Uniform Credentialing Application

Applica	pplicant Name (as shown on your state license):							
	Last	First		Middle	Suffix	Title		
CREDI	ENTIALING CONTACT INFOR	MATION						
Name				Phone Number				
Addres	ss			Fax Number				
				E-mail				
The cre more sp	dentialing application and attace is needed than provided of abbreviations when completing	on the application, please	attach additional sheets	and reference t	he question being a			
Current	ist (please complete): copies of the following docum , please forward application ar			ur application for	DEA and/or malpr	actice insurance are		
	Drug Enforcement Administra	ation Registration with corr	ect address (if applicable	e)				
	ECFMG certificate (if educate	ed outside of U.S. or Cana	da)					
	Disclosure Explanation Form	and supporting documen	tation (if applicable)					
	Professional liability insurance	e documentation (as defin	ed on page 11)					
	If not a U.S. citizen, copy of o	fficial document(s) indicat	ing authorization to work	in the United Sta	ates			
	Curriculum Vitae (all applicat	ion items must be complet	red)					
	Advanced Practice Registere	d Nurses: Board certificat	ion					
<u>In additi</u>	on, please verify that you have	:						
	Provided complete street add hospital and ambulatory surg	dress, phone, fax and e-matery center affiliations, and	ail addresses wherever I professional/peer refer	indicated, includi ences	ng education/trainir	ng, past employment,		
	Designated dates by month,	day and year time frames						
	Explained all gaps of greater	than three months in chro	nology wherever indicate	ed, including edu	cation/training and	past employment		
	Provided list of all insurance	policies you have held for	the past 5 years (Page 1	11)				
	Answered all of the Disclosur	e Questions on Page 13 a	nd completed the Disclo	sure Explanation	n Form for any affirm	mative answers		
	Signed and dated the Attesta	tion Signature and Date st	tatement (Page 16)					
П	Signed and dated the Author	zation and Release (Page	- · - 17)					

All Information Must Be Printed in Black Ink or Electronically Generated

Practitioner Name:	Last	First	Middle	Suffix	Title
Practitioner NPI:	Last		Wilde	Gullix	THIC
	Pro	actitioner Race o	and Ethnicity		
Door and other	aitu (far baaltb pla	anl			
	city (for health pla ormation is optional ar	nd may be used in pro	vider directories to he	elp members ma	ke informed
		r network of providers is			
Race (Select all th	nat apply):				
☐ American India	an or Alaskan Native				
☐ Asian					
☐ Black or Africa	an American				
☐ Middle Easterr	n or North African				
☐ Native Hawaiia	an or Other Pacific Islander				
☐ White					
Other (please	specify):				
☐ Prefer Not to S	Зау				
<u>Ethnicity</u>					
☐ Hispanic or La	itino				
☐ Non-Hispanic	or Latino				
☐ Prefer Not to S	Say				
Dua vielina una a	atlaniaitus and Janessa	us information on the	avadantialina, annlia	atian ia antinali.	antional and
refusal to provide	e this information will	ge information on the ' not subject you to ad	dverse treatment. We		
credentialing deci	sions on an applicant	's race, ethnicity, or lan	guage.		
information in pro	vider directories or in	oplication, the health internal resources to h adequate to meet the	elp members make in	formed choices	
Check here if yo	ou do not wish for yo	our race and ethnicity	to be displayed in pr	ovider director	ies:

Applicant Name (as shown on your state license): First Middle Suffix All Former Aliases: ______ Spouse Name (optional): _____ Gender: M - Male F - Female X - Unspecified or Another Gender Identity U - Undisclosed U.S. Citizen: Yes No Birthplace City: _____ State: ____ Country: ____ Date of Birth: _____ Social Security Number: _____ NPI: ____ Current Home Address: City/State/Country Zip Code Local Home Address (if different from above): City/State/Country Zip Code Preferred Mailing Address: Office Home Practitioner's Preferred E-mail address: Home Phone Number: _____ Cell Phone Number: ____ Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? $\ \square$ Yes $\ \square$ No If yes, specify languages: Military - Are you currently on active military duty? \square Yes \square No Primary or Pending Practice Location Primary Practice Location/Clinic Name: Address: City/State/Country Zip Code Office Phone Number: _____ Fax: _____ E-mail: _____ Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based ☐ Moonlighting Resident ☐ Other: _____ Services provided via (select all applicable): ☐ Telehealth ☐ In-Person Regularly sees patients here at least once per week: \square Yes \square No Primary Specialty in which care will be provided: Subspecialty(ies) 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 Fax Number: Office Phone Number:

E-mail address:

Personal Data

Additional Current or Future Practice Location(s	s) Applicant Name:
Please make additional copies as necessary	
1. Other Practice Name:	
Address:Street	City/State/Country Zip Code
	E-mail:
Federal Tax ID: Type II NPI:	Start Date (at this location):
Credentialing Contact:	Phone Number:
Practicing as (select all applicable): ☐ Primary Care ☐ Spec	cialist Urgent Care Locum Tenens Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other:	Services provided via (select all applicable): ☐ Telehealth ☐ In-Person
Accepting New Patients:	∵ □ Yes □ No
Regularly sees patients here at least once per week:	□ No
Primary Specialty in which care will be provided:	
Subspecialty(ies) in which care will be provided:	
2. Other Practice Name:	
Address:	
Street Office Phone Number: Fax:	City/State/Country Zip Code E-mail:
	Start Date (at this location):
	Phone Number:
Practicing as (select all applicable): ☐ Primary Care ☐ Spec	cialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other:	•
Accepting New Patients:	: ☐ Yes ☐ No
Regularly sees patients here at least once per week:	□ No
Primary Specialty in which care will be provided:	
Subspecialty(ies) in which care will be provided:	
3. Other Practice Name:	Phone Number:
Address:	
Street	City/State/Country Zip Code E-mail:
	Start Date (at this location):
	Phone Number:
Practicing as (select all applicable): ☐ Primary Care ☐ Spec	cialist 🔲 Urgent Care 🔲 Locum Tenens 🔲 Hospitalist/Hospital-Based
☐ Moonlighting Resident ☐ Other:	Services provided via (select all applicable): ☐ Telehealth ☐ In-Person
Accepting New Patients:	s: 🗆 Yes 🗀 No Regularly
sees patients here at least once per week: \square Yes \square No Pri	imary Specialty in which care
will be provided:	- · · · · · · · · · · · · · · · · · · ·
Subspecialty/ies) in which care will be provided:	

Education -	Medica	I/Graduate	e/Prof	essional
Euucanon -	Meuica	ı/Grauuau	E/PIUI	essiuliai

fonth, day, year required)	☐ Undergraduate	☐ Masters	☐ PhD	☐ Medical	☐ Dental	☐ Other Post-Graduate
From	Institution Name:					
- o						
	Address:					
	Street			City/State/Co	-	Zip Code
	E-mail address:					
	☐ Undergraduate			☐ Medical		
From	Institution Name:					
ō	Degree Received:			Area	a of Study:	
	Address:Street			City/State/Co	untry	Zip Code
					lumber:	
	E-mail address:					
Check here if you have	additional Medical/Graduate	/Professional	Education	on attached Ed	ducation/Trair	ning Addendum (page 18)
or wo rumber.		Date 13.		(month/day/yor	ar)	
				(IIIOIIII/day/yea	<i>,</i>	
nternship/Post-Grad	luate/Professional Tra	ining (if app	licable)	(попшисауу уег	,	
nternship/Post-Grad	luate/Professional Tra	ining (if app	licable)	(попилиау/уег		
nternship/Post-Grad Additional space is provide Month, day, year required)		ining (if app Addendum, p	licable) page 18.			
nternship/Post-Grad Additional space is provide Month, day, year required) From:	ed on the Education/Training	ining (if app	licable) page 18.			
Additional space is provide Month, day, year required)	ed on the Education/Training Institution Name: Type of Program/Specialty	ining (if app Addendum, p	licable) page 18. rotating, 5th	າ pathway, etc):	
Internship/Post-Grad Additional space is provide (Month, day, year required) From:	ed on the Education/Training Institution Name: Type of Program/Specialty	ining (if app Addendum, p (transitional,	rotating, 5th	n pathway, etc): ate:	
Internship/Post-Grad Additional space is provide (Month, day, year required) From:	ed on the Education/Training Institution Name: Type of Program/Specialty Completed Training:	Addendum, p r (transitional, res \square No If red, explain: _	rotating, 5th	n pathway, etc	.): ate:	
Additional space is provide Month, day, year required)	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director:	Addendum, p r (transitional, res \square No If red, explain: _	rotating, 5th	n pathway, etc	.): ate:	
Internship/Post-Grad Additional space is provide (Month, day, year required) From:	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address:	ining (if app Addendum, p (transitional, Tes No If r ed, explain:	rotating, 5th	n pathway, etc	.):ate:	Zip Code
Internship/Post-Grad Additional space is provide (Month, day, year required) From:	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address:	ining (if app Addendum, p (transitional, Tes No If r ed, explain:	rotating, 5th	n pathway, etc	.):ate:	
Internship/Post-Grad Additional space is provide (Month, day, year required) From:	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address:	ining (if app Addendum, p (transitional, es \(\sum \) No If r ed, explain: _	rotating, 5th	n pathway, etc	.):ate:	Zip Code
Additional space is provide (Month, day, year required) From: To: Time Gaps: Explain ga	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address: Street Phone Number: E-mail address: ps/interruptions of greater tha	ining (if app Addendum, p (transitional, es \sum No If r ed, explain: _	licable) page 18. rotating, 5th	n pathway, etc	.): ate: untry lumber:	Zip Code
Additional space is provide (Month, day, year required) From: To: Time Gaps: Explain gap provided on the Education.	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address: Street Phone Number: E-mail address:	ining (if app Addendum, p (transitional, es \sum No If r ed, explain: _	licable) page 18. rotating, 5th	n pathway, etc	.): ate: untry lumber:	Zip Code
Additional space is provided (Month, day, year required) From: To: Time Gaps: Explain gap or ovided on the Education. (Month, day, year required)	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address: Street Phone Number: E-mail address: ps/interruptions of greater tha	Addendum, p Addendum, p (transitional, es No If r ed, explain: an three (3) m 8.	onths before	City/State/Co	nte: untry Jumber:	Zip Code /Training. Additional space i
Additional space is provide (Month, day, year required) From: To: Time Gaps: Explain gap provided on the Education (Month, day, year required) From:	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address: Street Phone Number: E-mail address: ps/interruptions of greater that Training Addendum, page 1	Addendum, p Addendum, p (transitional, es No If r ed, explain: _ an three (3) m 8.	onths before	city/State/Co	nte: untry Jumber:	Zip Code /Training. Additional space i
Additional space is provide (Month, day, year required) From: To: Time Gaps: Explain gal provided on the Education (Month, day, year required) From: [Month, day, year required] From: To:	Institution Name: Type of Program/Specialty Completed Training: Y If not successfully complet Program Director: Address: Street Phone Number: E-mail address: ps/Interruptions of greater that Training Addendum, page 1 Explain:	Addendum, provided in the control of	rotating, 5th	city/State/Co	nte:	Zip Code /Training. Additional space i
Internship/Post-Grade Additional space is provide (Month, day, year required) From: To: Time Gaps: Explain gap provided on the Education (Month, day, year required) From: To: To: From:	Institution Name: Type of Program/Specialty Completed Training: If not successfully complet Program Director: Address: Street Phone Number: E-mail address: ps/interruptions of greater that Training Addendum, page 1 Explain:	Addendum, provided the control of th	rotating, 5th	n pathway, etc	ate: untry lumber:	Zip Code /Training. Additional space i

Page 5 of 23

Residency/Post-Graduate/Professional Training

Applicant Name:

Additional space is provide (Month, day, year required)	ed on the Education/Training Addendun	n, page 18.					
From:	Institution Name:						
To:							
	If not successfully completed, explain	1:					
	Program Director:						
	Address:Street						
		City/State/Country	Zip Code				
	Phone Number:	Fax Number:					
	E-mail address:						
From:	Institution Name:						
To:	Type of Program/Specialty:						
	Completed Training: ☐ Yes ☐ No	If no, expected completion date:					
	If not successfully completed, explain	n:					
	Program Director:						
	Address:	City/State/Country	Zip Code				
		Fax Number:	•				
From:	Institution Name:						
To:							
		If no, expected completion date:					
		n:					
	Address:						
	Street	City/State/Country	Zip Code				
	Phone Number:	Fax Number:					
	E-mail address:						
	ps/interruptions of <u>greater than three (3</u> n/Training Addendum, page 18.) months before, during or after Residency Traini	ng. Additional space is				
(Month, day, year required)	, rraining / tagoriaani, pago 10.						
From:	Explain:						
To:							
From:							
_							

☐ Check here if you have additional time gap information on attached Education/Training Addendum (page 18)

Fellowship/Post-Graduate/Professional Training

Applicant Name:

(Month, day, year						
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:	Fax Number:				
	E-mail address:					
From:	Institution Name:					
To:	Type of Program/Specialty:					
		no, expected completion date:				
	If not successfully completed, explain: _					
	Program Director:					
	Address: Street City/State/Country Zip					
	Street	City/State/Country	Zip Code			
	Phone Number:	Fax Number:				
	E-mail address:					
Professional	and Academic/Faculty Affiliations					
Month, day, year	r required)					
From:	Institution Name:					
Го:	Appointment Held/Position:					
	Address:					
	Street	City/State/Country	Zip Code			
	Phone Number:	Fax Number:				
	E-mail address:					
Ti 0						
	xplain gaps/interruptions of <u>greater than three (3) r</u> ional space is provided on the Education/Training		ning/Academic			
(Month, day, year	r required)					
From:	Explain:					
То:						
From:	Explain:					
_						
-						

Page 7 of 23

Additional space is provided on the Chronological Employment/Practice History Addendum, page 19.

Chronological listing of employment/practice history since completion of your post-graduate training.

List *all* experience, including military 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**.

(Month, day, year required))						
From:	Organization Name:						
To:	Title/Position:						
	Reason for Leaving:						
	Employment Contact		Clinic Still Open?	If no, attach sheet listing address and phone number of someone who can verify your time there.			
	Address:	City/State/Country		Zip Code			
	Phone Number:		_Fax Number:				
	E-mail address:						
From:	Organization Name:						
To:	Title/Position:						
	Reason for Leaving:		_				
	Employment Contact		Clinic Still Open?	If no, attach sheet listing address and phone number of someone who can verify your time there.			
	Address:	City/State/Country		Zip Code			
	Phone Number:		Fax Number:				
	E-mail address:						
From:	Organization Name:						
To:	Title/Position:						
	Reason for Leaving:		1	1			
	Employment Contact		Clinic Still Open?	If no, attach sheet listing address and phone number of someone who can verify your time there.			
	Address:						
	Street	City/State/Country		Zip Code			
	Phone Number:		_Fax Number:				
	E-mail address:						
\square Check here if you have	additional employment history on att	tached Chronological Employ	ment/Practice History	/ Addendum (page 19)			
	ps/interruptions of <u>greater than three (</u> Chronological Employment/Practice H ()	-	· ·	sional practice. Additional			
From:	Explain:						
To:							
From:	Explain:						
To:							
☐ Check here if you have	additional time gap information on a	ttached Chronological Emplo	yment/Practice Histor	ry Addendum (page 19)			

P	rimar	v Hos	pital	Affiliation	ì

	ting privileges, describe method/cove						
(Month, day, year required,							
From:	Facility Name:						
Го:	Type/category of privilege/affiliation (active, courtesy, etc.):						
☐ Application Pending	Department Chairperson:						
	Address:						
	Address: Street	City/State/Country	Zip Code				
	Phone Number:	Fax Number:					
	E-mail address:						
Admitting Privileges:	☐ Yes ☐ No (If no, please complete b	ox above)					
Other Hospital and A	Ambulatory Surgery Center Affiliati	ons - Present and past affiliations begi	nning with most recent.				
Additional space is provide (Month, day, year required	ed on the Hospital/ASC Affiliation Addendum,	page 20.					
From:	Facility Name:		Facility Still Open?				
Го:	Former Facility Name (if applicable):		Yes No				
	Type/category of privilege/affiliation (active	, courtesy, etc.):					
☐ Application Pending	Department Chairperson:						
	Address:						
	Street	City/State/Country	Zip Code				
	Phone Number:	Fax Number:					
	E-mail address:						
Admitting Privileges:	☐ Yes ☐ No (If no, please complete b	ox above)					
From:	Facility Name:						
ō:	Former Facility Name (if applicable):		Facility Still Open?				
0.							
7	Type/category of privilege/affiliation (active	,					
Application Pending	Department Chairperson:						
	Address:Street	City/State/Country	Zip Code				
	Phone Number:	Fax Number:					
	E-mail address:						
Admitting Privileges:	☐ Yes ☐ No (If no, please complete b						

,		led on the Specialty and l			ur efforts and eligibility, including
scheduled	d date of exa	am, past failures of w	ritten or oral exam	ns, if any.	
					:
•				•••••	
Primary Spe	=				
				_	
Secondary S	Specialty:			octunicate i chaing 🗖	
Certificate No	umber:			Original Certificate Date:	
Expiration Da	ate:			Certificate Pending \square	
Additional S Board Name:					
Board Sub-sp	pecialty:				
Certificate No	umber:			Original Certificate Date:	
Expiration Da	ate:			Certificate Pending \square	
Additional S Board Name					
Board Sub-sp	pecialty:				
				_	
Expiration Da	ate:			Certificate Pending \square	
☐ Check he	re if you have	additional specialty on at	tached Specialty and	Licensure Addendum (page	21)
Licensure	- List all past,	current and pending prof	essional licenses.		
Additional sp	ace is provide	d on the Specialty and Li	censure Addendum,	page 21.	
License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					_
					_ Active
					_ Active Inactive Pending
			_		_ Active Inactive Pending
					☐ Active ☐ Inactive ☐ Pending
			_		☐ Active ☐ Inactive ☐ Pending
			_		_ Active
					_ Active
					_ Active

 \Box Check here if you have additional licensure on attached Specialty and Licensure Addendum (page 21)

	st be in the state(s) where you will be pra	cticing as applicable to this application.
. ,	.,	Expiration Date:
Approved for all schedules?	<u></u>	
		Expiration Date:
Approved for all schedules?		
DEA Number:		Expiration Date:
Approved for all schedules?		
DEA Number:		
Approved for all schedules?	<u></u>	
DEA Number:	,	Expiration Date:
Approved for all schedules?	<u></u>	
f you do not maintain a DEA certificate, p	olease explain:	
		ed to DEA:
If you do not have a DEA with an a of the practitioner at your facility	address in the state in which you w with a valid DEA certificate in that you have a valid DEA certificate in	rill be practicing, you must provide state that will write all controlled s
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until	address in the state in which you w with a valid DEA certificate in that you have a valid DEA certificate in	rill be practicing, you must provide state that will write all controlled s n that state.
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until	address in the state in which you w with a valid DEA certificate in that I you have a valid DEA certificate in fication/Registration (If applicable - n	vill be practicing, you must provide state that will write all controlled s n that state. ot applicable to MN, WI, ND).
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	vill be practicing, you must provide state that will write all controlled so that state. ot applicable to MN, WI, ND). Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	ot applicable to MN, WI, ND). Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the property of the property o	ot applicable to MN, WI, ND). Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until state Controlled Substance Certification By: State By:	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the property of the property o	ot applicable to MN, WI, ND). Expiration Date: Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until state Controlled Substance Certification By: State By:	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	ot applicable to MN, WI, ND). Expiration Date: Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until state Controlled Substance Certification State Controlled Substance Certification Life Support Certification Do you have any current life support certification	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	ot applicable to MN, WI, ND). Expiration Date: Expiration Date: Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until state Controlled Substance Certification State Controlled Substance Certification Life Support Certification Do you have any current life support certification	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	ot applicable to MN, WI, ND). Expiration Date: Expiration Date: Expiration Date: Expiration Date:
If you do not have a DEA with an a of the practitioner at your facility prescriptions on your behalf until state Controlled Substance Certification State Controlled Substance Certification Life Support Certification Do you have any current life support certification	address in the state in which you we with a valid DEA certificate in that I you have a valid DEA certificate in the state	ot applicable to MN, WI, ND). Expiration Date: Expiration Date: Expiration Date: Expiration Date:

Coverage dates:

Applicant Name:

Insurance Carrier for Primary and/or Pending Practice Location and 5-year insurance history.

Enclose a copy of professional liability insurance coverage (e.g., certificate of insurance, face sheet, or verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

art:			
pire:	_ Address:Street	City/State/Country	Zip Code
	Phone Number:	Fax Number:	
	E-mail address:		
Certificate Pending	Name in which policy issued:		
	Policy number (if applicable):		
	Amount of coverage (per occurrence):		
	Amount of coverage (per aggregate):		
onth, day, year required)			
onth, day, year required)	the Federal Tort Claims Act, attach a copy of the fed	ioral tort lotter and provide applic	able dates of sove
art:	Insurance Carrier Name:		
pire:	_ Address:Street	City/State/Country	Zip Code
	Phone Number:	•	·
	E-mail address:		
	Name in which policy issued:		
	Name in which policy issued: Policy number (if applicable):		
	Policy number (if applicable):		
	Policy number (if applicable): Amount of coverage (per occurrence):		
	Policy number (if applicable):		
art:	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate):		
art: pire:	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address:		
	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address: Street	City/State/Country	Zip Code
	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address: Street Phone Number:	City/State/CountryFax Number:	Zip Code
	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address: Street Phone Number: E-mail address:	City/State/Country Fax Number:	Zip Code
	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address: Street Phone Number: E-mail address: Name in which policy issued:	City/State/CountryFax Number:	Zip Code
	Policy number (if applicable):	City/State/CountryFax Number:	Zip Code
	Policy number (if applicable): Amount of coverage (per occurrence): Amount of coverage (per aggregate): Insurance Carrier Name: Address: Street Phone Number: E-mail address: Name in which policy issued:	City/State/CountryFax Number:	Zip Code

☐ Check here if you have additional Liability Insurance on attached Liability Insurance Addendum (page 22)

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Professional/Peer References

Applicant Name:

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, 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.). **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, phone, fax and e-mail**. 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:			
	Street	City/State/Country	Zip Code
Phone Number:		Fax Number:	
E-Mail Address:			
Name:		Title:	
Facility Name:			
	Street		
	Street	City/State/Country	Zip Code
Phone Number:		Fax Number:	
E-Mail Address:			

Disclosure Quest	ions for initial Credentialing Applicant Name:
	ign this form, attesting to its accuracy. If any of the following questions are answered in the affirmative, provide an explanation by sure Explanation Form on the following page.
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? If so, provide details to include the reason for the investigation and the results on the following page.
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 you 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 pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?
11. □ Yes □ No	Have you ever been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in sexual harassment , sexual misconduct , stalking , or any other similar behavior or crime , or are you aware of any current allegations or charges pending of the same? <i>Allegations include</i> , but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.
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 judgments?
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 currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.
16. □ Yes □ No	Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?
	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 e, true and accurate while my application is being processed. I understand that the race, ethnicity, and language information I
that it remains complete	neld) on this application is optional and will not be used as basis for credentialing decisions or lead to discrimination.
that it remains complete have provided (or with	
that it remains complet have provided (or withh All signatures and da	neld) on this application is optional and will not be used as basis for credentialing decisions or lead to discrimination.

CONFIDENTIAL INFORMATION If you answered **yes** to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). Make additional copies of this form if needed. Applicable Disclosure Question(s): _____ Date of Occurrence: _____ Location of Occurrence: Facility (if applicable) Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative. Do **not** include name of patient or any other information that may identify a patient. Describe outcome, as applicable. Note: If responding to disclosure question #12, skip this section and complete next section. If you answered yes to Disclosure Question #12, complete the following section. **Describe Outcome of Claim or Lawsuit** Date Filed: CONCLUDED WITH NO PAYMENTS: (month/year) CONCLUDED WITH PAYMENTS: (month/year) Date:_____ Amount \$_____ Date:____ ☐ Verdict for Plaintiff ☐ Dropped/Closed Date: ☐ Settled Date:_____ Amount \$___ ☐ Verdict for you ☐ Dismissed with prejudice* PENDING Date:_____ ☐ Dismissed without prejudice** Date:_____ ☐ Filed, pending Date:_____ *Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim *Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim Represented by Legal Counsel for this lawsuit: \square Yes \square No - If yes, provide name and address of counsel. Counsel Name _____ Phone _____ Insurance company or employer that provided coverage for this claim. I hereby certify that all the information on this form is complete, true and accurate. Applicant Signature Date

Print Name

Phone___

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 organizational policy and/or applicable 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.

To check the status of your application, contact the applicable organization or go to the organization's website.

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

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 only <u>one</u> 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 in true and accurate.	formation on this application, including the Disclosure Questions, and I certify it is complete,
Signature	Date
	ble or signed with a unique electronic identifier.
Hardeda Adda adadia a Ciana adama and Bada	
Update Attestation Signature and Date	•
I have reviewed and updated all of the in true and accurate.	formation on this application, including the Disclosure Questions, and I certify it is complete,
Signature	Date
All signatures and dates must be clearly legi	ble or signed with a unique electronic identifier.
Update Attestation Signature and Date	•
I have reviewed and updated all of the in true and accurate.	formation on this application, including the Disclosure Questions, and I certify it is complete,

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

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Medicare/Medicaid and Other Government Reimbursement Programs Penalty Statement:

This statement is required by Medicare/Medicaid and other government reimbursement programs.

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

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/MEDICAID AND OTHER GOVERNMENT REIMBURSEMENT PROGRAM 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.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature:	Date:	
Name:		

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 any applicable 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.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature: Di	ate:

Signature/DEA Verification

Name:

All signatures and dates must be clearly legible or signed with a unique electronic identifier.		
Signature:	Date:	
Name:	DEA Number:	
Office Address:	Specialty:	
Phone Number:		

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

Authorization and Release

Please read the below information carefully before signing.

1 10	ase read the below information carefully before signing.
"Pa res	derstand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as rticipation") athereafter referred to as Entity), it is my ponsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.
	rther acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the ity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.
limi the	rther understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without tation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information shange 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.
l un	derstand that communication regarding my application may occur via email.
Ent law	nderstand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the ity, 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 or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for mination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the ity.
	knowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and Agents are done to achieve, maintain and improve quality patient care.
mis	information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material statement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and nowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.
	rther acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release III be as effective as the original.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Please make additional copies of this Addendum as necessary. Check the appropriate box and complete the following information for each level of education that is relevant to your Medical/Graduate/ Professional Education. ☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate (Month. dav. vear required) Institution Name: From Degree Received: _____ Area of Study: ____ Address: Street City/State/Country Zip Code Fax Number: _____ Phone Number: ____ E-mail address: Training (Internship/Residency/Fellowship/Professional) Addendum (Month, day, year required) 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 ____ Fax Number: ____ Phone Number: E-mail address: Institution Name: From: 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: Fax Number: E-mail address: Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Education/ Training. (Month, day, year required) From: _ Explain: ___ Explain: ___ From: Explain: ___

Applicant Name:

Education (Medical/Graduate/Professional) Addendum

Chronological Employment/Practice History Addendum Applicant Name: Please make additional copies of this Addendum as necessary. (Month, day, year required) Organization Name: To: Title/Position: Reason for Leaving: If no, attach sheet listing address Clinic Still Open? Employment Contact and phone number of someone who ☐ Yes ☐ No can verify your time there. Address: City/State/Country Zip Code Street Fax Number: ____ Phone Number: ___ Organization Name: ___ Title/Position: To: Reason for Leaving: Clinic Still Open? If no, attach sheet listing address and phone number of someone who Employment Contact ☐ Yes ☐ No can verify your time there. Address: _ City/State/Country Street Zip Code Phone Number: Fax Number: E-mail address: From: Organization Name: Title/Position: To: Reason for Leaving: If no, attach sheet listing address Clinic Still Open? **Employment Contact** and phone number of someone who ☐ Yes ☐ No can verify your time there. Address: __ City/State/Country Zip Code Phone Number: Fax Number: ___ E-mail address: **Time Gaps:** Explain gaps/interruptions of greater than three (3) months before, during, or after medical/professional practice. (Month, day, year required) Explain: To: Explain: From:

Explain:

Hospital/ASC Affiliation Addendum

Applicant Name:

(Month, day, year required)			
From:	Current Facility Name:		Facility Still Open?
To:	Former Facility Name (if applicable):		Yes No
	Type/category of privilege/affiliation (active, co	urtesy, etc.):	
☐ Application Pending	Department Chairperson:		
	Address:Street	City/State/Country	Zip Code
	Phone Number:		·
	E-mail address:		
Admitting Privileges:	☐ Yes ☐ No (If no, please complete box		
From:	Current Facility Name:		
To:	Former Facility Name (if applicable):		Facility Still Open? Yes No
	Type/category of privilege/affiliation (active, co	urtesy, etc.):	
☐ Application Pending	Department Chairperson:		
	Address:	City/State/Country	Zip Code
	Phone Number:		•
	E-mail address:		
Admitting Privileges:	☐ Yes ☐ No (If no, please complete box		
From:	Current Facility Name:		
To:	Former Facility Name (if applicable):		Facility Still Open? Yes No
	Type/category of privilege/affiliation (active, co	urtesy, etc.):	
☐ Application Pending	Department Chairperson:		
	Address:	City/State/Country	Zip Code
	Phone Number:		•
	E-mail address:		
Admitting Privileges:	☐ Yes ☐ No (If no, please complete box		
From:	Current Facility Name:		
То:	Former Facility Name (if applicable):		Facility Still Open? Yes No
	Type/category of privilege/affiliation (active, co	urtesy, etc.):	
☐ Application Pending	Department Chairperson:		
	Address:Street	City/Chata/Carrature	7in Cada
	Street Phone Number:	City/State/Country	Zip Code
	E-mail address:		
Admitting Privileges:	☐ Yes ☐ No (If no, please complete box		

Specialty and Licensure Addendum

Applicant Name:

Please make additional copies of this Addendum as necessary. **Specialty/Subspecialty Certification** Additional Specialty Board Name: Board Specialty: _ Original Certificate Date: ___ Certificate Number: ___ Certificate Pending Expiration Date:_ Additional Specialty Board Name: _ Board Specialty: _ __ Original Certificate Date: ___ Certificate Number: ___ Certificate Pending Expiration Date: _ Additional Specialty Board Name: _ Board Specialty: ___ Original Certificate Date: Certificate Number: __ _____Certificate Pending 🛘 Expiration Date: _ Additional Specialty Board Name: _ Board Specialty: ___ Original Certificate Date: ___ Certificate Number: ___ $_{--}$ Certificate Pending \square Expiration Date: __ **State Licensure** Expiration Date License Type State License Number Date Issued License Status ☐ Active ☐ Inactive ☐ Pending ☐ Active ☐ Inactive ☐ Pending

Please make additional copies of this Addendum as necessary.

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships. Specify dates of coverage for each policy.

For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage. (Month, day, year required)

Start:	Insurance Carrier Name:		
Expire:	Address:		
	Street	City/State/Country	Zip Code
	Phone Number:	Fax Number:	
	E-mail address:		
	Name in which policy issued:		
	Policy number (if applicable):		
	Amount of coverage (per occurrence):		
	Amount of coverage (per aggregate):		
itart:	Insurance Carrier Name:		
xpire:	Address:		
	Street	City/State/Country	Zip Code
	Phone Number:	Fax Number:	
	E-mail address:		
	Name in which policy issued:		
	Policy number (if applicable):		
	Amount of coverage (per occurrence):		
	Amount of coverage (per aggregate):		
tart:	Insurance Carrier Name:		
xpire:	Address:		
	Street	City/State/Country	Zip Code
	Phone Number:	Fax Number:	
	E-mail address:		
	Name in which policy issued:		
	Policy number (if applicable):		
	Amount of coverage (per occurrence):		
	Amount of coverage (per aggregate):		