IOWA STATEWIDE UNIVERSAL PRACTITIONER CREDENTIALING APPLICATION

NAME: _____
Last Name **First Name** **Middle Name** **Title**

- **Type or print responses in ink.**
- **Complete this form in its entirety and attach all requested documentation and explanations.**
- **A CV or "See CV" may not be used in lieu of completing any answers on this application.**
- **If a question does not apply to you, answer with "Non-Applicable" or "N/A".**
- **If additional space is necessary to provide answers, attach additional sheet(s) of paper.**
- **All dates must be formatted as: Month/Date/Year (MM/DD/YEAR) Type/print "present" in Ending Date year for current status of activity, if applicable.**

THIS APPLICATION MUST BE SIGNED AND DATED WHERE INDICATED

POSITION/RANK: _____ **ANTICIPATED START DATE:** _____
(Professor, Assist. Professor; if applicable)

PRIMARY PRACTICE SPECIALTY: _____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

SECONDARY PRACTICE SPECIALTY(IES): _____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

PERSON/ENTITY TO CONTACT REGARDING THIS APPLICATION:

NAME: _____

ENTITY/GROUP AFFILIATION: _____

ADDRESS: _____

_____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

E-MAIL: _____

SECTION A: DEMOGRAPHIC INFORMATION

_____

Legal Last Name First Middle Professional Title/Degree

_____

Preferred Last Name First Middle Professional Title/Degree

Other name(s) which you have been identified under:

_____ Effective from: _____ to: _____

(Last) (First) (Middle)

_____ Effective from: _____ to: _____

(Last) (First) (Middle)

SSN: _____ Birth Date: _____

For Directory purposes - Gender: Male ☐ Female ☐

Place of Birth:

_____

City County State Country

Are you a US Citizen? ☐ Yes ☐ No

If no, do you have: ☐ Green Card or ☐ Work Permit (If yes, attach a notarized copy) ☐ Neither (Explain Visa below)

Visa Type: _____ Visa Number: _____

Current Home Address: _____

_____

City: _____ State: _____ Zip Code: _____

_____ _____ _____

Phone Number Cell Phone Number E-Mail Address

New Home Address: _____ Effective Date: _____

_____

City: _____ State: _____ Zip Code:

_____ _____ _____

Phone Number Cell Phone Number E-Mail Address

Spouse/Significant Other's Full Name (if applicable): _____

In case of an emergency, contact: _____

Full Name Relationship

_____

Address (Street, City, State, Zip) Phone Number

SECTION B: OFFICE/PRACTICE SITE INFORMATION

Answer the following questions on pages 3-5, specific to you and the practice site listed below. Indicate if this ***site*** is the primary or additional site by marking the appropriate box. **Pages 3-5 should be duplicated and completed for every site at which you provide services.**

☐ **PRIMARY** ☐ **ADDITIONAL/SATELLITE**

Practice Location Name:_____

Address:_____

_____

City: _____ State: _____ Zip Code: _____

Main Office Phone Number: _____ Scheduling Phone Number: _____

Main Office Fax: _____ Emergency/After-hours Number: _____

Reports/test results Phone: _____ Reports/Results Fax: _____

Your Campus/In-house Address: (If applicable): _____

If different than above, provide your specific: Phone Number: _____ Fax Number: _____

Your E-mail Address: _____

Beginning practice date at this location: _____

Practice arrangement (Please check all that apply):

☐ Solo ☐ Specialty Group ☐ Multi-Specialty Group ☐ Employee ☐ Resident ☐ Fellow ☐ Fellow Associate

☐ Partner/Associate ☐ Locum Tenens - Start date: _____ End date: _____

List *your* office hours (hours available to see patients):

	Sun	***Mon***	***Tues***	***Wed***	***Thurs***	***Fri***	***Sat***
Open							
Close							

Describe your coverage arrangements (24x7):

_____

_____

List the name(s) of all provider back-ups:

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Supervising/Collaborative Physician for non-physician applicant:

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

SECTION B: OFFICE/PRACTICE SITE INFORMATION - continued

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

For the following questions check those boxes that apply to you at the *practice location identified on page 3*. (If you have more than one directory listing, photocopy and complete this section for each listing and/or each location):

Directory Listing/Specialty: _____

Check all that apply:
- ☐ Primary Care Provider (PCP)
- ☐ Co-Care Manager
- ☐ Specialist
- ☐ Both PCP & Specialist
- ☐ PCP Back-up Only
- ☐ Specialist serving as a Back-up

Are you (the applicant practitioner) accepting new patients? Yes ☐ No ☐

Special languages spoken/translated by you: _____

Identify your specific practice limitations on patients (age, gender, payer, scope of practice) if any:

_____

_____

Office handicapped accessible? Yes ☐ No ☐
Office accessible via public transportation? Yes ☐ No ☐
Services available for hearing impaired? Yes ☐ No ☐

Estimated waiting time in days for appointments: Non-Urgent/Elective _____ days Urgent _____ days.

Provide billing and registration numbers (if applicable). These may be individual or group/clinic numbers:

Type	***Group Number***	***Individual Number***
Federal Tax Identification Number:		
Medicare Number:		
Medicaid Number:		
Delta Dental Number:		
CLIA Certificate Number:		N/A
NPI Number		

Does this practice location bill under a group number listed above? ☐ Yes ☐ No
Does this practice location use a group Tax ID number listed above? ☐ Yes ☐ No
Does this practice location have the capability to submit claims electronically? ☐ Yes ☐ No

Billing Contact and Account/Billing Address if different than the practice location address identified on Page 3:

Full Name:_____

Make Checks Payable to: _____

Address: _____ Phone Number: _____

_____ Fax Number:_____

City: _____ State: _____ Zip Code:_____

E-Mail: _____

SECTION B: OFFICE/PRACTICE SITE INFORMATION – continued

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

Office Manager:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone Number: _____

Nurse Coordinator:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone Number: _____

Credentialing/Privileging Contact:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone Number: _____

List all MD, DO, DDS, DPM, DC, and OD practitioners at this location (attach additional sheets if necessary):

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

List all other licensed practitioners at this location (PA, ARNP, CRNA, PhD, LISW, etc.) (attach additional sheets if necessary):

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

Name: _____ Title: _____ License # _____

SECTION C: LICENSURE INFORMATION

State licensing examination(s) taken/used: ☐ Flex ☐ USMLE ☐ Reciprocity ☐ Other: _____

ECFMG Information: Certification Number: _____ Certification Date: _____

Provide all license information, **both current and expired** (copy and include additional sheets if necessary):

Professional License #	*Degree*	*Name on License*	*State Issued*	*Country*	*Issue Date*	*Expiration Date*

Do you hold a current DEA registration number? Yes ☐ No ☐ If No, explain: _____

_____

Do you hold a current State Controlled Substance Certificate (SCSC)? Yes ☐ No ☐ If No, explain: _____

_____

DEA and SCSC numbers and expiration dates:

Certificate	*State Issued*	*Certificate Number*	*Issue Date*	*Expiration Date*
Federal DEA				
Federal DEA				
State CSC				
State CSC				

SECTION D: PROFESSIONAL LIABILITY INSURANCE COVERAGE

By signing and dating this application you are attesting to the current malpractice coverage identified below.

Current Carrier: _____

Address:_____ Agent Name: _____

City: _____ State:_____ Zip Code:_____

Phone Number: _____ Policy Number:_____

Fax Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____ To: _____

Current Carrier: _____

Address:_____ Agent Name: _____

City: _____ State:_____ Zip Code:_____

Phone Number: _____ Policy Number:_____

Fax Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____ To: _____

List any privileges or procedures which are excluded or restricted under your current policy: _____

_____

_____

_____

Previous Carrier: _____

Address:_____ Agent Name: _____

City: _____ State:_____ Zip Code:_____

Phone Number: _____ Policy Number:_____

Fax Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____ To: _____

Previous Carrier: _____

Address:_____ Agent Name: _____

City: _____ State:_____ Zip Code:_____

Phone Number: _____ Policy Number:_____

Fax Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____ To: _____

SECTION E: HOSPITAL AND FACILITY PRIVILEGES

List all hospitals and facilities at which you have held, have pending or currently hold privileges and describe the type(s) of privileges, (DO NOT include privileges during internship, residency or training) (copy and include additional sheets if necessary):
PLEASE LIST PRIMARY HOSPITAL FIRST.

☐ I attest that I have hospital admitting privileges at the hospitals identified below.

☐ I **do not** have hospital privileges, but have the following arrangement for my patients to be admitted:

____ _______________________________________
Name of participating physician or physician group City/State

Hospital/Facility Name: ____

Address:____

____

City: ______________________ State: _______ Zip Code: ______ Email: ____________________

Phone Number: ________________ Fax Number: ________________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: _______________________________ Date From: ____________ To: ____________

Hospital/Facility Name: ____

Address:____

____

City: ______________________ State: _______ Zip Code: ______ Email: ____________________

Phone Number: ________________ Fax Number: ________________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: _______________________________ Date From: ____________ To: ____________

Hospital/Facility Name: ____

Address:____

____

City: ______________________ State: _______ Zip Code: ______ Email: ____________________

Phone Number: ________________ Fax Number: ________________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: _______________________________ Date From: ____________ To: ____________

Hospital/Facility Name: ____

Address:____

____

City: ______________________ State: _______ Zip Code: ______ Email: ____________________

Phone Number: ________________ Fax Number: ________________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: _______________________________ Date From: ____________ To: ____________

SECTION F: EDUCATION

Check the appropriate box and complete the following information for each level of education completed, month/year required (copy and include additional sheets if necessary): **MONTH/YEAR REQUIRED**

Level: ☐ **UNDERGRADUATE** ☐ **MASTERS** ☐ **PHD** ☐ **MEDICAL** ☐ **DENTAL** ☐ **OTHER POST-GRADUATE**

Institution Name:____

Address:____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: ________________ Ending Date: ________________

Degree Received: ________________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: ________________ Fax Number: ________________ Email: ____________________

Level: ☐ **UNDERGRADUATE** ☐ **MASTERS** ☐ **PHD** ☐ **MEDICAL** ☐ **DENTAL** ☐ **OTHER POST-GRADUATE**

Institution Name:____

Address:____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: ________________ Ending Date: ________________

Degree Received: ________________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: ________________ Fax Number: ________________ Email: ____________________

Level: ☐ **UNDERGRADUATE** ☐ **MASTERS** ☐ **PHD** ☐ **MEDICAL** ☐ **DENTAL** ☐ **OTHER POST-GRADUATE**

Institution Name:____

Address:____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: ________________ Ending Date: ________________

Degree Received: ________________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: ________________ Fax Number: ________________ Email: ____________________

Explain any gaps in education, month and year REQUIRED:

____

____

____

____

SECTION G: TRAINING

Give the following information for each training program completed (copy and include additional sheets if necessary):

Level (check one): ☐ **INTERNSHIP** ☐ **RESIDENCY** ☐ **FELLOWSHIP** ☐ **OTHER**

Institution Name:_____

Address:_____

_____

City : _____ State/Country: _____ Zip Code: _____

Dates Attended: Beginning Date: _____ Ending Date: _____

Type/Specialty: _____ Year Completed: _____ If not completed, please explain below.

Program Supervisor/Director Name: _____

Phone Number: _____ Fax Number: _____ Email: _____

Level (check one): ☐ **INTERNSHIP** ☐ **RESIDENCY** ☐ **FELLOWSHIP** ☐ **OTHER**

Institution Name: _____

Address:_____

_____

City: _____ State/Country: _____ Zip Code: _____

Dates Attended: Beginning Date: _____ Ending Date: _____

Type/Specialty: _____ Year Completed: _____ If not completed, please explain below.

Program Supervisor/Director Name: _____

Phone Number: _____ Fax Number: _____ Email: _____

Level (check one): ☐ **INTERNSHIP** ☐ **RESIDENCY** ☐ **FELLOWSHIP** ☐ **OTHER**

Institution Name: _____

Address:_____

_____

City: _____ State/Country: _____ Zip Code: _____

Dates Attended: Beginning Date: _____ Ending Date: _____

Type/Specialty: _____ Year Completed: _____ If not completed, please explain below.

Program Supervisor/Director Name: _____

Phone Number: _____ Fax Number: _____ Email: _____

Explain any incomplete training, any gaps in training, or any gaps between education and training month and year REQUIRED:

_____

_____

_____

SECTION H: CERTIFICATION

Please give the following information for each certification you have completed, or are eligible to complete (see below) (copy and include additional sheets if necessary):

☑ **NOT APPLICABLE**

☑ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________ Board Sub-specialty: ______________________

Issuing Entity Address (City and State): ______________________________

Phone Number: ______________ Fax Number: ______________

Certificate Number: ______________________ Original Certification Date: ____________

Expiration Date: ____________ Recertification Date(s): ____________, ____________

☐ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________ Board Sub-specialty: ______________________

Issuing Entity Address (City and State): ______________________________

Phone Number: ______________ Fax Number: ______________

Certificate Number: ______________________ Original Certification Date: ____________

Expiration Date: ____________ Recertification Date(s): ____________, ____________

☐ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________ Board Sub-specialty: ______________________

Issuing Entity Address (City and State): ______________________________

Phone Number: ______________ Fax Number: ______________

Certificate Number: ______________________ Original Certification Date: ____________

Expiration Date: ____________ Recertification Date(s): ____________, ____________

☐ **ELIGIBLE/ADMISSABLE FOR CERTIFICATION** (Attach letter confirming admissibility):

Board Name/Certificate Type: ______________________________

Written Examination: Completed ____________ Scheduled ____________

Oral Examination: Completed ____________ Scheduled ____________

Admissibility Dates: From ____________ to ____________

SECTION I: PROFESSIONAL HISTORY

List all professional career experience and mark appropriate box for ***type*** (include additional sheet(s) if necessary), beginning with current professional activity. **Be sure to explain any chronological gaps below (if applicable). MONTH/YEAR REQUIRED**

Type: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ____________________

Position: ____________________

Address: ____________________

____

City: ____________________ State: ____________________ Zip Code: __________

Phone Number: ____________________ Fax Number: ____________________

Beginning Date: ____________________ Ending Date: ____________________

Type: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ____________________

Position: ____________________

Address: ____________________

____

City: ____________________ State: ____________________ Zip Code: __________

Phone Number: ____________________ Fax Number: ____________________

Beginning Date: ____________________ Ending Date: ____________________

Type: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ____________________

Position: ____________________

Address: ____________________

____

City: ____________________ State: ____________________ Zip Code: __________

Phone Number: ____________________ Fax Number: ____________________

Beginning Date: ____________________ Ending Date: ____________________

***Explain any gaps in professional history, month and year REQUIRED*:** ____________________

____

____

____

____

SECTION J: PROFESSIONAL REFERENCES

Give **four** professional peer references that have personal knowledge of your recent clinical abilities, ethics, health status and can provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional ability. Do not include family or fellow students. Suggested peer references are: professors, practitioners in the same specialty, or department chairs.

Name: _____ Title: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Position:_____ Phone Number: _____

E-mail: _____ Fax Number: _____

Name: _____ Title: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Position: _____ Phone Number: _____

E-mail: _____ Fax Number: _____

Name: _____ Title: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Position: _____ Phone Number: _____

E-mail: _____ Fax Number: _____

Name: _____ Title: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Position:_____ Phone Number: _____

E-mail: _____ Fax Number: _____

Please be sure to carefully read and answer each question below, and explain *any* "yes" answers on page 15.

*** Note - A special form is attached for Malpractice Claim History on Addendum C ➔➔**

SECTION K: QUALITY FOCUSED QUESTIONS

1. Have you ever voluntarily or involuntarily surrendered or relinquished a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification?…….. ☐ YES ☐ NO

2. Have you ever voluntarily or involuntarily had a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification revoked, suspended, limited, denied or refused by an Iowa licensing, state or federal drug administration, certifying board, or by such an entity in any other state(s)?…….. ☐ YES ☐ NO

3. Have there been any previously successful or are there any currently pending challenges, complaint(s), sanction(s), disciplinary actions(s), investigations or denials recommended or taken against your state, district or federal professional license(s), registrations (DEA or State Controlled Substance Certificate), board certification or any other certification(s)?…… ☐ YES ☐ NO

4. Have you ever voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?…… ☐ YES ☐ NO

5. Have you ever voluntarily or involuntarily withdrawn a request for an increase in privileges?…… ☐ YES ☐ NO

6. Have you ever been refused membership on a clinical, medical, dental or professional staff (other than for a general closure of that staff to providers of your specialty)?…….. ☐ YES ☐ NO

7. Have you ever had a hospital, health care facility, or other health care organization invoke probation, issue a reprimand, impose proctoring (other than proctoring when privileges are initially granted), require a second opinion or initiate an investigation of your professional conduct or competency?…… ☐ YES ☐ NO

8. Are you currently performing or do you plan to perform any procedures for which you have ever been refused or lost privileges?…….. ☐ YES ☐ NO

9. Have you ever been the subject of a formal or public citation or warning or ever had a sanction of any kind imposed by any health care institution, health care organization, licensing authority or other governmental entity, or voluntarily or involuntarily resigned under threat of the same?..... ☐ YES ☐ NO

10. Have your employment, medical staff appointment/membership, or clinical privileges ever been challenged or voluntarily or involuntarily suspended, reduced, revoked, refused (denied), relinquished, terminated, limited or lost at any hospital, healthcare plan or other healthcare facility or organization?……. ☐ YES ☐ NO

11. Have you ever been convicted of any crime related to your clinical, medical, dental or professional practice? ☐ YES ☐ NO

12. Regarding Medicare, Medicaid, or any other governmental health-related programs, have you ever been convicted of a crime or been subjected to civil penalties, disciplinary proceedings, investigations, denial of or suspension from participation, or had any type of sanction?……. ☐ YES ☐ NO

13. Do you have any felony, grand jury indictment, or other criminal charges pending?…… ☐ YES ☐ NO

14. Have you ever been convicted of, found guilty of or pled no contest to a felony, grand jury indictment or crime, other than a minor traffic violation?…… ☐ YES ☐ NO

15. Do you presently have a physical, mental or emotional condition (including alcohol or drug dependence), or do you presently engage in the use of illegal substances that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients?..... ☐ YES ☐ NO

16. Has your malpractice insurance ever been denied, suspended, limited, not renewed or terminated by a carrier?……. ☐ YES ☐ NO

SECTION K: QUALITY FOCUSED QUESTIONS continued…

17. Have you ever had a malpractice case filed against you? (If yes, explain on Addendum C)……..…… ☐ YES ☐ NO

18. Have you ever had a malpractice judgment entered against you? (If yes, explain on Addendum C)……. ☐ YES ☐ NO

19. Have any malpractice settlements ever been made on your behalf? (If yes, explain on Addendum C)……. ☐ YES ☐ NO

20. Are there any open claims or pending malpractice cases presently filed against you? (If yes, explain on Addendum C)…….. ☐ YES ☐ NO

21. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank?…… ☐ YES ☐ NO

22. Have you ever been denied membership in or voluntarily or involuntarily been terminated by any professional organization?…….. ☐ YES ☐ NO

23. Have you ever had any sanctions or disciplinary action executed against you by a Professional Standards Review Organization (PSRO), utilization or quality control Peer Review Organization (PRO), or any professional organization?…….. ☐ YES ☐ NO

24. Has your participation in a managed care plan or healthcare organization been limited, denied, or terminated, or have you been sanctioned by such an organization?…… ☐ YES ☐ NO

For any "YES" answers to the Quality Focused Questions above, please provide detailed explanation here, with the exception of any Malpractice Claim History (for Malpractice Claim History provide detailed information on Addendum C).

Question #	Detailed Explanation

If there is additional information about you or your practice that you feel will have a bearing on the consideration of this application, please provide details (attach an additional page if needed):

_____

_____

_____

_____

_____

TO AVOID DELAY IN THE PROCESSING OF THIS APPLICATION
PLEASE BE SURE TO SIGN AND DATE FOR CERTIFICATION / ATTESTATION / and RELEASE BELOW AND ANY ADDENDUMS (if applicable).

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application;
- You may correct any erroneous information found in your credentialing files; and
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted.
- You will be informed about the status of your credentialing application.

I represent and warrant that all of the information provided and the responses given on this application are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of information could result in the rejection or termination of my participation in any plan, staff or panel, in addition to penalties provided by law. I hereby authorize the hospital, CVO, credentialing entity or managed care plan, or its delegated agents, staff and representatives to collect and review all records and documents which may include records of previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank and Criminal Background Check investigations, that may be material to an evaluation of my professional qualifications and competence. I also understand that certain fields of data on this application contain time-sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize the entity to which this application is submitted, to collect from me and other sources this information on an as-needed basis, and understand and agree they may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application. I hereby release from liability the entity to which this application is submitted and their delegated agents, staff and representatives for their acts performed in good faith and without malice in connection with the evaluation of my application and my credentials and qualifications. It is my understanding that the entity to which this application is submitted shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, my designated entity, or as authorized under state or federal law or regulation. I further release from liability any and all individuals and organizations who provide information to the entity reviewing my credentials, and its agents, staff and representatives, when released in good faith and without malice, concerning my professional qualifications, competence, ethics and character, and I hereby consent to the release of such information for purposes consistent with this application. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

If making this application for hospital privileges, I acknowledge that I have been provided the Bylaws, Rules and Regulations of the hospital to which this application applies, and I agree to abide by them and the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for staff membership. I also pledge to provide or arrange for continuous care of my patients.

_____ _____
(Practitioner's Signature) (Date Signed)

_____ _____
(Practitioner's Printed Name) (Practitioner's Initials)

PRACTITIONER ACKNOWLEDGEMENT STATEMENT

MEDICARE / MEDICAID / CHAMPUS (TRI-CARE)

Medicare/Medicaid and Champus (TriCare) payment to hospitals is based on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending practitioners by virtue of his or her signature in 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.

_____

Name (Please Print)

_____

Practitioner's Legal Signature

_____

Practitioner's signature as written on medical records

_____

Practitioner's initials

_____

Date

This statement must be signed, dated and returned with your completed application.

Medicare/Medicaid and Champus (Tri-Care) payment applies to all hospitals.

ALTERNATE COVERAGE- FOR HOSPITAL OR FACILITY APPLICANTS ONLY

Please list **TWO** alternate practitioners who have privileges at the hospital or facility to which you are applying. The alternates must be in the same department / section and have like privileges to cover for you in your absence**. If you are unable to list two alternates, please contact the medical staff office of the appropriate facility if further instructions are needed.**

_____	_____
Hospital/Facility	Alternate #1
	_____
	Alternate #2
_____	_____
Hospital/Facility	Alternate #1
	_____
	Alternate #2
_____	_____
Hospital/Facility	Alternate #1
	_____
	Alternate #2
_____	_____
Hospital/Facility	Alternate #1
	_____
	Alternate #2

MALPRACTICE CLAIM HISTORY FORM

Practitioner Name: _____

☐ **NO ACTIVITY TO REPORT (Proceed to Signature Line Below)**

If you have any professional malpractice activity to report on this application, complete this page for each professional liability incident (copy and include additional sheets if necessary).

Description of allegation or action taken: _____

_____

Date of incident: _____ Date of claim or suit filed: _____

Location of incident: _____

Insurance carrier name: _____

Insurance carrier address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Describe your involvement with the patient's care. Your narrative must include the following at a minimum:

1) Condition and diagnosis at time of incident
2) Dates and description of treatment rendered
3) Condition of patient subsequent to treatment

_____

_____

_____

_____

_____

Your Status: ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify) _____

Claim Status: ☐ Open ☐ Pending ☐ Closed

If closed, indicate the date closed and case outcome: Date Closed: _____

☐ Dismissed with prejudice ☐ Settled with Prejudice ☐ Judgment for Defendant

☐ Dismissed without prejudice ☐ Settled without Prejudice ☐ Judgment for Plaintiff

Amount of settlement or judgment paid on your behalf (if any): $_____

Date of payment: _____

I certify that the information in this document is correct and complete to the best of knowledge:

_____ _____

Practitioner's Signature Date

Additional information here:

ADDENDUM TWO
CONFIDENTIAL HEALTH STATUS INFORMATION

In order to process your application, it is necessary to inquire about your health status.
The purpose of this form is to confirm whether you are capable of performing the duties and responsibilities of appointment and exercising the clinical privileges requested safely and competently.

Complete this questionnaire and return to the Central Verification Office. We will place this form in a *sealed* Confidential Health Status envelope for each facility you are applying and send it to those medical staff offices. The envelope will not be opened until *after* the Medical Executive Committee has taken initial action on your application and evaluated your professional qualifications.

1. Do you have any physical or mental condition that could affect your ability to exercise the clinical privileges requested and perform the duties of staff appointment or that would require an accommodation in order for you to exercise the privileges requested safely and competently?
   ☐ Yes ☐ No
2. Have you ever had any problems with alcohol or drug dependency?
   ☐ Yes ☐ No
3. Are you currently taking any medication that may affect either your clinical judgment or motor skills?
   ☐ Yes ☐ No
4. Are you currently under any limitations concerning your activities or work load?
   ☐ Yes ☐ No

If the answer is "yes" to any question, please explain and submit a report from your treating physician specifically addressing how the condition may affect your ability to exercise the privileges you have requested or the duties of staff appointment. Please also explain any proposed accommodation.

Certification

I certify that my staff appointment and clinical privileges are conditional upon my demonstrating that I am capable of exercising my privileges safely and competently and performing the duties and essential functions of staff appointment. I understand that the burden is on me to request any proposed accommodations and to justify its reasonableness. By my signature below, I hereby certify that all the information provided above is true, complete and correct. I agree to inform the hospital and supplement, as necessary, should any statement of the information contained above, although true when made, becomes untrue do to a change in circumstances of discovery of new information. Any falsification to this health status questionnaire is grounds for termination.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**

ADDENDUM THREE
HIPAA
ACKNOWLEDGMENT OF
ORGANIZED HEALTH CARE ARRANGEMENT

The undersigned agrees that, with respect to activities at the Hospital, the undersigned shall be considered as part of an Organized Health Care Arrangement (OHCA) with the Hospital as that term is defined at 45 C.F.R. §164.501. The undersigned shall comply with all Hospital policies and federal and state laws and regulations relating to the use and disclosure of individually identifiable health information, and shall adopt such procedures and comply with such policies as may be required from time to time.

The Hospital will provide all patients presenting at their facilities with a Notice of Privacy Practices that includes a notification of the OHCA between the Hospital and its medical staff. The undersigned agrees to inform their patients seen outside the hospital setting of their participation in the OHCA, as a supplement to their own Notice of Privacy Practices.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**

ADDENDUM FIVE
SANFORD HEALTH PLAN
NCQA QUESTIONS

Sanford Health Plan requests the following information:

Access and Availability Questions:

1. Are you currently accepting new patients into your practice?

   ☐ Yes ☐ No

2. Are you willing, in the future, to accept new patients?

   ☐ Yes ☐ No

3. Does the office have wheelchair or handicapped access?

   ☐ Yes ☐ No

Ethnicity Question:
In an effort to fulfill a NCQA requirement, we are requesting the race/ethnicity of the practitioners in our network. This data will be collected and analyzed to determine if we are meeting the cultural needs of our member population. Please check your race/ethnicity below.

- ☐ African American/Black
- ☐ Asian
- ☐ Caucasian/White
- ☐ Hispanic/Latino/White
- ☐ Hispanic/Latino/Black
- ☐ Hispanic/Latino/Declined
- ☐ Middle Eastern
- ☐ Native American
- ☐ Native Hawaiian/Pacific Islander
- ☐ More than one race
- ☐ Declined
- ☐ Unavailable/Unknown
- ☐ Other _____

Military Questions:

Are you an active member of the Reserves: ☐ Yes ☐ No _____Branch

Are you an active member of the National Guard: ☐ Yes ☐ No _____Branch

ADDENDUM SIX
WAIVER OF LIABILITY &
CONSENT FOR RELEASE OF INFORMATION

ALL Applicants must SIGN and DATE the Waiver of Liability & Consent for Release of Information.

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

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

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

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

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

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

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

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

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

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

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

_____

PRINTED NAME

_____ _____

SIGNATURE **DATE**

ADDENDUM SEVEN
PHYSICIAN CONSULTING STATEMENT OR
COLLABORATING AGREEMENT

Physician Assistants/Nurse Practitioners/Clinical Nurse Specialists:

The following must be completed for all Physician Assistants. Nurse Practitioners and Clinical Nurse Specialists must complete this form if she/he is practicing in a state that requires a supervising physician/collaborative agreement:

I, _____ have an agreement with
(**Printed Name of Applicant)**

a licensed physician or a Medical Group to serve as a supervising physician for questions that arise about diagnosis and treatment of my patients.

_____	_____
Physician Name or Medical Group	Address, City, State and Zip Code
_____	_____
Phone Number	Fax Number
_____	_____
Signature of Supervising Physician	**Date**

_____
Printed Name of Supervising Physician

ADDENDUM EIGHT
CVO REQUIRED DOCUMENTS CHECKLIST

PROVIDER NAME: _____

PLEASE INCLUDE A COPY OF THE FOLLOWING WITH THIS APPLICATON:

- ☐ Copies of all current State License(s)
- ☐ Copies of all State Controlled Dangerous Substance Certificates (*if applicable*)
- ☐ Copies of all current Federal DEA registrations (*if applicable*)
- ☐ Copies of Board Certification Certificates or qualifying letter
- ☐ **Copies of your Current and Past Professional Liability Insurance face sheets *(for past 5 years, including periods of education if within the past 5 years)***
- ☐ Copies of your Medical or Dental school graduation, internship and residency certificates, ECFMG *(if applicable)*
- ☐ Emergency Care Training Certificates (CPR, BLS, ACLS, HCPC, ATLS, NALS, PALS etc., *as applicable*)
- ☐ DD-214 for Military Experience *(if applicable)*
- ☐ Current Curriculum Vitae (this will not be accepted in lieu of completing an application)
- ☐ Results of your most current TB skin test or assessment if previously positive. Your last test must be within the prior 12 months.
- ☐ Confidential Health Status Information Form (if any questions are answered yes, please provide additional documentation)
- ☐ Sanford Health Plan Addendum Five

BEFORE YOU RETURN THIS APPLICATION – DID YOU:

- ☐ Provide complete street addresses, phone and fax numbers wherever indicated, including past employment, affiliations, references, etc.
- ☐ Designated dates by mm/dd/yy format
- ☐ **EXPLAIN ALL TIME GAPS** of 90 days or greater from completion of highest education
- ☐ Answer all disclosure questions (if any questions are answered yes, please provide additional documentation)
- ☐ Central Verification Waiver of Liability
- ☐ Apply for all applicable state licensure, federal DEA, state controlled substance, and certifications
- ☐ Complete all delineation of privileges if enclosed
- ☐ Include all of the enclosures and documents listed above

<u>PLEASE NOTE:</u> Incomplete applications will be returned to you and will significantly delay your credentialing process.

ADDENDUM NINE
SANFORD HEALTH
APPOINTMENT REQUEST

You may complete one application if applying to multiple facilities affiliated with Sanford Health. In order to process verifications for all facilities affiliated with Sanford Health, it is important to identify all facilities for which you are applying on this page. Please check those facilities which apply. If Unsure, please contact your clinic manager for assistance.

NOTE: <u>All sites requested will be contacted for authorization of credentialing/privileging.</u>

I, _____, am applying for appointment/privileges with each of the following facilities checked in the "*Requesting at this Site*" box:

Facility Name	City	State	Requesting at this Site
Bethesda Nursing Home	Beresford	SD	☐
Community Memorial Hospital	Burke	SD	☐
Endoscopy Center	Rapid City	SD	☐
MN Veterans Home – Luverne	Luverne	MN	☐
Murray County Memorial Hospital	Slayton	MN	☐
Orange City Health System	Orange City	IA	☐
Pioneer Memorial Hospital & Health System	Viborg	SD	☐
Prairie Lakes Healthcare System	Watertown	SD	☐
Sanford Health Plan	Sioux Falls	SD	☐
Sanford Home Medical Equipment	Sioux Falls	SD	☐
TLC Advantage	Sioux Falls	SD	☐
Windom Area Hospital	Windom	MN	☐
Winner Regional Healthcare Center	Winner	SD	☐