PERSONAL INFORMATION

Do not use any nicknames or initials unless they are part of your legal name.

Name (Last, First, Middle): _____

Degree: _____

Have you ever used another name?* ☐ Yes ☐ No *If yes, please list all other names and dates of use below:

Other Name (Last, First, Middle): _____

Date span of using other name: _____-_____

Do you practice exclusively within the inpatient setting? ☐ Yes ☐ No

Mailing Address/Street: _____

City/State/Zip: _____

Mailing Phone: _____ Cell Phone: _____

E-mail: _____ Fax: _____

Preferred method of contact: ☐ Mail ☐ E-mail ☐ Fax

Date of Birth: _____ Sex: ☐ Male ☐ Female

Place of Birth (City, State, Country): _____

Citizenship: _____

If not an American Citizen, Status & Visa Number:

_____

SSN #: _____

Beeper #: _____Digital: ☐ Yes ☐ No

Answering Service #: _____

Enter all non-English Languages you speak:

_____, _____, _____, _____, _____

Only enter a Foreign National ID number if you do not have a SSN. Do not enter NPI here.

Foreign National ID Number: (FNIN): _____

FNIN Country of Issue: _____

PROFESSIONAL IDs

Provide all current and previous licenses/certifications. Non-licensed professionals should enter certification/registration number in the space provided for license number.

State License #	Issuing State	Issue Date	Expiration Date	Practicing in this State? (Y/N)

Federal DEA Number: _____ DEA issue date: _____

DEA State of registration: _____ DEA expiration date: _____

Federal DEA Number: _____ DEA issue date: _____

DEA State of registration: _____ DEA expiration date: _____

CDS Certificate Number: _____ CDS issue date: _____

CDS State of registration: _____ CDS expiration date: _____

CDS Certificate Number: _____ CDS issue date: _____

CDS State of registration: _____ CDS expiration date: _____

Medicare Number: _____ UPIN: _____

Medicaid Number: _____ Medicaid State: _____

National Provider ID (NPI) Number: _____

USMLE Number: _____

Worker's Compensation Number: _____

ECFMG Number (Non-U.S./Canadian Graduate only): ____-____ ____ ____-____ ____ ____-____

ECFMG Certificate issue date (Non-U.S./Canadian Graduate only): _____

EDUCATION

Graduate Type:

Provide the appropriate information for the school that issued your professional degree.

Graduate Type: ☐ U.S. or Canadian Graduate ☐ Non-U.S. or Canadian Graduate ☐ Fifth Pathway Graduate

U.S. or Canadian School:

Name of U.S. Canadian School: _____ Degree awarded: _____

Start date (MM/YYYY): _____ End (graduation) date: (MM/YYYY): _____

Did you complete your graduate education at this school? ☐ Yes ☐ No

Non U.S. or Canadian School:

Name of Non-U.S. School: _____ Degree awarded: _____

Address: _____ City: _____

Country: _____ Postal Code: _____

Start date (MM/YYYY): _____ End (graduation) date: (MM/YYYY): _____

Did you complete your graduate education at this school? ☐ Yes ☐ No

TRAINING

List all training programs you attended. Use one section per institution.

Institution/Hospital Name (use both lines if required):

_____

_____

Affiliated medical school: _____

Number: _____ Street: _____ Suite/Building: _____

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

Telephone: _____-_____-_____ Fax: _____-_____-_____

Did you complete this training program at this institution? ☐ Yes ☐ No

If not, please use the space below to explain:

_____

_____

_____

_____

List each department separately, if applicable.
List Internship/Residency, Fellowship, and Other programs separately.

☐ Internship/Residency ☐ Fellowship ☐ Other

Start date (MM/YYYY): _____ End date: (MM/YYYY): _____

Department/Specialty (do not abbreviate): _____

Name of Director: _____

☐ Internship/Residency ☐ Fellowship ☐ Other

Start date (MM/YYYY): _____ End date: (MM/YYYY): _____

Department/Specialty (do not abbreviate): _____

Name of Director: _____

Internship/Residency ☐ Fellowship ☐ Other

Start date (MM/YYYY): _____ End date: (MM/YYYY): _____

Department/Specialty (do not abbreviate): _____

Name of Director: _____

PROFESSIONAL/MEDICAL SPECIALTY INFORMATION

Specialty	Primary	Secondary	Board Certified		Name of Board	Year Certified	Past Re-Certified	Expiration Date
			Yes	No				
Allergy and Immunology								
Cardiology								
Cardiothoracic Surgery								
Chiropractor								
Dermatology								
Endocrinology								
ENT/Otolaryngology								
Family Practice								
Gastroenterology								
General Practice								
General Surgery								
Geriatrics								
Gynecology, OB/GYN								
Infectious Diseases								
Internal Medicine								
Nephrology								
Neurology								
Neurosurgery								
Oncology - Medical, Surgical								
Oncology - Radiation/ Radiation Oncology								
Ophthalmology								
Optometrist								
Orthopedic Surgery								
Physiatry, Rehabilitative Medicine								
Physical Therapist								
Plastic Surgery								
Podiatry								
Primary Care - Nurse Practitioners								
Psychiatry								
Pulmonology								
Rheumatology								
Urology								
Vascular Surgery								

If not Board Certified (select one):

☐ I have taken exam, results pending for (enter Certifying Board Code): _____

☐ I intend to sit for an exam on (MM/DD/YYYY): _____

☐ I do not intend to take a certifying board exam.

If you indicated that you did not intend to take a certifying board exam, please use the following space to explain. Otherwise, leave the space blank.

_____

_____

_____

Primary Credentialing Contact

_____**CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.**

Last Name: _____ First Name: _____ M.I.: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

*E-mail address: _____

*Even if you checked the box above, please provide the e-mail address here, if available.

Practice Location Information

***NOTE: If you indicated you practice exclusively within the inpatient setting on page 1, you are only required to complete the credentialing contact question above. This section may be left blank.**

Primary Practice Location

- If you have additional practice locations
- *"General Correspondence"* refers to any correspondence that might be sent to the provider that does not solely relate to the credentialing or billing information.
- Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise.

Currently practicing at this address: ☐ Yes ☐ No If no, what is your expected start date _____

Physician Group/Practice name to appear in directory (do not abbreviate):

_____

Group/Corporate name as it appears on W-9, if different from above (do not abbreviate):

_____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Send general correspondence here? ☐ Yes ☐ No

Telephone: _____-_____-_____ Fax: _____-_____-_____

Office e-mail address: _____

Individual Tax ID: _____-_____-_____ Group Tax ID: _____-_____-_____

Primary Tax ID (one only): ☐ Use Individual Tax ID ☐ Use Group Tax ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience.
Do not write instructions like "see above". These responses will require follow-up after rejection.

Last Name: _____ First Name: _____ M.I.: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

E-mail address: _____

Billing Contact

☐ **Check here to use the above Office Manager and Office Address as Billing Information.**

Last Name: _____ First Name: _____ M.I.: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

*E-mail address: _____

*Even if you checked the box above, please provide the e-mail address here, if available.

Payment and Remittance

Your "check payable to" information should be consistent with your W-9.

_____Check here to use the above Office Manager and Office Address as Payee Information.

Electronic billing capabilities? ☐ Yes ☐ No (If yes please complete the attached EDI form)

Billing Department (if hospital-based): _____

Check payable to: _____

Last Name: _____ First Name: _____ M.I.: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

*E-mail address: _____

*Even if you checked the box above, please provide the e-mail address here, if available.

Office Hours

NOTE: After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Start							
End							

24/7 Phone Coverage? ☐ Yes ☐ No If yes, check one:

☐ Answering Service ☐ Voicemail with Instructions to call answering service ☐ Voicemail with other instructions

After hours back office telephone: _____-_____-_____

Open Practice Status

Accept new patients into this practice?	☐ Yes	☐ No
Accept all new patients?	☐ Yes	☐ No
Accept existing patients with change of payor?	☐ Yes	☐ No
Acccept new Medicare patients?	☐ Yes	☐ No
Accept new patients with physician referral?	☐ Yes	☐ No

Mid-Level Practitioners

Do mid-level practitioners (nurse practitioners, physician assistants, etc.) care for patients in your practice?

☐ Yes ☐ No **If yes, please complete a credentialing application for each mid-level practitioner.**

Languages

Non-English language spoken by office personnel:

_____ _____ _____ _____ _____ _____

Interpreters available? ☐ Yes ☐ No Languages interpreted:

_____ _____ _____ _____ _____ _____

Covering Colleagues

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 29. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

List all covering colleagues that are not partners at this practice.

Last name: _____ First Name: _____ M.I.:____
Specialty: _____

Last name: _____ First Name: _____ M.I.:____
Specialty: _____

Last name: _____ First Name: _____ M.I.:____
Specialty: _____

HOSPITAL AFFILIATIONS

Do you have any hospital privileges? ☐ Yes ☐ No
Hospital Name: _____
Number: _____ Street: _____ Suite/Building: _____
City: _____ State: _____ Zip: _____
Telephone: _____-_____-_____ Fax: _____-_____-_____
Department Name: _____
Department Director's Last Name: _____
Department Director's First Name: _____ M.I.: _____
Affiliation start date (MM/YYYY): _____ Affiliation end date (MM/YYYY): _____
Full, unrestricted privileges? ☐ Yes ☐ No Are privileges temporary? ☐ Yes ☐ No
Admitting privilege status (e.g. non, full unrestricted, provisional, temporary): _____
Of your total annual admissions, what percentage is to this hospital*? _____%

Please explain terminated affiliation: _____

_____

_____

Professional Liability Insurance Carrier

☐ **If you do not carry malpractice insurance check this box and skip this section.**

Carrier or Self-Insured Name: _____

Self-Insured? ☐ Yes ☐ No

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Original effective date (MM/YYYY): _____ Effective date (MM/YYYY): _____

Expiration date (MM/YYYY): _____ Type of Coverage? ☐ Individual ☐ Shared

Do you have unlimited coverage with this insurance carrier? ☐ Yes ☐ No

Amount of coverage per occurrence: $_____

Amount of coverage per aggregate: $_____ Policy includes tail coverage? ☐ Yes ☐ No

Policy Number: _____

WORK HISTORY

Include a chronological work history for the past 10 years.

Are you currently on active military duty or military reserve? ☐ Yes ☐ No

WORK HISTORY

Practice/Employer Name: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

Country: _____ Start date (MM/YYYY): _____ End date (MM/YYYY): _____

Reason for departure: _____

_____

_____

WORK HISTORY

Practice/Employer Name: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

Country: _____ Start date (MM/YYYY): _____ End date (MM/YYYY): _____

Reason for departure: _____

_____

_____

WORK HISTORY

Practice/Employer Name: _____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____ Fax: _____-_____-_____

Country: _____ Start date (MM/YYYY): _____ End date (MM/YYYY): _____

Reason for departure: _____

_____

_____

Gaps in Professional/Work History

Please explain any time periods or gaps in training or work history that have occurred since graduation from your professional school and are longer than three months in duration if required by the organization for which you are being credentialed.

Gap start date (MM/YYYY): _____ Gap End date (MM/YYYY): _____

_____

_____

_____

_____

DISCLOSURE QUESTIONS

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 18

LICENSURE

1. ☐ Yes ☐ No — Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

2. ☐ Yes ☐ No — Has there been any challenge to your licensure, registration, or certification?

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ Yes ☐ No — Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

4. ☐ Yes ☐ No — Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?

5. ☐ Yes ☐ No — Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

EDUCATION, TRAINING, AND BOARD CERTIFICATION

6. ☐ Yes ☐ No — Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

7. ☐ Yes ☐ No — Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

8. ☐ Yes ☐ No — Have any of your board certifications or eligibility ever been revoked?

9. ☐ Yes ☐ No — Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

DEA OR STATE CONTROLLED CUBSTANCE REGISTRATION

10. ☐ Yes ☐ No Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

11. ☐ Yes ☐ No Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ Yes ☐ No Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

13. ☐ Yes ☐ No To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

14. ☐ Yes ☐ No Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

15. ☐ Yes ☐ No Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

16. ☐ Yes ☐ No Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ Yes ☐ No Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

18. ☐ Yes ☐ No Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

MALPRACTICE CLAIMS HISTORY

19. ☐ Yes ☐ No Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.

***If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 19.**

CRIMINAL/CIVIL HISTORY

20. ☐ Yes ☐ No Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

21. ☐ Yes ☐ No In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

22. ☐ Yes ☐ No Have you ever been court-martialed for actions related to your duties as a medical professional?

ABILITY TO PERFORM JOB

23. ☐ Yes ☐ No Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ Yes ☐ No Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ Yes ☐ No Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

26. ☐ Yes ☐ No Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

Standard Authorization, Attestation, and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, 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 in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise 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 action 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 were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any

other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

_____ _____

Signature Name (print)

Disclosure Questions
Supplemental Form

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the space provided, then your explanation in the corresponding lines.
If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

Question #: _____

Question #: _____

Question #: _____

Malpractice Claims Explanation Supplemental Form

Use this form to report any "Yes" response to Disclosure Question #19. If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

Date of Occurrence: _____ Date claim was filed: _____

Status of Claim (NOTE: if case is pending, select "open"): ☐ Open ☐ Closed

If settled, enter date claim was settled: _____

Professional Liability Carrier involved: _____

_____

Number: _____ Street: _____ Suite/Building: _____

City: _____ State: _____ Zip: _____

Telephone: _____-_____-_____

Policy Number: _____

Amount of award or settlement: $_____,_____

Method of resolution: ☐ Dismissed ☐ Settled ☐ Mediation ☐ Arbitration

☐ Judgment for defendant(s) ☐ Judgment for plaintiff(s)

Description of allegations:

_____

_____

_____

_____

Were you the primary defendant or co-defendant? ☐ Primary defendant ☐ Co-Defendant

Number of other defendants (if any): _____

Your involvement in case (attending, consulting, etc.):

_____

Description of alleged injury to the patient:

_____

_____

_____

_____

Did the alleged injury result in death? ☐ Yes ☐ No

To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)?

☐ Yes ☐ No