

# STATE OF ILLINOIS

## Health Care Professional Credentialing and Business Data Gathering 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:**

<input type="checkbox"/> Curriculum Vitae
<b>CONFIDENTIAL INFORMATION:</b>
<input type="checkbox"/> All Current Professional Licenses
<input type="checkbox"/> Current Federal DEA License, If Applicable
<input type="checkbox"/> Current State Controlled Substance License(s), If Applicable
<input type="checkbox"/> Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
<input type="checkbox"/> Current CLIA Certificate, If Applicable
<input type="checkbox"/> Current W-9s, If Applicable
<input type="checkbox"/> ECFMG Certificate, If Applicable
<input type="checkbox"/> 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. \*\***

**CHAPTER A:  
PRACTICE AND PROFESSIONAL INFORMATION**

**SECTION A. GENERAL INFORMATION**

Name: \_\_\_\_\_ MD  
Last First MI Degree

List other names by which you have been known: \_\_\_\_\_  
Last First MI

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

Resident Visa No: _____	<b>CONFIDENTIAL INFORMATION</b>
Social Security Number: _____	
Emergency Contact Person: _____	
Last First MI	
Telephone Number: ( ) _____	

Mailing Address: \_\_\_\_\_  
Street City State Zip

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: \_\_\_\_\_  
 \_\_\_\_\_

**Current and Previous Professional License(s) in Other States**

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
 \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
 \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
 \_\_\_\_\_

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

**Current Federal DEA License Number: \_\_\_\_\_ *CONFIDENTIAL INFORMATION***

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):**

	<b><i>CONFIDENTIAL INFORMATION</i></b>			
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.**

\_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (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: \_\_\_\_\_  
(mm/yy) (mm/yy)

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: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (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: \_\_\_\_\_  
(mm/yy) (mm/yy)

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: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (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: \_\_\_\_\_  
(mm/yy) (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: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (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: \_\_\_\_\_  
(mm/yy) (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:**

Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Policy Number: \_\_\_\_\_ Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)  
Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_  
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:**

Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Policy Number: \_\_\_\_\_ Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)  
Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_  
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:**

Carrier: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Policy Number: \_\_\_\_\_ Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_

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:**

Carrier: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Policy Number: \_\_\_\_\_ Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_

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



**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:

**INTERNSHIP**

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: \_\_\_\_\_  
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: \_\_\_\_\_  
mm/yy mm/yy

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: \_\_\_\_\_  
mm/yy mm/yy

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: \_\_\_\_\_  
Last Name First Name MI Degree

Mailing Address: \_\_\_\_\_  
Street City State Zip

Telephone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Dates attended: From: \_\_\_\_\_ To: \_\_\_\_\_  
mm/yy mm/yy

Type of fellowship: \_\_\_\_\_

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 FELLOWSHIP**

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: \_\_\_\_\_  
mm/yy mm/yy

Type of fellowship: \_\_\_\_\_

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 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.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

**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? \_\_\_\_\_

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**C. 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? \_\_\_\_\_  
\_\_\_\_\_

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**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.)**

---

**A. 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? \_\_\_\_\_  
\_\_\_\_\_

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**B. 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. 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? \_\_\_\_\_  
\_\_\_\_\_

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**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( ) \_\_\_\_\_

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

**B. Other Ambulatory Surgery Center**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( ) \_\_\_\_\_

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

**C. Other Ambulatory Surgery Center**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( ) \_\_\_\_\_

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

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.**

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**Current work place:** \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Telephone: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ **to Present**  
(mm/yy)

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**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)

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**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)

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**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)

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**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)

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**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)

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**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)

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**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)

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**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)

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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.

**CONFIDENTIAL INFORMATION**

1. **Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street City State Zip  
Telephone: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_  
Relationship: \_\_\_\_\_ Years Known: \_\_\_\_\_

2. **Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street City State Zip  
Telephone: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_  
Relationship: \_\_\_\_\_ Years Known: \_\_\_\_\_

3. **Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
Last First MI Degree  
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:** \_\_\_\_\_

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*(Please continue next page)*

**CHAPTER B:  
BUSINESS INFORMATION**

**SECTION K. PRIMARY SITE INFORMATION**

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

**Primary  
Site**

\_\_\_\_\_  
Group/Business Name

\_\_\_\_\_  
Building Name

\_\_\_\_\_  
Office Address – Number and Street – Suite

\_\_\_\_\_  
City County State Zip

( ) \_\_\_\_\_  
Main Telephone Number Office Administrator – Last First MI

( ) \_\_\_\_\_  
Beeper Number FAX Number E-mail

( ) \_\_\_\_\_  
Emergency Number Answering Service

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:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Hours</b>	to	to	to	to	to	to	to

**Please indicate standard patient waiting times to schedule an appointment at this site for:**

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

**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:	
	Emergency Situation:	
	Routine Call:	

**Please check all procedures you perform at this site:**

<input type="checkbox"/> Age-appropriate immunizations	<input type="checkbox"/> EKG	<input type="checkbox"/> Drawing blood
<input type="checkbox"/> Tympanometry/audiometry screening	<input type="checkbox"/> X-rays	<input type="checkbox"/> Minor surgery
<input type="checkbox"/> Pulmonary function studies	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Laceration repair
<input type="checkbox"/> Office gynecology (routine pelvic/PAP)	<input type="checkbox"/> Asthma treatment	<input type="checkbox"/> Allergy skin testing
<input type="checkbox"/> Osteopathic /Chiropractic manipulation	<input type="checkbox"/> IV hydration/treatment	<input type="checkbox"/> 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

<b>If yes, list Tax ID Numbers used:</b>	<b>CONFIDENTIAL INFORMATION</b>
_____	

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: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays

**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

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

**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
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: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI



**SECTION L. PRIMARY SITE TAX INFORMATION**

**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): \_\_\_\_\_

**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: ( ) \_\_\_\_\_

**SECTION M. ADDITIONAL SITE INFORMATION**

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

<b>Site #</b>
-------------------

\_\_\_\_\_

Group/Business Name

\_\_\_\_\_

Building Name

\_\_\_\_\_

Office Address – Number and Street – Suite

\_\_\_\_\_

City County State Zip

( ) \_\_\_\_\_

Main Telephone Number Office Administrator – Last First MI

( ) \_\_\_\_\_

Beeper Number FAX Number E-mail

( ) \_\_\_\_\_

Emergency Number Answering Service

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:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Hours</b>	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

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:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

<input type="checkbox"/> Age-appropriate immunizations	<input type="checkbox"/> EKG	<input type="checkbox"/> Drawing blood
<input type="checkbox"/> Tympanometry/audiometry screening	<input type="checkbox"/> X-rays	<input type="checkbox"/> Minor surgery
<input type="checkbox"/> Pulmonary function studies	<input type="checkbox"/> Flexible sigmoidoscopy	<input type="checkbox"/> Laceration repair
<input type="checkbox"/> Office gynecology (routine pelvic/PAP)	<input type="checkbox"/> Asthma treatment	<input type="checkbox"/> Allergy skin testing
<input type="checkbox"/> Osteopathic /Chiropractic manipulation	<input type="checkbox"/> IV hydration/treatment	<input type="checkbox"/> 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: _____ <b>CONFIDENTIAL INFORMATION</b>
-------------------------------------------------------------------------

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: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays  
**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays  
**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
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: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Last First MI

**SECTION N. ADDITIONAL SITE TAX INFORMATION**

**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: \_\_\_\_\_  
Last First MI

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:** \_\_\_\_\_

**FORM C – LIABILITY INSURANCE**

**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. 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:** \_\_\_\_\_



**FORM D – CRIMINAL ACTIONS**

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

Applicant Name: \_\_\_\_\_  
Last First MI

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: \_\_\_\_\_  
Last First MI

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.

Name				Telephone Number
_____	_____	_____	_____	( ) _____
Last	First	MI	Degree	
_____	_____	_____	_____	( ) _____
Last	First	MI	Degree	

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE**

**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: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_