Minnesota Uniform Credentialing Application

Initial

Physician/Dentist/Allied Health Professional

Applicant Name (as shown on your state license):

_____

Last First Middle Suffix Title

CREDENTIALING CONTACT INFORMATION

Name _____ **Phone Number** _____

Address _____ **Fax Number** _____

_____ **E-mail** _____

_____

This Box to be Completed by Allied Health Professionals Only

Profession/Title _____

Sponsoring/Collaborative Physician _____
(Must complete if PA-C or APRN)

Instructions

The initial credentialing application and attachments should be filled out completely and accurately and must be legible or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **ALL SIGNATURES AND DATES MUST BE CLEARLY LEGIBLE.**

Checklist (please complete):

Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- ☐ Drug Enforcement Administration Registration with correct address (if applicable)
- ☐ ECFMG certificate (if educated outside of U.S. or Canada)
- ☐ Malpractice Litigation and Professional Complaints Form (if applicable)
- ☐ Malpractice liability insurance documentation (as defined on page 11)
- ☐ If not a U.S. citizen, copy of official document(s) indicating authorization to work in the United States
- ☐ Curriculum Vitae (all application items must be completed)
- ☐ Allied Health Professionals: License/registration and/or certification (if applicable)

In addition, please verify that you have:

- ☐ Provided complete street address, phone, fax and e-mail addresses wherever indicated, including education/training, past employment, hospital affiliations & references
- ☐ Designated dates by month, day and year time frames
- ☐ Explained all gaps of greater than three months in chronology wherever indicated, including education/training and past employment
- ☐ List of all insurance policies you have held for the past 10 years (Page 11)
- ☐ Answered all of the Disclosure Questions on Pages 13 and 14 and enclosed explanations for affirmative answers
- ☐ Signed and dated the Attestation Signature and Date statement (Page 14)
- ☐ Signed and dated the Authorization and Release (Page 16)

All Information Must Be Printed in Black Ink or Electronically Generated

Personal Data

Name (as shown on your state license):

_____
Last First Middle Suffix Title

All Former Aliases: _____ Spouse Name (optional): _____

Gender: ☐ Male ☐ Female U.S. Citizen: ☐ Yes ☐ No

Birthplace: City: _____ State: _____ Country: _____

Date of Birth: _____ Social Security Number: _____ NPI: _____

Current Home Address: _____
Street

_____
City/State/Country Zip Code

Local Home Address
(if different from above): _____
Street

_____
City/State/Country Zip Code

Preferred Mailing Address: ☐ Office ☐ Home Practitioner's Preferred E-mail address: _____

Cell Phone Number: _____ Home Phone Number: _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages: _____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ Type II NPI: _____

E-mail Address: _____

Start Date (at this location): _____

Practicing as: ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Moonlighting Resident ☐ Hospitalist

☐ Hospital Based only ☐ Teaching/Research only ☐ Other (specify) _____

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Sub Specialty (ies) in which care will be provided: _____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

_____

_____

Billing Information

Billing Name: _____ Contact Person: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

E-mail address: _____

(Please make as many extra copies as necessary)

1. Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary): _____ Type II NPI: _____

Credentialing Contact: _____ Phone Number: _____

Start Date (at this location): _____

Practicing as: ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Moonlighting Resident ☐ Hospitalist

☐ Hospital Based only ☐ Teaching/Research only ☐ Other (specify) _____

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Sub Specialty (ies) in which care will be provided: _____

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2. Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary): _____ Type II NPI: _____

Credentialing Contact: _____ Phone Number: _____

Start Date (at this location): _____

Practicing as: ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Moonlighting Resident ☐ Hospitalist

☐ Hospital Based only ☐ Teaching/Research only ☐ Other (specify) _____

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Sub Specialty (ies) in which care will be provided: _____

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3. Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary): _____ Type II NPI: _____

Credentialing Contact: _____ Phone Number: _____

Start Date (at this location): _____

Practicing as: ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Moonlighting Resident ☐ Hospitalist

☐ Hospital Based only ☐ Teaching/Research only ☐ Other (specify) _____

Accepting new patients? ☐ Yes ☐ No Directory Suppress? ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Sub Specialty (ies) in which care will be provided: _____

(Additional space is provided on the Education – Medical/Graduate/Professional Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Education.)

Check the appropriate box and complete the following information for each level of education that is relevant to your Medical/Graduate/ Professional training.

(Month, day and year required) ☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ **Check here if you have additional Medical/Graduate/Professional Education on attached Education/Training Addendum (page 19)**

ECFMG - Applicable to International Medical Graduates

ECFMG Number: _____ Date Issued: _____
(month/day/year)

Internship/Post-Graduate/Professional Training (If applicable)

(Additional space is provided on the Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

(Month, day and year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty (transitional, rotating, 5th pathway, etc.): _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Education/Training (additional space is provided on the Education/Training Addendum, page 19)

(Month, day and year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

☐ **Check here if you have additional time gap information on attached Education/Training Addendum (page 19)**

(Additional space is provided on the Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

(Month, day and year required)

From: _______________ Institution Name: ______________________________

To: _______________ Type of Program/Specialty: ______________________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ______________________________

If not successfully completed, explain: ______________________________

Program Director: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

From: _______________ Institution Name: ______________________________

To: _______________ Type of Program/Specialty: ______________________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ______________________________

If not successfully completed, explain: ______________________________

Program Director: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

From: _______________ Institution Name: ______________________________

To: _______________ Type of Program/Specialty: ______________________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ______________________________

If not successfully completed, explain: ______________________________

Program Director: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Residency Training (additional space is provided on the Post Graduate/Professional Training Addendum, page 19)

(Month, day and year required)

From: _______________ Explain: ______________________________

To: _______________ ______________________________

From: _______________ Explain: ______________________________

To: _______________ ______________________________

☐ **Check here if you have additional time gap information on attached Post Graduate/Professional Training Addendum (page 19)**

(Additional space is provided on the Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

(Month, day and year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Professional and Academic/Faculty Affiliations

(Month, day and year required)

From: _____ Institution Name: _____

To: _____ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Fellowship Training/Academic Affiliations (additional space is provided on the Post Graduate/Professional Training Addendum, page 19)

(Month, day and year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

☐ **Check here if you have additional time gap information on attached Post Graduate/Professional Training Addendum (page 19)**

(Additional space is provided on the Chronological Employment/Practice History Addendum, page 20. You may make extra copies of page 20 or attach a separate sheet for additional employments.)

Chronological listing [month/day/year] of employment/practice history **since completion of your post-graduate training.** List all experience, including military service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. **LEAVE NO GAPS IN CHRONOLOGY**.

(Month, day and year required)

From: _______________ Organization Name: _______________

To: _______________ Title/Position: _______________

Reason for Leaving: _______________

Employment Contact Name: _______________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _______________
Street City/State/Country Zip Code

Phone Number: _______________ Fax Number: _______________

E-mail address: _______________

From: _______________ Organization Name: _______________

To: _______________ Title/Position: _______________

Reason for Leaving: _______________

Employment Contact Name: _______________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _______________
Street City/State/Country Zip Code

Phone Number: _______________ Fax Number: _______________

E-mail address: _______________

From: _______________ Organization Name: _______________

To: _______________ Title/Position: _______________

Reason for Leaving: _______________

Employment Contact Name: _______________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _______________
Street City/State/Country Zip Code

Phone Number: _______________ Fax Number: _______________

E-mail address: _______________

☐ **Check here if you have additional employment history on attached Chronological Employment/Practice History Addendum (page 20)**

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after medical/professional practice (additional space is provided on the Chronologic al Employment/Practice History Addendum, page 20)

(Month, day and year required)

From: _______________ Explain: _______________

To: _______________ _______________

From: _______________ Explain: _______________

To: _______________ _______________

☐ **Check here if you have additional time gap information on attached Chronological Employment/Practice History Addendum (page 20)**

(pertinent to Primary or Pending Practice Location listed on page 2)

***If no hospital admitting privileges,* describe method/coverage for continuity of care. Please provide covering physician's name, if applicable.**

_____

_____

(Month, day and year required)

From: _____ Facility Name: _____

To: _____ Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

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

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

Other Hospital Affiliations - **Present and past affiliations beginning with most recent.**

(Additional space is provided on the Hospital Affiliation Addendum, page 21. You may make extra copies of page 21 or attach a separate sheet for additional affiliations.)

(Month, day and year required)

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____ Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

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

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____ Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

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

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

☐ **Check here if you have additional hospital affiliations on attached Hospital Affiliation Addendum (page 21)**

(Additional space is provided on the Specialty and Licensure Addendum, page 22. You may make extra copies of page 22 or attach a separate sheet for additional Specialty and Licensure.)

Primary Specialty:

Board Name: ______________________________

Board Specialty: ______________________________

Certificate Number: ____________________ Original Certificate Date: ____________________

Expiration Date: ____________________ Certificate Pending ☐

Secondary Specialty:

Board Name: ______________________________

Board Sub-specialty: ______________________________

Certificate Number: ____________________ Original Certificate Date: ____________________

Expiration Date: ____________________ Certificate Pending ☐

Additional Specialty:

Board Name: ______________________________

Board Sub-specialty: ______________________________

Certificate Number: ____________________ Original Certificate Date: ____________________

Expiration Date: ____________________ Certificate Pending ☐

Additional Specialty:

Board Name: ______________________________

Board Sub-specialty: ______________________________

Certificate Number: ____________________ Original Certificate Date: ____________________

Expiration Date: ____________________ Certificate Pending ☐

☐ **Check here if you have additional specialty on attached Specialty and Licensure Addendum (page 22)**

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any.

____

____

Licensure - List all past, current and pending professional licenses.

(Additional space is provided on the Specialty and Licensure Addendum, page 22. You may make extra copies of page 22 or attach a separate sheet for additional Specialty and Licensure.)

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending

☐ **Check here if you have additional licensure on attached Specialty and Licensure Addendum (page 22)**

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application.

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice ☐ DEA certificate pending; date application submitted to DEA: _____

☐ Other _____

If you do not have a DEA with an address in the state in which you will be practicing, you must provide the name of the practitioner at your facility with a valid DEA certificate in that state that will write all controlled substance prescriptions on your behalf until you have a valid DEA certificate in that state.

_____

_____

State Controlled Substance Certification/Registration (If applicable - not applicable to MN, WI, ND).

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Life Support Certification

Do you have any current life support certifications (BLS, ACLS, ATLS, etc.)? ☐ Yes ☐ No

If Yes: Type of Certification Expiration Date(s)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Insurance Carrier for Primary, Pending Practice Location and 10-year insurance history (Additional space is provided on the Liability Addendum, page 23. You may make extra copies of page 23 or attach a separate sheet for additional Liability Insurance.)

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

Coverage dates:

(Month, day and year required)

Start: _____ Current Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Certificate Pending Name in which policy issued: _____

Policy number: _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Please list all insurance policies that you have held in the past 10 years. Include policies covering Residency and Fellowships.

(Month, day and year required)

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number: _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number: _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

☐ **Check here if you have additional Liability Insurance on attached Liability Insurance Addendum (page 23)**

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.) Limit to one **(1) current office associate. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). **Provide current and complete addresses, phone, fax and e-mail**. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

1. ☐ Yes ☐ No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. ☐ Yes ☐ No Has your **professional license or registration** ever been investigated or is it currently being investigated and, if so, what were the results?

3. ☐ Yes ☐ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. ☐ Yes ☐ No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. ☐ Yes ☐ No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. ☐ Yes ☐ No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. ☐ Yes ☐ No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

9. ☐ Yes ☐ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. ☐ Yes ☐ No Are there any **charges pending or are you currently charged** with or have you ever pled guilty, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

11. ☐ Yes ☐ No Have you ever been found liable, guilty or responsible for **sexual impropriety** or misconduct or sexual harassment \ with a patient, co-worker, or other?

12. ☐ Yes ☐ No Have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.** You may be asked for additional information by individual organizations.

13. ☐ Yes ☐ No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. ☐ Yes ☐ No Have you ever practiced within your profession without **professional liability insurance?**

15. ☐ Yes ☐ No Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

16. ☐ Yes ☐ No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

17. ☐ Yes ☐ No Are you currently using illegal drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It “does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.” The term does include, however, the unlawful use of prescription controlled substances.)

Notice of Applicant’s Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.
To check the status of your application, go to the applicable organization website.

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

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

Signature _____ Date _____

Name _____

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.
To check the status of your application, go to the applicable organization website.

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

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign only **one** of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

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

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

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

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

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

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as

"Participation") at _____ (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

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

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

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

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

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

I understand that communication regarding my application may occur via email.

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

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

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

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

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

Signature _____ **Date** _____

Name _____

Medicare/Medicaid and Other Government Reimbursement Programs Penalty Statement: This statement is required by Medicare/Medicaid and other government reimbursement programs.

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

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

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

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

Signature: _____ Date: _____

Name: _____

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet the licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

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

Signature: _____ Date: _____

Name: _____

Signature/DEA Verification

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

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

Signature: _____ Date: _____

Name: _____ DEA Number: _____

Office Address: _____ Specialty: _____

_____

Phone Number: _____

Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Month/Year of incident: _____ Reported to National Practitioner Data Bank (NPDB): ☐Yes ☐No

Where incident occurred: Facility Name _____

Address _____ City _____ State _____ Zip _____

Describe the nature of incident (Complaint, Allegation) - Do Not Include Patient Name or Identifiers:

_____

_____

_____

_____

_____

Provide a narrative description of your participation/level of care:

_____

_____

_____

_____

_____

Outcome of incident:

CONCLUDED WITH NO PAYMENTS: *(month/year)*		CONCLUDED WITH PAYMENTS: *(month/year)*		
☐ Dropped/Closed	Date: _____	☐ Verdict for plaintiff	Date: _____	Amount $_____
☐ Verdict for you	Date: _____	☐ Settled	Date: _____	Amount $_____
☐ Dismissed with prejudice*?	Date: _____	PENDING:		
☐ Dismissed without prejudice**?	Date: _____	☐ Date of filing	Date: _____	

**Dismissed with prejudice - set aside the lawsuit and deny the right to file another suit on that same claim*
***Dismissed without prejudice - set aside the lawsuit but leave open the possibility of another suit on the same claim*

Represented by Legal Counsel for this claim/malpractice lawsuit? ☐Yes ☐No If yes, give the name and address of counsel.

Name: _____

Address: _____

Phone Number: _____

Insurance company or employer that provided coverage for this claim:

Name: _____

Address: _____

Phone Number: _____ Policy Number: _____

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

Applicant Signature _____ **Date** _____

Print Name _____ **Phone Number** _____

Education – Medical/Graduate/Professional Addendum

Applicant Name:

(Please make as many extra copies as necessary)

☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

(Month, day and year required)

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Internship/Residency/Fellowship/Professional Training Addendum

(Month, day and year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after Education/Training

(Month, day and year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

(Please make as many extra copies as necessary)

(Month, day and year required)

From: _______________ Organization Name: ______________________________

To: _______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact Name: ______________________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

From: _______________ Organization Name: ______________________________

To: _______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact Name: ______________________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

From: _______________ Organization Name: ______________________________

To: _______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact Name: ______________________________

Clinic Still Open? ☐ Yes ☐ No	If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after medical/professional practice

(Month, day and year required)

From: _______________ Explain: ______________________________

To: _______________ ______________________________

From: _______________ Explain: ______________________________

To: _______________ ______________________________

From: _______________ Explain: ______________________________

To: _______________ ______________________________

(Please make as many extra copies as necessary)

(Month, day and year required)

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

(Please make as many extra copies as necessary)

Specialty/Subspecialty Certification

Additional Specialty:

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty:

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty:

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty:

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

State Licensure

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending

(Please make as many extra copies as necessary)

Please list all insurance policies that you have held in the past 10 years. Include policies covering Residency and Fellowships.

(Month, day and year required)

Start: _______________ Insurance Carrier Name: ____

Expire: _______________ Address: ____

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ____

Name in which policy issued: ____

Policy number: ____

Amount of coverage (per occurrence): ____

Amount of coverage (per aggregate): ____

Start: _______________ Insurance Carrier Name: ____

Expire: _______________ Address: ____

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ____

Name in which policy issued: ____

Policy number: ____

Amount of coverage (per occurrence): ____

Amount of coverage (per aggregate): ____

Start: _______________ Insurance Carrier Name: ____

Expire: _______________ Address: ____

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ____

Name in which policy issued: ____

Policy number: ____

Amount of coverage (per occurrence): ____

Amount of coverage (per aggregate): ____

Check Appropriate Boxes and enclose documentation from healthcare provider. *Verbal history or written date only are not acceptable forms of documentation.*

1. **MEASLES (RUBEOLA), MUMPS, RUBELLA:**
Documentation of immunity to measles (rubeola), mumps and rubella defined as one of the following:
- ❑ Documentation from my healthcare provider that shows I have had all of these diseases
- ❑ Documentation of Two doses of live virus vaccines for MMR
- ❑ Documentation of positive serology indicating immunity (antibody test)

2. **VARICELLA (CHICKEN POX):**
Immunity to Varicella (chicken pox) is defined as one of the following:
- ❑ Documentation from my healthcare provider that shows I have had this disease
- ❑ Documentation of Two doses of live virus vaccines for Varicella
- ❑ Documentation of positive serology indicating immunity (antibody test)

3. **HEPATITIS B IMMUNITY:**
Documentation of immunity to Hepatitis B as defined by one of the following:
- ❑ Documentation of completed series (3 shots)
- ❑ Documentation of positive serology indicating immunity (antibody test).
- ❑ I would like to receive the Hepatitis B Vaccine
- ❑ I do not wish to receive the Hepatitis B Vaccine at this time

4. **INFLUENZA:**
- ❑ Documentation of influenza vaccination for current influenza season

5. **PERTUSSIS (TDAP)**
- ❑ Documentation of One dose of Tdap (Tetanus-Diphtheria-Pertussis)

****

6. **TUBERCULIN SKIN TEST (TST)/MANTOUX/PPD (TB):**
Documentation for Tuberculosis Status is defined by one of the following:
MUST BE A 2 STEP PROCESS WITHIN 12 MONTHS
- ❑ Documentation of my 2 recent Mantoux skin tests or QuantiFERON TB-Gold test
**negative TST or Quantification Gold from last 12 months
- ❑ Documentation of positive Mantoux, documentation of most recent CXR and completed the below symptom questions
** CXR documentation within the past 5 years is acceptable

Positive TST Symptom Questions:
Do you have any of the following symptoms?
- ❑ Unexplained weight loss
- ❑ Unexplained loss of appetite for more than 2 months
- ❑ Unexplained fatigue that interferes with daily activities
- ❑ Persistent or explained fevers, especially at night
- ❑ Sweating that leaves the bedclothes moist
- ❑ Persistent cough
- ❑ Coughing up blood
- ❑ Exposure to Mycobacterium Tuberculosis in the last 2 years
- ❑ Abnormal chest x-rays
- ❑ I have NOT had any of the above symptoms within the past 12 months

if you develop any of these symptoms, report immediately to Employee Health Services

I certify that the information I have provided on this form is true and complete to the best of my knowledge.

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

Name _____

Signature _____ **Date** _____

RN Reviewer Signature (optional) _____ **Date** _____