1) **If you ARE registered with CAQH**, complete the “CAQH Provider Data Form” enclosed. You DO NOT need to complete the “State of Illinois Health Care Professional Credentialing and Business Data Gathering Form”.

2) **If you ARE NOT registered with CAQH**, complete the “State of Illinois Health Care Professional Credentialing and Business Data Gathering Form” enclosed. You will also need to include the items listed on the “Credentialing Application Checklist” You DO NOT need to complete the “CAQH Provider Data Form.”
# CAQH Provider Data Form

## For Credentialing Purposes

<table>
<thead>
<tr>
<th>Date:</th>
<th>Are you registered with CAQH? Yes No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If Yes, CAQH Provider ID:</th>
<th>Social Security:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Birth Place:</th>
<th>Race/ Ethnicity:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Email Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Department Name (If Hospital Based):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Office Street Address:</th>
<th>Suite #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Office City:</th>
<th>State:</th>
<th>County:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Telephone:</th>
<th>Primary Fax:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Type (MD, DO, PhD, LCSW, LPC, etc):</th>
<th>Tax ID:</th>
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</table>

<table>
<thead>
<tr>
<th>Credentialing Contact Information:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Specialty:</th>
<th>Applying As:</th>
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<tbody>
<tr>
<td></td>
<td>- Specialist</td>
</tr>
<tr>
<td></td>
<td>- Allied Health Professional</td>
</tr>
<tr>
<td></td>
<td>- Primary Care Physician</td>
</tr>
<tr>
<td></td>
<td>- Group Practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you board certified?</th>
<th>Yes No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If Yes, board name:</th>
<th>Exp. Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medicaid ID #:</th>
<th>NPI:</th>
<th>NPI Group:</th>
</tr>
</thead>
</table>

Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.:

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

<table>
<thead>
<tr>
<th>Do you have a CLIA Certificate? Yes No</th>
<th>Do you have a CLIA waiver? Yes No</th>
<th>Type of Service Provided:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Certificate Number:</th>
<th>Certificate Expiration Date:</th>
<th>Billing Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tax ID #:</td>
</tr>
</tbody>
</table>

Note: If you have already completed your application with CAQH, please ensure that you have authorized IlliniCare Health Plan to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding IlliniCare Health Plan to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with IlliniCare Health Plan.
### Credentialing Application Checklist

YOU MUST INCLUDE THE FOLLOWING WITH THE COMPLETED

ILLINOIS STANDARDIZED CREDENTIALING APPLICATION

(Please use this checklist as a guide)

| ☐  | Signed and Dated Copy of Practitioner Application with dated and signed Provider Statement to Release Information signed within the last 120 days from submission |
| ☐  | Any gaps of time six (6) months or greater from professional school/training to the present date must be documented |
| ☐  | History of malpractice claims paid (past 5 years) |
| ☐  | Copies of all Current, Unrestricted Professional State License in all states |
| ☐  | Copy of Current DEA Registration |
| ☐  | Copy of Current, Unrestricted State Controlled Dangerous Substance (CDS) License (if applicable) |
| ☐  | Copy of Declaration Page of Professional Liability Policy |
| ☐  | Copy of Board Certification Certificate (if applicable) |
| ☐  | Copy of ECFMG Certificate (if applicable) |
| ☐  | W-9 Form |
The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

**INSTRUCTIONS**

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

- **Chapter A:** Practice and Professional Information
- **Chapter B:** Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

**GENERAL INSTRUCTIONS:** Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as “Confidential Information” shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.
ATTACHMENTS

Attach forms A-F as needed to support “yes” responses in Section J: Professional History and copies of the following:

- Curriculum Vitae

CONFIDENTIAL INFORMATION:
- All Current Professional Licenses
- Current Federal DEA License, If Applicable
- Current State Controlled Substance License(s), If Applicable
- Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- Current CLIA Certificate, If Applicable
- Current W-9s, If Applicable
- ECFMG Certificate, If Applicable
- Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant’s Signature ___________________________ Type or Print Name ___________________________ Date ___________________________

** PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM. **
# SECTION A. GENERAL INFORMATION

Name:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

List other names by which you have been known:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

If you have been known by other names, please explain why your name changed:

---

Birth Date:       Place of Birth:  
(mm/dd/yy)  City  State  Country

Sex:  Male  Female  

Language Fluency of Applicant:  English  Other:  

U.S. Citizen?  Yes  No  Spanish  

If no, do you have a legal right to reside permanently and work in the U.S.?  Yes  No

<table>
<thead>
<tr>
<th>Resident Visa No:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Security Number:</th>
</tr>
</thead>
</table>

<p>| Emergency Contact Person: |</p>
<table>
<thead>
<tr>
<th>Last  First  MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Number:</td>
</tr>
</tbody>
</table>

Mailing Address:

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Daytime Phone: (   )       Fax Number: (   )

E-Mail Address: ____________________________

Check here if you have appended additional information for this section: ☐

(Please continue next page)
**SECTION B. PROFESSIONAL INFORMATION**

Illinois Professional License Number: 
License Unlimited?  Yes ☐  No ☐ If No, please explain limitation: 

<table>
<thead>
<tr>
<th>Current and Previous Professional License(s) in Other States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State:</strong></td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>State:</td>
</tr>
</tbody>
</table>

Check here if you have appended additional information for this section: ☐

**Current Federal DEA License Number:** 
DEA License Number Expiration Date: | License Unlimited? | Yes ☐  No ☐ | If No, please explain limitation: |

Check here if you have appended additional information for this section: ☐

**Current and Previous State Controlled Substance Number(s):**

| State: | **CS License #:** | **Expiration Date:** | (mm/dd/yy) |
| State: | **CS License #:** | **Expiration Date:** | (mm/dd/yy) |
| State: | **CS License #:** | **Expiration Date:** | (mm/dd/yy) |

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

__________________________________________________________

__________________________________________________________

Health Care Professionals Credentialing & Business Data Gathering Form
Applicant Name:
Medicare Unique Provider ID# (UPIN): __________________________
National Provider Identification Number (NPI): __________________________
Medicaid ID#: __________________________

X-Ray Certification: State: ________ Certificate #: ________ Expiration Date: ________ (mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

Specialty I:

Are you Board Certified in Specialty I? Yes ☐ No ☐
If Yes, name of Certifying Board: __________________________

Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date: ________ Certification Expiration Date, if Any: ________
If not taken, date scheduled to take Specialty Boards: (mm/yy)

Specialty/Subspecialty II:

Are you Board Certified in Specialty II? Yes ☐ No ☐
If Yes, name of Certifying Board: __________________________

Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date: ________ Certification Expiration Date, if Any: ________
If not taken, date scheduled to take Specialty Boards: (mm/yy)

(Please continue next page)
Specialty/Subspecialty III:

Are you Board Certified in Specialty III?  Yes ☐   No ☐
If Yes, name of Certifying Board: ____________________________

Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification?  Yes ☐   No ☐
If Certifying Boards taken, give date: (mm/yy) Certification Expiration Date, if Any: (mm/yy)
If not taken, date scheduled to take Specialty Boards: (mm/yy)

Specialty/Subspecialty IV:

Are you Board Certified in Specialty IV?  Yes ☐   No ☐
If Yes, name of Certifying Board: ____________________________

Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification?  Yes ☐   No ☐
If Certifying Boards taken, give date: (mm/yy) Certification Expiration Date, if Any: (mm/yy)
If not taken, date scheduled to take Specialty Boards: (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)
### SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

#### CURRENT PROFESSIONAL LIABILITY INSURANCE

**CONFIDENTIAL INFORMATION:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
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<tbody>
<tr>
<td></td>
<td>Street</td>
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<tr>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>Original Effective Date:</th>
<th>Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(mm/dd/yy)</td>
<td>(mm/dd/yy)</td>
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</table>

<table>
<thead>
<tr>
<th>Policy Limits:</th>
<th>Per Occurrence: $</th>
<th>Aggregate: $</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

| Retroactive Date: | |
|                   | (mm/dd/yy) |

What type of coverage do you have?  
☐ Claims Made  ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  
☐ Yes  ☐ No

#### PREVIOUS PROFESSIONAL LIABILITY INSURANCE

**CONFIDENTIAL INFORMATION:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
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<td>Street</td>
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<table>
<thead>
<tr>
<th>Policy Number:</th>
<th>Original Effective Date:</th>
<th>Expiration Date:</th>
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<tr>
<td></td>
<td>(mm/dd/yy)</td>
<td>(mm/dd/yy)</td>
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</table>

<table>
<thead>
<tr>
<th>Policy Limits:</th>
<th>Per Occurrence: $</th>
<th>Aggregate: $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Retroactive Date: | |
|                   | (mm/dd/yy) |

What type of coverage do you have?  
☐ Claims Made  ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  
☐ Yes  ☐ No
**PREVIOUS PROFESSIONAL LIABILITY INSURANCE**

**CONFIDENTIAL INFORMATION:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street</td>
</tr>
<tr>
<td></td>
<td>Policy Number:</td>
</tr>
<tr>
<td></td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Policy Limits:</td>
<td>Per Occurrence: $</td>
</tr>
<tr>
<td>Retroactive Date:</td>
<td>(mm/dd/yy)</td>
</tr>
</tbody>
</table>

What type of coverage do you have?  □ Claims Made  □ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  □ Yes  □ No

---

**PREVIOUS PROFESSIONAL LIABILITY INSURANCE**

**CONFIDENTIAL INFORMATION:**

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street</td>
</tr>
<tr>
<td></td>
<td>Policy Number:</td>
</tr>
<tr>
<td></td>
<td>(mm/dd/yy)</td>
</tr>
<tr>
<td>Policy Limits:</td>
<td>Per Occurrence: $</td>
</tr>
<tr>
<td>Retroactive Date:</td>
<td>(mm/dd/yy)</td>
</tr>
</tbody>
</table>

What type of coverage do you have?  □ Claims Made  □ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  □ Yes  □ No

---

Check here if you have appended additional information for this section: □
SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: ____________________________

Mailing Address: Street ____________________________ City __________ State ______ Zip _____

Telephone Number: (____ ) __________ Fax Number: (____ ) __________

Degree: __________ Year Graduated: __________

Dates attended: From: __________ To: __________

mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? □ Yes □ No

Date Issued: __________ Serial Number for ECFMG: __________

mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? □ Yes □ No

(Attach an explanation of a “Yes” answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: □

INTERNERSHIP

Institution Name: ____________________________

Department Chair or Program Director: ____________________________

Last Name ____________________________ First Name ____________________________ M1 ____________________________ Degree ____________________________

Mailing Address: Street ____________________________ City __________ State ______ Zip _____

Telephone Number: (____ ) __________ Fax Number: (____ ) __________

Dates attended: From: __________ To: __________

mm/yy mm/yy

Type of internship: □ Rotating □ Straight If straight, please list specialty: ____________________________

Did you successfully complete this program? □ Yes □ No If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? □ Yes □ No

(Attach an explanation of a “Yes” answer.)

If more than one internship, please check here and attach additional information that duplicates the information requested above: □
**FIRST RESIDENCY**

Institution Name: ________________________________________________

Department Chair or Program Director: _____________________________

Last Name  |  First Name  |  MI  |  Degree

Mailing Address: ____________________________

Street  |  City  |  State  |  Zip

Telephone Number: (   )  |  Fax Number: (   )

Dates attended: From: ___________ To: ___________

Type of residency: __________________________

Did you successfully complete this program?  ☐ Yes  ☐ No  If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  ☐ Yes  ☐ No

(Attach an explanation of a “Yes” answer.)

**SECOND RESIDENCY**

Institution Name: ________________________________________________

Department Chair or Program Director: _____________________________

Last Name  |  First Name  |  MI  |  Degree

Mailing Address: ____________________________

Street  |  City  |  State  |  Zip

Telephone Number: (   )  |  Fax Number: (   )

Dates attended: From: ___________ To: ___________

Type of residency: __________________________

Did you successfully complete this program?  ☐ Yes  ☐ No  If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  ☐ Yes  ☐ No

(Attach an explanation of a “Yes” answer.)

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)
FIRST FELLOWSHIP

Institution Name:
Department Chair or Program Director:  
Mailing Address:  
Telephone Number: (   )       Fax Number: (   )
Dates attended:  From:        To:  
Type of fellowship:
Did you successfully complete this program?  
Weren't you the subject of any disciplinary action during your attendance at this institution?  
(Attach an explanation of a “Yes” answer.)

SECOND FELLOWSHIP

Institution Name:  
Department Chair or Program Director:  
Mailing Address:  
Telephone Number: (   )       Fax Number: (   )
Dates attended:  From:        To:  
Type of fellowship:
Did you successfully complete this program?  
Weren't you the subject of any disciplinary action during your attendance at this institution?  
(Attach an explanation of a “Yes” answer.)
If more than two fellowships, please check here and attach additional information that duplicates the information requested above:  

(Please continue next page)
TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: __________________________________________

Department Chair or Program Director: Last Name First Name MI Degree

Mailing Address: Street City State Zip

Telephone Number: (_____) Fax Number: (____) ______________________

Dates: From: _________ To: _________ Rank/Position, if applicable: ____________________________

mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution?  ☐ Yes ☐ No

(Attach an explanation of a “Yes” answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: __________________________________________

Department Chair or Program Director: Last Name First Name MI Degree

Mailing Address: Street City State Zip

Telephone Number: (_____) Fax Number: (____) ______________________

Dates: From: _________ To: _________ Rank/Position, if applicable: ____________________________

mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution?  ☐ Yes ☐ No

(Attach an explanation of a “Yes” answer.)

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)
MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

<table>
<thead>
<tr>
<th>A. Active</th>
<th>E. Suspended / Terminated/ Resigned</th>
<th>I. Provisional</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Courtesy</td>
<td>F. Active Provisional Staff</td>
<td>J. Affiliate</td>
</tr>
<tr>
<td>C. Consulting</td>
<td>G. Senior Staff</td>
<td>K. Pending</td>
</tr>
<tr>
<td>D. Adjunct</td>
<td>H. Associate</td>
<td>L. Other (Specify)</td>
</tr>
</tbody>
</table>

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: ____________________________

Address: ____________________________________________________________

Street: ____________________________ City: ____________________________ State: ___ Zip: ___

Membership Status: ____________________________ Dates: ____________________________ To: Present

From (mm/yy) ____________________________

Department/Division: ____________________________ Medical Staff Office FAX #: ( ___ )

Department Telephone #: (___) ____________________________

Any Limitations in Your Area of Specialty at this Hospital? ____________________________

B. Other Hospital

Hospital Name: ____________________________

Address: ____________________________________________________________

Street: ____________________________ City: ____________________________ State: ___ Zip: ___

Membership Status: ____________________________ Dates: ____________________________ To: ____________________________

From (mm/yy) ____________________________ To (mm/yy) ____________________________

Department/Division: ____________________________ Medical Staff Office FAX #: ( ___ )

Department Telephone #: (___) ____________________________

Any Limitations in Your Area of Specialty at this Hospital? ____________________________
C. Other Hospital

<table>
<thead>
<tr>
<th>Hospital Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street City State Zip</td>
</tr>
<tr>
<td>Membership Status:</td>
<td>Dates: From (mm/yy) To (mm/yy)</td>
</tr>
<tr>
<td>Department/Division:</td>
<td>Medical Staff Office FAX #: (   )</td>
</tr>
<tr>
<td>Department Telephone #: (   )</td>
<td></td>
</tr>
</tbody>
</table>

Any Limitations in Your Area of Specialty at this Hospital?

Check here if you have appended additional information for this section: ☐

**SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS**

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

<table>
<thead>
<tr>
<th>Hospital Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street City State Zip</td>
</tr>
<tr>
<td>Membership Status:</td>
<td>Dates: From (mm/yy) To (mm/yy)</td>
</tr>
<tr>
<td>Department/Division:</td>
<td>Medical Staff Office FAX #: (   )</td>
</tr>
<tr>
<td>Department Telephone #: (   )</td>
<td></td>
</tr>
</tbody>
</table>

Any Limitations in Your Area of Specialty at this Hospital?

---

B. Hospital Name: ____________________________

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street City State Zip</td>
</tr>
<tr>
<td>Membership Status:</td>
</tr>
<tr>
<td>Department/Division:</td>
</tr>
<tr>
<td>Department Telephone #: (   )</td>
</tr>
</tbody>
</table>

Any Limitations in Your Area of Specialty at this Hospital?

---
**C. Hospital Name:**

<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Status:</td>
<td>Dates:</td>
<td>To:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department/Division:</td>
<td>Medical Staff Office FAX #:</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department Telephone #:</td>
<td>( )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any Limitations in Your Area of Specialty at this Hospital?

---

Check here if you have appended additional information for this section: ☐

### SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

#### A. Primary Ambulatory Surgery Center

<table>
<thead>
<tr>
<th>ASC Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Membership Status:</td>
</tr>
<tr>
<td>From (mm/yy)</td>
</tr>
</tbody>
</table>

#### B. Other Ambulatory Surgery Center

<table>
<thead>
<tr>
<th>ASC Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Membership Status:</td>
</tr>
<tr>
<td>From (mm/yy)</td>
</tr>
</tbody>
</table>

#### C. Other Ambulatory Surgery Center

<table>
<thead>
<tr>
<th>ASC Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Street</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Membership Status:</td>
</tr>
<tr>
<td>From (mm/yy)</td>
</tr>
</tbody>
</table>

Check here if you have appended additional information for this section: ☐
SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place:

Address: __________________________________________
Street: ___________________ City: ___________________ State: _______ Zip: ___________
Telephone: (___)____ Fax Number: (___)____________
Title or Professional Occupation: _____________________________
Time in this employment: From: ___________ to: Present
(mm/yy)

Previous work place:

Address: __________________________________________
Street: ___________________ City: ___________________ State: _______ Zip: ___________
Telephone: (___)____ Fax Number: (___)____________
Title or Professional Occupation: _____________________________
Time in this employment: From: ___________ to: ___________
(mm/yy) (mm/yy)

Previous work place:

Address: __________________________________________
Street: ___________________ City: ___________________ State: _______ Zip: ___________
Telephone: (___)____ Fax Number: (___)____________
Title or Professional Occupation: _____________________________
Time in this employment: From: ___________ to: ___________
(mm/yy) (mm/yy)

Previous work place:

Address: __________________________________________
Street: ___________________ City: ___________________ State: _______ Zip: ___________
Telephone: (___)____ Fax Number: (___)____________
Title or Professional Occupation: _____________________________
Time in this employment: From: ___________ to: ___________
(mm/yy) (mm/yy)

Previous work place:

Address: __________________________________________
Street: ___________________ City: ___________________ State: _______ Zip: ___________
Telephone: (___)____ Fax Number: (___)____________
Title or Professional Occupation: _____________________________
Time in this employment: From: ___________ to: ___________
(mm/yy) (mm/yy)
Previous work place: ____________________________________________

Address: ____________________________________________________

Telephone: (   )       Fax Number: (   )

Title or Professional Occupation: ________________________________

Time in this employment: From: (mm/yy) to: (mm/yy) 

Previous work place: ____________________________________________

Address: ____________________________________________________

Telephone: (   )       Fax Number: (   )

Title or Professional Occupation: ________________________________

Time in this employment: From: (mm/yy) to: (mm/yy) 

Previous work place: ____________________________________________

Address: ____________________________________________________

Telephone: (   )       Fax Number: (   )

Title or Professional Occupation: ________________________________

Time in this employment: From: (mm/yy) to: (mm/yy) 

Previous work place: ____________________________________________

Address: ____________________________________________________

Telephone: (   )       Fax Number: (   )

Title or Professional Occupation: ________________________________

Time in this employment: From: (mm/yy) to: (mm/yy) 

Check here if you have appended additional information for this section: ☐

(Please continue next page)
SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

Specialty: ____________________________

Mailing Address:
Street ____________________________
City ____________________________
State ____________________________
Zip ____________________________

Telephone: (____) __________ Fax Number: (____) __________

Relationship: ____________________________ Years Known: ____________________________

(Please continue next page)
SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

**ADVERSE OR OTHER ACTIONS**

Submit with all applications. Please answer the following questions to the best of your knowledge with a “yes” or “no.” If you answer “yes” to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each “yes” answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? □ Yes □ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? □ Yes □ No

3. Have you lost any board certification(s), and/or failed to recertify? □ Yes □ No

4. Have you been examined by a Certifying Board but failed to pass? □ Yes □ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? □ Yes □ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? □ Yes □ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? □ Yes □ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? □ Yes □ No

9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? □ Yes □ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? □ Yes □ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? □ Yes □ No
12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO??
   ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?
   ☐ Yes ☐ No

**PROFESSIONAL LIABILITY ACTIONS**

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you?
   ☐ Yes ☐ No

2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?
   ☐ Yes ☐ No

3. Are there any currently pending professional liability suits, actions and/or claims filed against you?
   ☐ Yes ☐ No

4. Has any person or entity ever been sued for your clinical actions?
   ☐ Yes ☐ No

**LIABILITY INSURANCE**

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?
   ☐ Yes ☐ No

**CRIMINAL ACTIONS**

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?
   ☐ Yes ☐ No

2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?
   ☐ Yes ☐ No
### MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?  
☐ Yes  ☐ No

### CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances?  
   ☐ Yes  ☐ No

2. Do you currently overuse and/or abuse alcohol or any other controlled substances?  
   ☐ Yes  ☐ No

3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?  
   ☐ Yes  ☐ No

4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?  
   ☐ Yes  ☐ No

### INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?  
☐ Yes  ☐ No

If Yes, please provide explanation:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

(Please continue next page)
Please provide the following information for the primary site at which you practice.

**Primary Site**

<table>
<thead>
<tr>
<th>Group/Business Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Address – Number and Street – Suite</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Telephone Number</th>
<th>Office Administrator – Last Name First Name M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beeper Number</th>
<th>FAX Number</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Number</th>
<th>Answering Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)?

- [ ] Yes
- [ ] No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location?

- [ ] Yes
- [ ] No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

**Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
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<td>to</td>
<td>to</td>
<td>to</td>
<td>to</td>
<td>to</td>
</tr>
</tbody>
</table>
Please indicate standard patient waiting times to schedule an appointment at this site for:

<table>
<thead>
<tr>
<th>Waiting Time</th>
<th>New Patient</th>
<th>Existing Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic Care (e.g., sore throat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Visits (e.g., blood pressure check)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Routine Care (e.g., school or annual physical)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the following regarding your practice at this site:

| Maximum Number of Appointments per Hour | | |
|-----------------------------------------| | |
| Average Waiting Time in Office (from scheduled appointment time to actual examination) | | |
| Average Response Time for Returning Patient Calls: | Acute or Urgent Situation: | |
| Routine Call: | Emergency Situation: | |

Please check all procedures you perform at this site:

- ☐ Age-appropriate immunizations
- ☐ Tympanometry/audiometry screening
- ☐ Pulmonary function studies
- ☐ Office gynecology (routine pelvic/PAP)
- ☐ Osteopathic /Chiropractic manipulation
- ☐ EKG
- ☐ X-rays
- ☐ Flexible sigmoidoscopy
- ☐ Asthma treatment
- ☐ IV hydration/treatment
- ☐ Drawing blood
- ☐ Minor surgery
- ☐ Laceration repair
- ☐ Allergy skin testing
- ☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: ________________________________

Special Skills of Staff: ________________________________

Languages Spoken by Practitioner: ________________________________

Languages Written by Practitioner: ________________________________

Languages Spoken by Staff: ________________________________

Languages Written by Staff: ________________________________

Is this practice site handicapped accessible (check all that apply)?

☐ Building  ☐ Parking  ☐ Wheelchair  ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes  ☐ No

If yes, is supervision always provided on premises during paraprofessionals’ direct patient care?

☐ Yes  ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes  ☐ No

If yes, list Tax ID Numbers used:  

CONFIDENTIAL INFORMATION
Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: __________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Availability:</td>
<td>☐ Days</td>
<td>☐ Nights</td>
<td>☐ Weekends</td>
<td>☐ Holidays</td>
</tr>
</tbody>
</table>

**CONFIDENTIAL INFORMATION:** Tax ID #: __________

Name: | Last | First | MI | Degree |
------|------|-------|----|--------|
| Specialty: | | | |
| Address: | | | |
| Street | City | State | Zip |
| Availability: | ☐ Days | ☐ Nights | ☐ Weekends | ☐ Holidays |

**CONFIDENTIAL INFORMATION:** Tax ID #: __________

Name: | Last | First | MI | Degree |
------|------|-------|----|--------|
| Specialty: | | | |
| Address: | | | |
| Street | City | State | Zip |
| Availability: | ☐ Days | ☐ Nights | ☐ Weekends | ☐ Holidays |

**CONFIDENTIAL INFORMATION:** Tax ID #: __________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: Last | First | MI | Specialty: |
------|------|----|----------|
Name: Last | First | MI | Specialty: |
Name: Last | First | MI | Specialty: |
Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

**Business Arrangement #1**
Name of Business Arrangement On SS4 or W-9 Form: 
Type of Arrangement (e.g., solo or group practice, IPA, PHO): 

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

Billing Address, if Different from Primary Site: 
Telephone Number, if Different from Primary Site: (   )

**Business Arrangement #2**
Name of Business Arrangement On SS4 or W-9 Form: 
Type of Arrangement (e.g., solo or group practice, IPA, PHO): 

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

Billing Address, if Different from Primary Site: 
Telephone Number, if Different from Primary Site: (   )

**Business Arrangement #3**
Name of Business Arrangement On SS4 or W-9 Form: 
Type of Arrangement (e.g., solo or group practice, IPA, PHO): 

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

Billing Address, if Different from Primary Site: 
Telephone Number, if Different from Primary Site: (   )

**Business Arrangement #4**
Name of Business Arrangement On SS4 or W-9 Form: 
Type of Arrangement (e.g., solo or group practice, IPA, PHO): 

<table>
<thead>
<tr>
<th>CONFIDENTIAL INFORMATION:</th>
<th>Tax ID for this Arrangement:</th>
</tr>
</thead>
</table>

Billing Address, if Different from Primary Site: 
Telephone Number, if Different from Primary Site: (   )
SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

<table>
<thead>
<tr>
<th>Site #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group/Business Name</td>
</tr>
<tr>
<td>Building Name</td>
</tr>
<tr>
<td>Office Address – Number and Street – Suite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(    )</td>
<td>Office Administrator – Last</td>
<td>First</td>
<td>MI</td>
</tr>
<tr>
<td>(    )</td>
<td>FAX Number</td>
<td>E-mail</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Main Telephone Number</th>
<th>Beeper Number</th>
<th>Emergency Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(    )</td>
<td>(    )</td>
<td>(    )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty practiced at this site:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your practice restricted within your specialty (e.g., by age or type of patient)?</td>
</tr>
<tr>
<td>If yes, describe the restrictions:</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Briefly describe your practice at this location, including any special practice focus or equipment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently accepting new patients at this location?</td>
</tr>
<tr>
<td>If yes, describe any restrictions (e.g., appointment type, patient type):</td>
</tr>
<tr>
<td>Please provide the number of active patients enrolled with you at this site:</td>
</tr>
<tr>
<td>Please provide the number of patient visits you have at this site per year:</td>
</tr>
</tbody>
</table>

**Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:**

<table>
<thead>
<tr>
<th>Hours</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
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<td>to</td>
<td>to</td>
<td>to</td>
<td>to</td>
<td>to</td>
</tr>
</tbody>
</table>
Please indicate standard patient waiting times to schedule an appointment at this site for:

<table>
<thead>
<tr>
<th></th>
<th>New Patient</th>
<th>Existing Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic Care (e.g., sore throat)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Visits (e.g., blood pressure check)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Routine Care (e.g., school or annual physical)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide the following regarding your practice at this site:

<table>
<thead>
<tr>
<th>Maximum Number of Appointments per Hour</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Waiting Time in Office (from scheduled appointment time to actual examination)</td>
<td></td>
</tr>
<tr>
<td>Average Response Time for Returning Patient Calls:</td>
<td></td>
</tr>
<tr>
<td>Acute or Urgent Situation:</td>
<td></td>
</tr>
<tr>
<td>Emergency Situation:</td>
<td></td>
</tr>
<tr>
<td>Routine Call:</td>
<td></td>
</tr>
</tbody>
</table>

Please check all procedures you perform at this site:

<table>
<thead>
<tr>
<th>Age-appropriate immunizations</th>
<th>EKG</th>
<th>Drawing blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tympanometry/audiometry screening</td>
<td>X-rays</td>
<td>Minor surgery</td>
</tr>
<tr>
<td>Pulmonary function studies</td>
<td>Flexible sigmoidoscopy</td>
<td>Laceration repair</td>
</tr>
<tr>
<td>Office gynecology (routine pelvic/PAP)</td>
<td>Asthma treatment</td>
<td>Allergy skin testing</td>
</tr>
<tr>
<td>Osteopathic /Chiropractic manipulation</td>
<td>IV hydration/treatment</td>
<td>Physical Therapy</td>
</tr>
</tbody>
</table>

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: ______________________________________________________

Special Skills of Staff: ______________________________________________________________

Languages Spoken by Practitioner: __________________________________________________

Languages Written by Practitioner: _________________________________________________

Languages Spoken by Staff: _________________________________________________________

Languages Written by Staff: _______________________________________________________

Is this practice site handicapped accessible (check all that apply)?

- Building
- Parking
- Wheelchair
- Restroom

Does this site employ paraprofessionals for direct patient care?  Yes  No

If yes, is supervision always provided on premises during paraprofessionals’ direct patient care?

- Yes  No

Do the paraprofessional(s) bill under any of your Tax ID Numbers?  Yes  No

If yes, list Tax ID Numbers used:  CONFIDENTIAL INFORMATION
Lab Service at this site?  □ Yes  □ No
If yes, check whether:  □ Primary  □ Secondary  □ Tertiary
CLIA Waiver:  □ Yes  □ No
If yes, CLIA Expiration Date:  

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name:  
Last  First  MI  Degree
Specialty:  
Address:  
Street  City  State  Zip  Telephone: (   )
Availability:  □ Days  □ Nights  □ Weekends  □ Holidays

CONFIDENTIAL INFORMATION:  Tax ID #:  

Name:  
Last  First  MI  Degree
Specialty:  
Address:  
Street  City  State  Zip  Telephone: (   )
Availability:  □ Days  □ Nights  □ Weekends  □ Holidays

CONFIDENTIAL INFORMATION:  Tax ID #:  

Name:  
Last  First  MI  Degree
Specialty:  
Address:  
Street  City  State  Zip  Telephone: (   )
Availability:  □ Days  □ Nights  □ Weekends  □ Holidays

CONFIDENTIAL INFORMATION:  Tax ID #:  

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name:  
Last  First  MI  Degree
Specialty:  
Name:  
Last  First  MI  Degree
Specialty:  
Name:  
Last  First  MI  Degree
Specialty:  

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Applicant Name:  
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Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

**Business Arrangement #1**
Name of Business Arrangement On SS4 or W-9 Form: ____________________________________________
Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________________________

**CONFIDENTIAL INFORMATION:** Tax ID for this Arrangement: ____________________________

Billing Address, if Different from Primary Site: ________________________________________________
Telephone Number, if Different from Primary Site: (  ) ________________________________

**Business Arrangement #2**
Name of Business Arrangement On SS4 or W-9 Form: ____________________________________________
Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________________________

**CONFIDENTIAL INFORMATION:** Tax ID for this Arrangement: ____________________________

Billing Address, if Different from Primary Site: ________________________________________________
Telephone Number, if Different from Primary Site: (  ) ________________________________

**Business Arrangement #3**
Name of Business Arrangement On SS4 or W-9 Form: ____________________________________________
Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________________________

**CONFIDENTIAL INFORMATION:** Tax ID for this Arrangement: ____________________________

Billing Address, if Different from Primary Site: ________________________________________________
Telephone Number, if Different from Primary Site: (  ) ________________________________

**Business Arrangement #4**
Name of Business Arrangement On SS4 or W-9 Form: ____________________________________________
Type of Arrangement (e.g., solo or group practice, IPA, PHO): ____________________________________

**CONFIDENTIAL INFORMATION:** Tax ID for this Arrangement: ____________________________

Billing Address, if Different from Primary Site: ________________________________________________
Telephone Number, if Different from Primary Site: (  ) ________________________________

End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.
FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name: ___________________________  ___________________________  ___________________________  ___________________________

Indicate the number of ONE of the questions in Section J to which you answered “yes”: Question Number: __________

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

B. Provide an explanation of any actions taken. Please include the date the action was taken.

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

C. Provide the current status of the issue.

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

D. If known: Contact: __________________________________________________________

Department/Committee: ______________________________________________________

Address: _________________________________________________________________

Street  City  State  Zip

Telephone: (____) ______________________

Signature: ____________________________________________________________  Date: ______________________
FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: ____________________________________________

Last First MI

A. Plaintiff’s Name:

                           Last First MI

If court case, Case Name & Case Number: ____________________________________________

B. Your Involvement in the Care (Attending, Consulting, Etc.): ____________________________________________

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): ____________________________________________

D. Allegations, including Patient Outcome, if Available: ____________________________________________

E. Date of Incident (mm/yy): _______  F. Date Filed (mm/yy): _______

G. Date Case Closed (mm/yy): _______

Resolution Case: ☐ Dismissed ☐ Judgment ☐ Arbitration ☐ Other
☐ Settlement out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $__________

I. Professional Liability Insurer Name (if one was involved): ____________________________________________

J. Insurer Telephone Number: (____) _________  K. Policy Number: ____________________________

L. Insurer Address (Street, City, State, Zip Code):

                                                                                          ____________________________

Signature: ____________________________  Date: ____________________________
Applicant Name: ____________________________

A. History of Professional Liability Insurance (Please check One)

☐ Canceled Voluntarily   ☐ Non-Renewed
☐ Canceled Involuntarily   ☐ Application Denied

B. Carrier Name: ____________________________

C. Carrier Telephone Number: (___)___________

D. Policy Number: ____________________________

E. Carrier Address (Street, City, State, Zip Code):

__________________________________________

__________________________________________

F. Dates of Coverage: From (mm/yy): ___________ To (mm/yy): ___________

G. Circumstances Involved: ____________________________

__________________________________________

__________________________________________

Signature: ____________________________ Date: ____________________________
Applicant Name: ____________________________

A. Date of Incident (mm/yy): ___________

B. Date of Complaint or Conviction (mm/yy): ___________

C. Date of Resolution (mm/yy): ___________

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _______________________

E. Allegation(s):
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

F. Details of Incident:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

G. Actions Taken Against You:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

H. Current Status of Situation:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

I. Medical Practice Privileges Affected as a Result of This Situation: _______________________
_________________________________________________________________
_________________________________________________________________

Signature: ____________________________ Date: ___________
FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: 

A. Describe this medical condition: __________________________________________________________

____________________________________________________________________________________

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

____________________________________________________________________________________

____________________________________________________________________________________

C. What is the current status of your condition? ______________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(   )</td>
</tr>
<tr>
<td>Last</td>
<td>First</td>
</tr>
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<td></td>
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</tr>
<tr>
<td></td>
<td>(   )</td>
</tr>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: _______________________________ Date: ___________________
DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name: 

Last First MI

Describe the substance you use:

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

B. Monitored by State Board Mandate (Name and Address)  

C. Monitored Voluntarily (Name and Address)

D. Other information about the current status of your use of substances:

E. Abstinent since (mm/yy):__________

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: ____________________________

Address: __________________________

Telephone: (____) ________

Signature: ___________________________ Date: ____________________

Health Care Professionals Credentialing & Business Data Gathering Form

Applicant Name: 

FORM F