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Provider Application

CORRECT NUMBERS AND LETTERS A	BC123 CORRECT X INCORRECT S CORRECT X INCORRECT S COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.	I
Instructions Read all instructions carefully prior to submitting your application.	 Tips to avoid processing delays Complete only this application and its supplemental forms. Do not use another provider's application. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen. Print legibly and inside the boxes provided based upon the examples given above. Do not enter more than 1 character per box. If necessary, write outside the provided spaces. Complete all sections that are applicable to you. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blan 	
SECTION 1	Personal Information and Professional IDs	
Provider Type	Code list is found on page 36. Enter the associated 3-digit code in the space provided.* DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTIN (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NI PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)	
Name Do not use nicknames or initials, unless they are part of your legal	LAST NAME*	t, III)
name.	FIRST NAME* MIDDLE NAME HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES. PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BE	
	HAVE YOU EVER USED ANOTHER NAME?* YES IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BE	_Ow.
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	DATE STARTED USING OTHER NAME DATE STOPPED USING OTHER NAME	
General Information Only enter a Foreign	GENDER* MALE FEMALE DATE OF BIRTH* M M D D Y Y Y Y	
National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI)	CITY OF BIRTH STATE OF BIRTH COUNTRY OF BIRTH	
Number here. Code lists are found on pages 36-43. Enter the	SSN*	SUE
associated 3-digit code in the space provided.	ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE	
Home Address		
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NOTE: CAQH will use this method for application follow-up.		
	FAX - - PREFERRED METHOD OF CONTACT* E-MAIL FAX	
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Section 1	* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND RE Personal Information and Professional IDs. (Contin	
	Personal Information and Professional IDs (Contin	
Professional IDs Include all state licenses, DEA Registration and State Controlled Dangerous	FEDERAL DEA NUMBER	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications.	CDS STATE OF REGISTRATION	M M D D Y Y Y Y CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
Non-licensed professionals should enter certification/ registration number in the space provided for license number. If you have additional	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO	LICENSE ISSUING STATE MMDDYYYYY LICENSE ISSUE DATE MMDDYYYYY LICENSE EXPIRATION DATE
Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	LICENSE ISSUING STATE $M M D D Y Y Y Y$ LICENSE ISSUE DATE $M M D D Y Y Y Y$ LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	LICENSE STATUS CODE LICENSE TYPE	
Other ID Numbers If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	ARE YOU A PART- ICIPATING MEDICARE PROVIDER?* ARE YOU A PART- ICIPATING MEDICAID PROVIDER?* MEDICAID NUMBER MEDICAID NUMBER MEDICAID NUMBER MEDICAID NUMBER WORKERS COMPENSATION NUMBER ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY) ECIMA STATES STATE	
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Section 2	Education and Training	ĺ
Undergraduate	UNDERGRADUATE SCHOOL	
School(s) Provide the appropriate information for the school that issued your undergraduate degree and all schools	OFFICIAL NAME OF UNDERGRADUATE SCHOOL	
attended.	ADDRESS	
Drefessional	CITY STATE ZIP/POSTAL CODE	
Professional School(s)		
Provide the appropriate information for the school that issued your professional degree.	COUNTRY CODE TELEPHONE FAX M M Y Y Y START DATE END DATE (GRADUATION DATE) DEGREE AWARDED	
Fifth Pathway Graduates please complete the following sections: U.S. School that issued your	DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION YES NO AT THIS SCHOOL?	
certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed	GRADUATE TYPE*:	-
your training on Supplemental Page 20.	U.S. OR CANADIAN SCHOOL	•
Code lists are found on pages 36-43. Enter the associated 3-digit code	SCHOOL CODE (U.S./ CANADIAN ONLY) NAME OF U.S./ CANADIAN SCHOOL:	
in the space provided.		
lf you have additional Undergraduate or	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED	
Professional Schools to report, use the Education Supplemental Form on page 20.	DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS YES NO SCHOOL?	_
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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			CNP, NF
	PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
	PRACTITIONER LAST NAME		
	PRACTITIONER FIRST NAME		M.I. PRACTITIONER TYPE (E.G., P/
			CNP, NF
	PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	
	PRACTITIONER LAST NAME		
	PRACTITIONER FIRST NAME		M.I. PRACTITIONER TYPE (E.G., PA
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			CNP, NF
	PRACTITIONER LICENSE / CERTIFICATE NUMBER	PRACTITIONER STATE	

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Section 4	* REQUIRED RESPO						AYS A	ND REC	QUIRE F	-OLLOW-	UP.											ī
Languages					Jonunu	. u)																1
Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.	NON-ENGLISH LANG SPOKEN BY OFFICE INTERPRETERS AVAILABLE?*			NGUAGE CODI LANGUAC INTERPRI	GES ETED	GUAGE		[GE CODE		LANGU				ANGL						
Accessibilities	DOES THIS OFFICE	IEET ADA A	CCESSIBIL	ITY REQUIREN		YES		NO	ANGUA	GE CODE		LANGU	AGEC	ODE	I	ANGU	JAGE	CODE				-
	DOES THIS SITE OF ACCESS FOR THE F		APPED		DES THIS SI ERVICES FO					YES	NC	D	ACC PUB	ESSIE LIC TR	BLE BY RANSP	ORTA	FION?	*	YE	6	NO	
	BUILDING?*	YES	NO		TEXT TEL	EPHON	Υ (ΤΤΥ)*		YES	N	0		E	BUS*				YE	6	NO	
	PARKING?*	YES	NO		AMERICA	N SIGN	LANG	JAGE*		YES	N	0		5	SUBWA	Y*			YE	6	NO	
	RESTROOM?*	YES	NO		MENTAL/		AL IMP	AIRMEN'	T	YES	N	0		F	REGIO	NAL TF	RAIN*		YE	6	NO	
	OTHER HANDICAPP	ED ACCESS			OTHER DIS	ABILITY	SERV	ICES					оті	IER T	RANSP	ORTA	TION	ACCES	s			
Services	Does this locatior	n provide a	ny of the	following ser	vices?																	-
	LABORATORY SERVICES?	YES	NO	CERTIFYIN	OVIDE ACCE IG PROGRAM , COLA, MLE	N	G/															
	RADIOLOGY SERVICES?	YES	NO		OVIDE X-RA TION TYPE	Y																_
	EKGS?	YES	NO	ALLERGY	IS?	YES		NO	ALLE TEST	RGY SKIN ING?	N	YES	6	NO		ROUT GYNE (PELV	COLO			YES		NO
	DRAWING BLOOD?	YES	NO	AGE APPROPRI IMMUNIZA		YES		NO	FLEX	IBLE OIDOSCO	PY?	YES	6	NO		TYMP. Y/ AUI SCRE	DIOME	TRY		YES		NO
	ASTHMA TREATMENT? PULMONARY	YES	NO	OSTEOPAT MANIPULA		YES		NO		DRATION	I/	YES	5	NO		CARD STRE		ST?		YES		NO
	FUNCTION TESTING?	YES	NO	PHYSICAL THERAPY?	?	YES		NO	CARE LACE	E OF MINC	DR S?	YES	6	NO								_
	IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES	NO	IF YES, WH CLASS/CA DO YOU US	TEGORY																	
	IF YES, WHO ADMINISTERS IT?	LAST NAME										FIRS		E]	
	TYPE OF PRACTICE (SELECT ONE ONLY)		SOLO F	PRACTICE		SIN	GLE SI	PECIALI	Y GRO	UP		MUL	TI-SPE	CIALT	ry gro	DUP						
	ADDITIONAL OFFICE	E PROCEDUR	RES PROVI	DED (INCLUDI	NG SURGIC	AL PRO	CEDUR	ES)														
						30)8(5														

Section 4	* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.		
Section 4	Practice Location Information (Continued)		
Partners/ Associates	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE		
Code lists are found on pages 36-43. Enter the			SPECIALTY CODE COVERING COLLEAGUE
associated 3-digit code in the space provided.			(Y/N)?
If you have additional	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
partners/associates at THIS location, use the			
Partner/Associate			SPECIALTY CODE COVERING
Supplemental Form on page 23. Photocopy as			COLLEAGUE (Y/N)?
necessary. Be certain to check "Primary	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Location" at the top of the page.			
			SPECIALTY CODE COVERING COLLEAGUE
			(Y/N)?
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Covering	LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE		
Colleagues			
Code lists are found on			SPECIALTY CODE
Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided. If you have additional covering colleagues			
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
			FROMDER TIPE (CODE PG 30)
that are not partners at THIS location, use the			
Covering Colleagues Supplemental Form on			SPECIALTY CODE
page 24. Photocopy as			
necessary. Be certain to check "Primary	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Location" at the top of the page.			
			SPECIALTY CODE
	FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)
Section 5	Hospital Affiliations		
Admitting Arrangements	DO YOU HAVE HOSPITAL PRIVILEGES?* YES VESTICATION OF ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?		
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tion 5	Hos	pita	I Affil	iatio	ons	(Co	ntin	ued)																		
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vileges																										
licable, list all	HOSPIT	TAL NA	ME																							
tal affiliations. Li ry hospital, then																										
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on page 30.																										
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p to 100% for nt hospitals.																		ADMI		S, WH	AT PE	RCEN	TAGE			%
wise, you will to correct this			RIVILEGE		JS (E.G	i. NON	E, FUL		ESTRIC	CTED,	PROVI	SIONA	AL, TE	MPOR	ARY)											
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Section 6	Professional Liability I	nsur	anc	e C	arri	er																	
Professional								1										ec. c	-INSU	2502*		YES	
Liability	CARRIER OR SELF-INSURED NAME*																	JELF	-111301	(ED :		113	
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INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION.	CITY*							1	_							STAT			ZIP (CODE*	_		
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	ORIGINAL EFFECTIVE DATE*	EFFE	CTIVE	DATE	*				EXPI	RATIO	N DATE				1								
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*		YES		NO										\$								
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	POLICY INCLUDES TAIL COVERAGE?		YES		NO																		
	POLICY NUMBER*															_							
Professional																		SELF	-INSU	RED?		YES	
Liability Insurance	CARRIER OR SELF-INSURED NAME																						
Carrier																							
List other current, future, or previous	NUMBER* STR	EET*																	SUITE	/BUILC	DING		
carrier(s) if current																							
carrier is less than ten (10) years.	CITY*														L	STAT	ſE*		ZIP (CODE*			
NOTE: A longer period	ммүүүү	Μ	М	Y	Y	Y	Y	1	М	М	Y	Y	Y	Y			F \GE?*		INDI		_	SH	ARED
may be required by your healthcare entity.	ORIGINAL EFFECTIVE DATE*		CTIVE	DATE	*			1		RATIO					00	VERA	AGE ?						
If you have additional	DO YOU HAVE UNLIMITED COVERAGE]] ¢[
Insurance, use the	WITH THIS INSURANCE CARRIER?		YES		NO	4		JNT OF		PAGE		,		`E	Ψ			COVE	PAGE	AGGRE	GATI		
Supplemental Insurance Form on	POLICY INCLUDES TAIL COVERAGE?		YES		NO		Amov		0011						-			0012	NACE.	HOOKE	.0411		
page 31.	FOLICT INCLUDES TAIL COVERAGE?		123		NO																		
	POLICY NUMBER*																						
Section 7	Work History and Refe	rence	es																				
Military	Are you currently on active military																						
Duty	duty or military reserve?*		YE	S	NC)																	
Work History	WORK HISTORY																						
Include a chronological work history for the																							
past 10 years.	PRACTICE / EMPLOYER NAME																						
A longer period may be																							
required by your healthcare entity.	NUMBER STR	EET																	SUIT	E/BUIL	DING		
If you have additional										1													
work history, use the Supplemental Work	СІТҮ		1	1		1			1	1	STATI	 E		ZIP/P	OSTAL	сор	1 			1			
History Form on page																							

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Section 7	Work Histo	ory and R	efere	nces	(Co	ntinu	ied)															
Baps in Professional /	PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.																					
Vork History	GAP START DATE	MM	YY	Y	Y	GAP I	END DATE	Μ	М	Y	Y	Y	Y									
you have additional																						
ofessional / work story gaps, use the																	_					
upplemental ofessional Work																						
istory Gaps Form on age 33.																						
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ovide three	LAST NAME*							1														1
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lated or are not artners in your actice.	FIRST NAME*																	Г	PROVI	DER TY	PE (CO	DE P
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ages 36-43. Enter the ssociated 3-digit code																						
r provider type.	CITY*								_			_	_			STATI	E*	Z	IP COD	E*		
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	* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.
Section 8	Disclosure Questions
Disclosure	LICENSURE
Questions Answer all questions.	1. YES NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
For any "Yes"	ditions of initiations by any state of professional incensing, registration of certification board?
response, provide an explanation on the Supplemental	2. YES NO Has there been any challenge to your licensure, registration or certification?*
Disclosure Question	HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS
Explanation Form on page 34.	3. YES NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings
Allied Health Providers	toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
If you are an Allied Health Provider and	4. YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
you do not believe a question is applicable to you, you should	5. YES NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*
answer the question	EDUCATION, TRAINING AND BOARD CERTIFICATION
"NO".	6. YES NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
	7. YES NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
	8. YES NO Have any of your board certifications or eligibility ever been revoked?*
	9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*
	DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION
	10. YES NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*
	MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION
	11. YES NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*
	OTHER SANCTIONS OR INVESTIGATIONS
	12. YES NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa- tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
	13. YES NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
	14. YES NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
	15. YES NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
	16. YES Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency?*
	PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY
	17. YES NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
	18. YES NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8	Disclosure Questions (Continued)
Disclosure Questions	MALPRACTICE CLAIMS HISTORY
Answer all questions. For any "Yes" response, provide an	19. YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*
explanation on the	CRIMINAL/CIVIL HISTORY
Supplemental Disclosure Question Explanation Form on page 34.	20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*
IMPORTANT If you answered "Yes" to question #19 , you	21. YES In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, compare tence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
must complete the Supplemental Malpractice Claims	22. YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?*
Explanation Form on page 35 for each malpractice claim.	Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.
	ABILITY TO PERFORM JOB
	23. YES NO Are you currently engaged in the illegal use of drugs?* ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of applica- tion, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses author- ized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
	24. YES NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the fur tions of your job with reasonable skill and safety?*
	25. YES NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*
	26. YES NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

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

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

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

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

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

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

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

Signature*	Name (print)*	
M M D D Y Y Y Y DATE SIGNED*		
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