | Phone, Fax, Email | Provide the **current** phone, fax and email information for the medical staff office for affiliations and Human Resources office manager for group practices |
| 13 | Attestation Questions | Questions | Responding adversely to any of the Attestation Questions will open an Explanations Form where further details should be provided. |
| 14 | Application Attestation | Electronic Signature | An Electronic Signature in cursive font must be provided together with the last four digits of the SSN and date. |
| 17 | Insurance |  | Provide the phone, fax and email information for the Risk Manager, or organization representative who can complete the verification of Professional Liability. Please do not list the Insurance Broker. |

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| *Please select whether you are applying as a:* | | | |
| *Physician:* |  | *Advanced Practice Provider:* |  |

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| **General Information** | | |
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Please complete all relevant fields.

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|  |  |  | |  | |  |
| *First Name* | *Middle Name* | *Last Name* | | *Suffix* | | *Title(s)* |
|  | |  |  | |  | |
| *AppCentral Contact Email Address* | | *Cell Phone* | *Pager* | | *Fax* | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Gender:* | Male: |  | Female: |  | *Social Security:* |  |
| *Birth Date:* |  | | | | *NPI:* |  |
| *Birth Place:* |  | | | | *UPIN:* |  |
| *Ethnicity:* |  | | | | *Medicare:* |  |
| *Marital Status:* |  | | | | *Medicaid:* |  |
| *Spouse’s Name:* |  | | | | *ITIN:* |  |

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| **Home Address** | | |
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Please enter your home address in full.

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| --- | --- | --- | --- |
| *Home Address Line 1:* |  | | |
| *Home Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Email:* | *Phone:* | *Fax:* |  |

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| **Other Names** | | |  |
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Please enter any other names by which you have been known.

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|  |  |  |  |  |
| *Other First Names* | *Other Middle Names* | *Other Last Names* | *From Date* | *To Date* |

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| **Citizenship** | | |
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Please provide information on your citizenship status.

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|  |  |  |  |
| *Country of Citizenship* | *Citizenship Status* | *Visa Number* | *Visa Date* |

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| **Military Service** | | |
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Please enter details of any military service.

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|  | | |  |  |
| *Military Service Branch* | | | *Date of Entry* | *Date of Separation* |
| *Military Reserves?* |  |

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| **Provider Language** | | |
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Please list all languages spoken other than English.

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|  |  |  |
| *Language 1* | *Language 2* | *Language 3* |

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| **Licensure** |  | | Pending |  |  |  | Click to add more. |
|  |  |  | | | | | | |

Please list all current and past licenses, including type (e.g., MD, DO, DDS, RN).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| **DEA Registration** |  | | Not Applicable |  | Pending |  | Click to add more. |
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Please provide details of all DEA registrations.

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| **Other Certification** |  | | Not Applicable |  | Click to add more. |
|  |  |  | | | | |

Please provide details of any other certifications, including type (e.g., BLS, CPR, ACLS).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| **Additional Licensure** | | |
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Please list all current and past licenses, including type (e.g., MD, DO, DDS, RN).

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Licensure Type:* | *License Number:* | | |  | |
| *License Status:* | *Field of Licensure:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| **Additional DEA Registration** | | |
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Please provide details of all DEA registrations.

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

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| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *DEA Number:* | *Status:* | | | | | | | | | |  | | | | | | |
| *State:* | *Issue Date:* | | | | | | | *Expiration Date:* | | | | | | |  | | |
| *DEA Schedule:* | *1* |  | *L1* |  | *2* |  | *2N* |  | *3* |  | | *3N* |  | *4* |  | *5* |  |

|  |  |  |
| --- | --- | --- |
| **Additional Other Certification** | | |
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Please provide details of any other certifications, including type (e.g., BLS, CPR, ACLS).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- | --- | --- | --- |
| *Certification Type:* | *Certification Number:* | | |  | |
| *State:* |  | *Issue Date:* |  | *Expiration Date:* |  |

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| --- | --- | --- |
| **Office Location** | | |
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Please provide full details of any current office or anticipated practice department/location.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Practice Name:* | *Address Type:* | | |  | | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* |  | | | | | |
| *City:* | *State:* | | *Zip:* | | |  |
| *Tax ID:* | *Phone:* | *Fax:* | | |  | |
| *Credentialing Contact:* | *Credentialing Contact Phone:* | | | |  | |
| *Office Manager:* | *Office Manager Phone:* | | | |  | |
| *Email Address:* |  | | | | | |
| *Answering Service:* |  | | | | | |

|  |  |
| --- | --- |
| *If you would like to use the above address for* ***Mailing*** *in addition to the type selected, check here:* |  |

|  |  |
| --- | --- |
| *If you would like to use the above address for* ***Billing***  *in addition to the type selected, check here:* |  |

|  |
| --- |
| *Notes:* Please provide further details about this office. |
|  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Call Coverage** |  | Not Applicable (if APP, not required) |  |  | | | |
|  |  |  |

Please list below your coverage arrangements. If the providers are in your practice group, you may attach a sheet of letterhead that lists each practitioner with his/her specialty. Your practice must provide 24 hour, 7 day-a-week coverage.

|  |
| --- |
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| --- | --- | --- |
| **Office Hours** | | |
|  |  |  |

Please provide the hours during which you practice at this location.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | *AM Open* | *AM Close* | *PM Open* | *PM Close* |
| *Monday:* |  |  |  |  |
| *Tuesday:* |  |  |  |  |
| *Wednesday:* |  |  |  |  |
| *Thursday:* |  |  |  |  |
| *Friday:* |  |  |  |  |
| *Saturday:* |  |  |  |  |
| *Sunday:* |  |  |  |  |

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| --- | --- | --- |
| **Practice Specialties** |  | Click to add more. |
|  | | | |

Please complete all relevant fields.

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| --- | --- | --- |
| *Primary Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| --- | --- | --- |
| *Secondary Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |

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| --- | --- | --- | --- | --- | --- |
| **Board Certification** |  | | Not Applicable |  | Click to add more. |
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Physicians and Dentists, please complete all relevant fields. Advanced Practice Providers, please select “Not Applicable.” All APP Certifications are to be listed on page 3 in the “Other Certifications” section of the application.

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
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| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |

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| --- | --- | --- |
| Have you ever taken a Board exam and failed to pass? |  |  |
|  | *Yes* | *No* |
| If you are not board certified, do you intend to become certified? |  |  |
|  | *Yes* | *No* |
| *Anticipated Board test date:* |  | | |  |
|  | *Written* | | | *Oral* |

|  |  |  |
| --- | --- | --- |
| **Additional Practice Specialties** | | |
|  |  |  |

Please complete all relevant fields.

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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
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| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |
|  | | |

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| --- | --- | --- |
| *Alternate Practice Specialty:* |  | |
| *Specialty Status:* |  |  |

|  |  |  |
| --- | --- | --- |
| **Additional Board Certifications** | | |
|  |  |  |

Please complete all relevant fields.

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |
|  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| *Board Certificate:* |  | | |
| *Certification Number:* | *Board Status:* | |  |
| *Certification Date:* | *Expiration Date:* | |  |
| *Lifetime Certified:* |  | *Recertification Date:* |  |
| *Maintenance of Certification / Osteopathic Continuous Certification:* | | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Education** |  |  |  | Click to add more. |
|  | | | | | |

Please complete all relevant fields. Note: Advanced Practice Providers (APPs) should also provide undergraduate education. Training Programs will be listed on the following page.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **ECFMG** |  | | Not Applicable |
|  |  |  | | |

Where applicable, please provide any Educational Commission for Foreign Medical Graduates details below.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Name on Certificate* | *ECFMG Number* | *Issue Date* |

|  |  |  |
| --- | --- | --- |
| **Gap Explanation** | | |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Do you have any gap in your education, work history, and/or affiliations greater than thirty (30) days? |  |  |
|  | *Yes* | *No* |

|  |  |  |
| --- | --- | --- |
| **Additional Education** | | |
|  |  |  | |

Please complete all relevant fields. Note: Advanced Practice Providers (APPs) should provide undergraduate education.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Education Type:* | *Degree Earned:* | | |  | |
| *Institution Name:* |  | | | | |
| *Address Line 1:* |  | | | | |
| *Address Line 2:* |  | | | | |
| *City:* | *State:* | | | *Zip:* |  |
| *Email:* |  | | | | |
| *Phone:* |  | *Fax:* |  | *Country (If non-U.S.):* |  |
| *From:* |  | *To:* |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Training** |  | | Not Applicable |
|  |  |  | | |

Please include all training programs, regardless of whether they were completed or not.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Program Type:* |  | | | | | | |
| *Institution Name:* | *Degree Earned:* | | | |  | | |
| *Program Director:* | *Area of Training:* | | | |  | | |
| *Address Line 1:* |  | | | | | | |
| *Address Line 2:* |  | | | | | | |
| *City:* | *State:* | | | *Zip:* | |  | |
| *Phone:* | *Fax:* | *Email:* | |  | | | |
| *Country (if non-U.S.):* | *From:* | | *To:* | *Completed:* | | |  |

If program not completed, please explain.

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Program Type:* |  | | | | | | |
| *Institution Name:* | *Degree Earned:* | | | |  | | |
| *Program Director:* | *Area of Training:* | | | |  | | |
| *Address Line 1:* |  | | | | | | |
| *Address Line 2:* |  | | | | | | |
| *City:* | *State:* | | | *Zip:* | |  | |
| *Phone:* | *Fax:* | *Email:* | |  | | | |
| *Country (if non-U.S.):* | *From:* | | *To:* | *Completed:* | | |  |

If program not completed, please explain.

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| --- |
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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Program Type:* |  | | | | | | |
| *Institution Name:* | *Degree Earned:* | | | |  | | |
| *Program Director:* | *Area of Training:* | | | |  | | |
| *Address Line 1:* |  | | | | | | |
| *Address Line 2:* |  | | | | | | |
| *City:* | *State:* | | | *Zip:* | |  | |
| *Phone:* | *Fax:* | *Email:* | |  | | | |
| *Country (if non-U.S.):* | *From:* | | *To:* | *Completed:* | | |  |

If program not completed, please explain.

|  |
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|  |  |  |  |
| --- | --- | --- | --- |
| **Practice History** |  | | Not Applicable |
|  |  |  | | |

Initial applicants, please list all places of clinical practice and/or employment, since completion of training, over the last ten years. For reappointments please list all current places of clinical practice and/or employment in the previous two years. Please begin with the most current and list in chronological order. **DO NOT include hospital or healthcare affiliations in this Section**.

|  |  |  |  |
| --- | --- | --- | --- |
| *Practice/Group Name:* |  | | |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Contact Name:* |  | |
| *Phone:* | *Email:* |  | |
| *Fax:* | *From:* | *To:* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| *Practice/Group Name:* |  | | |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Contact Name:* |  | |
| *Phone:* | *Email:* |  | |
| *Fax:* | *From:* | *To:* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| *Practice/Group Name:* |  | | |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Contact Name:* |  | |
| *Phone:* | *Email:* |  | |
| *Fax:* | *From:* | *To:* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| *Practice/Group Name:* |  | | |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Contact Name:* |  | |
| *Phone:* | *Email:* |  | |
| *Fax:* | *From:* | *To:* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital & Healthcare Affiliations** | |  | Not Applicable |
| ` |  | | | |

Initial Applicants, please list all hospital and/or accredited healthcare facility affiliations (e.g., Free Standing Facility, Ambulatory Care, Urgent Care) where you hold or have held membership and/or clinical privileges. Please begin with the most recent affiliation and list in chronological order. **DO NOT list hospitals that are part of post graduate training**. For reappointments please list all hospital and/or healthcare affiliations in the previous two years.

|  |  |  |  |
| --- | --- | --- | --- |
| *Hospital Name:* |  | | |
| *Affiliation Type:* | *Specialty:* | |  |
| *Current Status:* | *Department:* | |  |
| *Appointment Date:* | *Resignation Date:* | |  |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Phone:* | |  |
| *Email:* | *Fax:* | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| *Hospital Name:* |  | | |
| *Affiliation Type:* | *Specialty:* | |  |
| *Current Status:* | *Department:* | |  |
| *Appointment Date:* | *Resignation Date:* | |  |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Phone:* | |  |
| *Email:* | *Fax:* | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| *Hospital Name:* |  | | |
| *Affiliation Type:* | *Specialty:* | |  |
| *Current Status:* | *Department:* | |  |
| *Appointment Date:* | *Resignation Date:* | |  |
| *Address Line 1:* |  | | |
| *Address Line 2:* |  | | |
| *City:* | *State:* | *Zip:* |  |
| *Country (if non-U.S.):* | *Phone:* | |  |
| *Email:* | *Fax:* | |  |

|  |  |  |
| --- | --- | --- |
| **Peer References** | | |
|  |  |  | |

Please list the names and addresses of references as follows and based upon the definitions below:

**Professional Reference Information:**

* + Provide a minimum of 3 references
  + All references must have knowledge of your clinical competence within the last 24 months, and have known you for at least one year.
  + References **may not** include your internship, residency or fellowship program director or relatives.
  + At least one reference must be in the same professional discipline (e.g., PA/PA, APRN/APRN, MD/MD, etc.)

**Professional Peer Reference**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Reference Name:* | *Reference Type:* | |  | |
| *Contact Phone:* | *Specialty:* | |  | |
| *Contact Fax:* | *Contact Email:* |  | | |
| *Institution Name:* |  | | | |
| *Address Line 1:* |  | | | |
| *Address Line 2:* |  | | | |
| *City:* | *State:* | *Zip:* | |  |

**Professional Peer Reference**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Reference Name:* | *Reference Type:* | |  | |
| *Contact Phone:* | *Specialty:* | |  | |
| *Contact Fax:* | *Contact Email:* |  | | |
| *Institution Name:* |  | | | |
| *Address Line 1:* |  | | | |
| *Address Line 2:* |  | | | |
| *City:* | *State:* | *Zip:* | |  |

**Professional Peer Reference**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Reference Name:* | *Reference Type:* | |  | |
| *Contact Phone:* | *Specialty:* | |  | |
| *Contact Fax:* | *Contact Email:* |  | | |
| *Institution Name:* |  | | | |
| *Address Line 1:* |  | | | |
| *Address Line 2:* |  | | | |
| *City:* | *State:* | *Zip:* | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Insurance** |  | | Not Applicable |  | Click to add more. |
|  |  |  | | | | |

**Please list all carriers for the past 5 years for initial applications (including training, if applicable); for reappointments list all carriers for the past 2 years.** Provide the phone, fax and email information for the risk manager, or organization representative who can complete the verification of professional liablity. Please do not list the insurance broker. **Please attach a copy of your current malpractice certificate.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |
| --- | --- | --- |
| **Additional Insurance** | | |
|  |  |  | |

Please list all carriers for the past 5 years (including training, if applicable). Provide the phone, fax and email information for the risk manager, or organization representative who can complete the verification of professional liablity. Please do not list the insurance broker.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Carrier Name:* |  | | | | | |
| *Policy #:* | *Coverage Type:* | | | |  | |
| *Address Line 1:* |  | | | | | |
| *Address Line 2:* | *Email:* | | |  | | |
| *City:* |  | | *State:* | *Zip:* | |  |
| *Phone:* |  | | *Fax:* |  | | |
| *Effective Date:* | *Expiration Date:* | *Retroactive Date:* | | | |  |
| *Primary Per Claim Limit:* | *Primary Aggregate Limit:* | | | |  | |

|  |  |  |
| --- | --- | --- |
| **Professional Claims History** | | |
|  |  |  | |

|  |  |  |
| --- | --- | --- |
| Do you have or have you ever had any claims of malpractice which have been commenced against you, whether closed, pending, reported, settled or currently open? (For reappointments: since last reappointment only.) |  |  |
|  | *Yes* | *No* |

|  |  |
| --- | --- |
| Please indicate the number of separate claim explanations submitted with this application: |  |

**If you indicated that you have any claims, please complete a separate Professional Liability Claims Information section for each open or closed claim, beginning on the next page. If you have more than one, please copy that page for each additional claim you have.**

By signing below, you acknowledge that you have no claims to disclose or that the number of claims indicated above is correct.

|  |  |
| --- | --- |
|  |  |
| *Electronic Signature - Type full name* | *Date* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Claim Details** | |  | |  |  |  |
|  |  | |  | | | |

Please provide details below for a single claim. If you have more than one, please copy this page for each additional claim you have.

**NOTE: Explanations must be provided by the Practitioner, not the insurance company or attorney.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Claim Number |  | of |  | *Date of Alleged Incident:* |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Reporting Institution Name:* |  | | | |
| *Address Line 1:* |  | | | |
| *Address Line 2:* |  | | | |
| *City:* | *State:* |  | *Zip:* |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Action / Omission:* |  | | *Type of Payment:* |  |
| *Alternate:* |  | | *Payment Result of:* |  |
| *Report Source:* |  | | *Status:* |  |
| *Professional Liability Insurer Involved:* | |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| *Start* | *End* | *Payment Date* | *Payment Amount* | *Multiple Payments* | *Payment Total* |

*Description (Please include Policy #, Patient Age and Gender):*

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| *# of Practitioners* | *Case #* | *Court File # / Docket #* | *Judgment Date* |

*Provider Statement:*

|  |
| --- |
|  |

*Judgment Description:*

|  |
| --- |
|  |

By signing below, you acknowledge that the details provided above are accurate and complete to the best of your knowledge.

|  |  |
| --- | --- |
|  |  |
| *Electronic Signature - Type full name* | *Date* |

|  |  |  |
| --- | --- | --- |
| **Professional Liability History (including Internship, Residency & Fellowship)** | | |
|  |  |  | |

**If your answer to any of the following questions is “yes”, please provide an explanation. (For reappointments, please only answer “yes” if the event occurred in the previous two years.)**

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| 1. Are there any professional liability claims pending against you? |  |  |
| 1. Have any professional liability claims ever been filed against you? |  |  |
| 1. Have you reported any malpractice claims to your insurance carrier? |  |  |
| 1. Has any judgment been entered against you in any professional liability cases? |  |  |
| 1. Has any settlement been made in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment? |  |  |
| 1. Have you received any letters of intent to sue? |  |  |
| 1. Have you ever been denied professional liability insurance? |  |  |
| 1. Has a policy ever been canceled covering you? |  |  |
| 1. Has your professional liability insurer refused to renew you policy or placed limitation on the scope of your coverage? |  |  |
| 1. Are any privileges excluded on your policy? |  |  |

|  |  |  |
| --- | --- | --- |
| **Practice History/Disclosure Information** | | |
|  |  |  | |

**If your answer to any of the following questions is “yes”, please provide an explanation. (For reappointments, please only answer “yes” if the event occurred in the previous two years.)**

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| 1. Regarding your license to practice your profession: Has your license application ever been withdrawn or denied? |  |  |
| 1. Has your license ever been voluntarily or involuntarily limited, reduced, restricted, suspended, revoked, surrendered, relinquished, not renewed, or such actions pending? |  |  |
| 1. Has the relevant licensing board ever placed your license on probation, issued a disciplinary action or non-disciplinary action, an Assurance of Compliance, required monitoring, counseling or additional educational training, or censured you for matters having to do with professional practice, or are any such actions pending? |  |  |
| 1. Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board, or are any such actions pending? |  |  |
| 1. Have you ever been fined by a medical licensing board, or are any such actions pending? |  |  |
| 1. Have you ever been, or are you currently, under investigation or involved in any proceeding involving your practice before any state licensing board? |  |  |
| 1. Have you ever been denied membership or clinical privileges at any hospital, other health care facility, or managed care organization? |  |  |
| 1. Have you ever withdrawn an application for membership or request for clinical privileges at any hospital, other health care facility or managed care organization before a decision was made thereon? |  |  |
| 1. Has your hospital, other health care facility, or managed care organization membership or clinical privileges ever been voluntarily limited, reduced, restricted, suspended, revoked, surrendered, relinquished, or not renewed, or are any such actions pending? |  |  |
| 1. Have you ever been the subject of disciplinary action and/or a hearing under any set of medical staff bylaws managed care organization policies or resigned from a medical staff or provider panel in lieu of, or during, a disciplinary action and/or a hearing, or are any such actions pending? |  |  |
| 1. Has any hospital, other health care facility, or managed care organization ever, in connection with your membership and clinical privileges, placed you on probation, issued a written reprimand, required monitoring, counseling, a leave of absence or additional educational training, or any such actions pending? |  |  |
| 1. Have you ever been reported to the National Practitioner Data Bank by any individual or organization for any reason? |  |  |
| 1. Have you ever been denied a state or federal registration to prescribe controlled substances? |  |  |
| 1. Is any registration to prescribe controlled substances currently under investigation? |  |  |
| 1. Has any registration to prescribe controlled substances ever been voluntarily or involuntarily limited, reduced, restricted, suspended, revoked, surrendered, relinquished, not renewed, subjected to probationary terms, or are any such actions pending? |  |  |
|  |  |  |
| 1. Have you ever been placed on probation or asked to resign and internship, residency, or fellowship training program or academic appointment? |  |  |
| 1. Have you ever been denied membership in or renewal thereof, or been subject to disciplinary action by, any medical organization, or are any such actions pending? |  |  |
| 1. Have you ever been sanctioned by a specialty board or has your specialty or subspecialty certification ever been voluntarily or involuntarily limited, reduced, restricted, suspended, revoked, surrendered, relinquished, or have you failed to recertiy, or are any such actions pending? |  |  |
| 1. Has your ability to participate in the Medicare or Medicaid programs ever been suspended or terminated or have you ever been threatened with exclusion or debarment from either program, or are any such actions pending? |  |  |
|  | *Yes* | *No* |
| **Have you ever been charged by any local, state or federal authority, official or agency, plead guilty to, or been convicted of, any of the following:** |  |  |
| 1. Crimes or offenses related to the delivery of medical services or other health care items under the Medicare and Medicaid programs? |  |  |
| 1. Crimes or offenses related to the abuse or neglect of patients in connection with the delivery of healthcare? |  |  |
| 1. Crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in the whole or in part by any federal, state or local government? |  |  |
| 1. Obstruction of justice? |  |  |
| 1. Crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substances? |  |  |
| 1. Any other crimes or offenses (including misdemeanors other than parking tickets)? |  |  |
| 1. Have you ever entered into a integrity agreement with a government agency or been assessed a civil monetary penalty for false or fraudulent submittal of claims for payment, or other violation of billing practice standards, or are any such actions pending? |  |  |

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| **Health Status\*\*** | | |
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**If your answer to any of the following questions is “yes”, please provide an explanation in full.**

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |
| 1. Is there any reason, physical, mental, or substance abuse related, that could impede your ability to carry out the obligations and prerogatives of the professional position for which you are applying, perform the clinical privileges that you are requesting, and provide care according to accepted standards of professional performance, with or without reasonable accommodation, and without exposing yourself or others to health and safety risks? |  |  |
| 1. Are you currently engaged in the illegal use of drugs? |  |  |

\*\*Regardless of how the health status questions are answered, the application will be processed in the usual manner. If there is an affirmative response and the practitioner is found to be professionally qualified for Medical Staff appointment or professional membership, with clinical privileges requested, then the practitioner will be given the opportunity to meet with any credentialing body of entities to determine what accommodations are necessary and/or feasible to allow the practitioner to practice safely.

\*Job offers and/or staff privileges/membership may be contingent upon the successful completion of a pre-employment and/or appointment/membership medical exam.

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| **Application Attestation** | | |
|  |  |  | |

I represent that I have personally completed this application or have reviewed the completed application. I acknowledge that any material misstatements in or omissions from this application may be grounds for the rejection of my application and the refusal to consider any future applications. **I represent that all the information submitted by me in this application is complete and correct to the best of my knowledge.**

I agree that I must immediately notify the individual entities to which I am applying if there is any change in the status of any condition that would alter response(s) to any questions asked in this application or if any new condition develops which would be covered in this application.

**A copy of this original statement as signed by me shall have all the same force and effect as the signed original.**

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| --- | --- | --- |
|  |  |  |
| *Electronic Signature -Type full name* | *Last 4 digits of SSN* | *Date* |