Kentucky Application for Provider Evaluation and Reevaluation

April 2009

KAPER-l (04/2009)

Kentucky Department of Insurance

Kentucky Application for Provider Evaluation and Reevaluation – 2009

Introduction. Development of a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, was mandated under KRS 304.17 A-545 (5). In response to the requirement, the Department of Insurance developed the form entitled Kentucky Application for Provider Evaluation and Reevaluation in December 2005. The form has undergone several modifications since that time. However, the current KAPER-1 (04/2009) consists of two (2) parts, including Part A and Part B.

The KAPER-1, Part A was adopted with consent from the Council for Affordable Quality Healthcare form entitled "Provider Application." All health insurers offering managed care plans in Kentucky are required to use either the CAQH provider application or the KAPER-1 (04/2009), Part A, for the evaluation (credentialing) and reevaluation (recredentialing) of health care providers, including psychologists, who will be on their lists of participating providers. The KAPER-1 (04/2009), Part A is also used by the Cabinet for Health and Family Services (CHFS) pursuant to KRS 205.560.

The KAPER-1, Part B was initially developed in collaboration with health care providers, insurers, and the CHFS. This part is for use by Kentucky hospitals and health care facilities and consists of two (2) sections, including Part B, Section 1, used for initial evaluation (credentialing) of a physician or allied health professional, and Part B, Section 2, used for reevaluation (recredentialing) of a physician or allied health professional. The KAPER-1(04/2009), Part B is also used by the CHFS pursuant to KRS 216B.155.

The KAPER-1 (04/2009) may be accessed on the Department's Web site at http://insurance.ky.gov or obtained directly from the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, P. O. Box 517, Frankfort, KY 40602-0517. Reproduction of the form without any changes is allowed.

KAPER-l (04/2009), Part A

For Evaluation (Credentialing) and Reevaluation (Recredentialing) of Health Care Providers Desiring Participation in Kentucky Managed Care Plans and the Kentucky Medicaid Program.

Commonwealth of Kentucky
Instructions - Form KAPER-l (04/2009), Part A

A. **Uniform Kentucky Application for Evaluation (Credentialing) and Reevaluation (recredentialing) Form.** Following is the KAPER-l (04/2009), Part A, which was adopted with consent of the Council for Affordable Quality Health Care pursuant to KRS 304.17 A-545(5). A complete KAPER-l (04/2009), Part A, with required attachments, as specified in item C of this instruction, must be accepted by an insurer offering a managed care plan in Kentucky for the evaluation (credentialing) and reevaluation (recredentialing) of a health care provider who will be on the insurer's list of participating providers. "Health care provider" is defined in 806 KAR 17:480, Section 1. The KAPER-l (04/2009), Part A, which must be accepted by the insurer in an electronic or handwritten format, is available on the Web site of the Department of Insurance http://insurance.ky.gov or at a location identified by the health insurer.

Prior to completing the KAPER-l (04/2009), it is advised that a health care provider desiring participation in a managed care plan contact the insurer for information regarding electronic or handwritten submission of the form with required attachments, as specified in item C of this instruction, and cover letter, as applicable.

Prior to completing the KAPER-1 (04/2009), it is advised that a health care provider desiring participation in the Kentucky Medicaid Program contact the KY Cabinet for Health and Family Services for submission of required attachments, as specified in item C of this instruction, and cover letter, as applicable.

B. Cover Letter. If a complete KAPER-l (04/2009), Part A is submitted to an insurer, a cover letter signed and dated by the health care provider requesting consideration of evaluation or revaluation may be required by the insurer.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following eight (8) supporting documents shall be on 8 ½" X 11" paper, labeled, and attached to the complete KAPER-l (04/2009), Part A in the following order.

1. Drug enforcement agency (DEA) registration certificate;
2. State controlled dangerous substance (CDS) certificate, if applicable;
3. W-9 of each tax identification number;
4. Workers' compensation certificate of coverage;
5. Current professional liability insurance policy face sheet (showing expiration dates, limits and health care provider's name);
6. Signed and dated authorization, attestation and release form;
7. Supplemental forms, if any, in page number order; and
8. Additional pages, if indicated (e.g. lists, etc.).

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

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.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

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

LAST NAME* | SUFFIX (JR, III)

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 BELOW.

OTHER LAST NAME | SUFFIX (JR, III)

OTHER FIRST NAME | OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) | DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE

DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH | STATE OF BIRTH | COUNTRY OF BIRTH

SSN* (- -)

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) | FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Home Address

NUMBER | STREET | APT NUMBER

CITY | STATE | ZIP CODE

TELEPHONE (- -)

NOTE: CAQH will use this method for application follow-up.

E-MAIL

FAX (- -)

PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

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

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

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — — —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (M M D D Y Y Y Y)

3077

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

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

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

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (M M Y Y Y Y) | END DATE (GRADUATION DATE) (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOOL:

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

CITY | COUNTRY CODE | POSTAL CODE

START DATE* (M M Y Y Y Y) | END DATE (GRADUATION DATE)* (M M Y Y Y Y) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

3078

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

Section 2 — Education and Training (Continued)

Training

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

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by the organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE M M Y Y Y Y

END DATE M M Y Y Y Y

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE M M Y Y Y Y

END DATE M M Y Y Y Y

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

START DATE M M Y Y Y Y

END DATE M M Y Y Y Y

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3080

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

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

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

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

Section 3 — Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifications? If yes, provide expiration dates.

			EXPIRATION DATE																									
BASIC LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV LIFE SUPPORT IN OB?*	YES	NO	M	M	D	D	Y	Y	Y	Y						
CPR?*	YES	NO	M	M	D	D	Y	Y	Y	Y	ADV TRAUMA LIFE SUPPORT?*	YES	NO	M	M	D	D	Y	Y	Y	Y						
ADV CARDIAC LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y						
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M	M	D	D	Y	Y	Y	Y																		

Practice Interests

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

Primary Credentialing Contact

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

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

LAST NAME

FIRST NAME M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

3082

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

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

Section 4 — Practice Location Information

NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

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

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

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

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

3084

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

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3085

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

Section 4 — Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3086

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

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

Section 4 — Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

3087

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

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

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

3088

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

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

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

CARRIER OR SELF-INSURED NAME* | SELF-INSURED?* ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? ☐ YES ☐ NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

3089

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

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

Section 7 — Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE

FAX

COUNTRY CODE

START DATE (M M Y Y Y Y)

END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE (M M Y Y Y Y)

END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

TELEPHONE

FAX

COUNTRY CODE

START DATE (M M Y Y Y Y)

END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

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

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

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

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.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Reference 1

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 2

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 3

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

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

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

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

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

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED 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, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

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

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

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

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

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

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

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 application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

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

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

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

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

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

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

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

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

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

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

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

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

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

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Other Relevant Education
Supplemental Form

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

Section 2 | **Education and Training**

Fifth Pathway Education

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

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

Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2 — Education and Training

Training

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

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

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Additional Specialty Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

3097

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Partners/Associates
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ **PRIMARY PRACTICE**

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME / M.I.	PROVIDER TYPE (CODE PG 36)	

(repeated 10 times)

3098

Covering Colleagues
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3099

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

LOCATION* #

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROUP TAX ID

Office Manager or Business Office Contact

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

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

3100

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

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

24/7 PHONE COVERAGE?* YES NO

IF YES ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY NONE FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* # ☐☐

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

3102

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

3103

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE

FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3104

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Hospital Privileges (Current)
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

MMYYYY AFFILIATION START DATE | MMYYYY AFFILIATION END DATE | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Liability Insurance Carrier
Supplemental Form

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

Section 6 | **Professional Liability Insurance Carrier**

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME — SELF-INSURED? YES NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) — EFFECTIVE DATE* (M M Y Y Y Y) — EXPIRATION DATE (M M Y Y Y Y) — TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO — $ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME — SELF-INSURED? YES NO

NUMBER* — STREET* — SUITE/BUILDING

CITY* — STATE* — ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) — EFFECTIVE DATE* (M M Y Y Y Y) — EXPIRATION DATE (M M Y Y Y Y) — TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO — $ AMOUNT OF COVERAGE PER OCCURRENCE — $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

3106

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

Work History
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Work History**

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (MMYYYY)

REASON FOR DEPARTURE (IF APPLICABLE)

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Professional Training / Work History Gaps
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 7 | **Professional Training / Work History Gaps**

Professional Training / Work History Gaps

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 month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

3108

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Disclosure Questions**

Disclosure Questions

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

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

3109

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 | **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.

DATE OF OCCURRENCE* M M D D Y Y Y Y

DATE CLAIM WAS FILED* M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED M M D D Y Y Y Y

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE POLICY NUMBER

$, , AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

3110

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

Code Lists

Country Codes (continued)

882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pushto
086 Persian (Farsi)
087 Polish
088 Portuguese
089 Punjabi
090 Quechua
091 Rhaeto-Romance
092 Romanian
093 Russian
094 Samoan
095 Sangho
096 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Volapuk
132 Welsh
133 Wolof
134 Xhosa
135 Yiddish
136 Yoruba
10 Zerbaijani
137 Zhuang
138 Zulu

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Dentistry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Medicine
100 University of Puerto Rico School of Medicine
344 University of Puerto Rico School of Dentistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of South Carolina College of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman College of Chiropractic
103 University of South Carolina School of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tennessee
105 East Tennessee State University
346 Meharry Medical College School of Dentistry
106 Meharry Medical College School of Medicine
347 University of Tennessee College of Dentistry
107 University of Tennessee College of Medicine
108 Vanderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Practice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interventional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
802 Internal Medicine, Sleep Medicine
397 Internal Medicine, Sports Medicine
433 Laboratories, Clinical Medical Laboratory
481 Legal Medicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
803 Orthopaedic Surgery, Pediatric Orthopaedic Surgery
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
804 Otolaryngology, Sleep Medicine
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pathology
244 Pediatrics
805 Pediatric Anesthesiology
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology

Code Lists

Specialty Codes - MD/DO Only

346	Pediatrics, Pediatric Cardiology
347	Pediatrics, Pediatric Critical Care Medicine
463	Pediatrics, Pediatric Emergency Medicine
349	Pediatrics, Pediatric Endocrinology
350	Pediatrics, Pediatric Gastroenterology
351	Pediatrics, Pediatric Hematology-Oncology
352	Pediatrics, Pediatric Infectious Diseases
355	Pediatrics, Pediatric Nephrology
359	Pediatrics, Pediatric Pulmonology
361	Pediatrics, Pediatric Rheumatology
806	Pediatrics, Sleep Medicine
398	Pediatrics, Sports Medicine
365	Physical Medicine & Rehabilitation
468	Physical Medicine & Rehabilitation, Pain Medicine
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469	Physical Medicine & Rehabilitation, Sports Medicine
419	Plastic Surgery
470	Plastic Surgery, Plastic Surgery Within the Head and Neck
407	Plastic Surgery, Surgery of the Hand
242	Preventive Medicine, Aerospace Medicine
429	Preventive Medicine, Medical Toxicology
112	Preventive Medicine, Occupational Medicine
471	Preventive Medicine, Sports Medicine
431	Preventive Medicine, Undersea and Hyperbaric Medicine
114	Preventive Medicine/Occupational Environmental Medicine
370	Psychiatry & Neurology, Addiction Medicine
473	Psychiatry & Neurology, Addiction Psychiatry
371	Psychiatry & Neurology, Child & Adolescent Psychiatry
313	Psychiatry & Neurology, Clinical Neurophysiology
274	Psychiatry & Neurology, Forensic Psychiatry
373	Psychiatry & Neurology, Geriatric Psychiatry
472	Psychiatry & Neurology, Neurodevelopmental Disabilities
100	Psychiatry & Neurology, Neurology
311	Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474	Psychiatry & Neurology, Pain Medicine
368	Psychiatry & Neurology, Psychiatry
809	Psychiatry & Neurology, Sleep Medicine
475	Psychiatry & Neurology, Sports Medicine
476	Psychiatry & Neurology, Vascular Neurology
366	Public Health & General Preventive Medicine
252	Radiology, Body Imaging
173	Radiology, Diagnostic Radiology
430	Radiology, Diagnostic Ultrasound
314	Radiology, Neuroradiology
319	Radiology, Nuclear Radiology
360	Radiology, Pediatric Radiology
380	Radiology, Radiation Oncology
477	Radiology, Radiological Physics
381	Radiology, Therapeutic Radiology
384	Radiology, Vascular & Interventional Radiology
434	Supplier
399	Surgery
418	Surgery, Pediatric Surgery
420	Surgery, Plastic and Reconstructive Surgery
405	Surgery, Surgery of the Hand
425	Surgery, Surgical Critical Care
413	Surgery, Surgical Oncology
423	Surgery, Trauma Surgery
400	Surgery, Vascular Surgery
421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
442	Transplant Surgery
424	Urology
811	Urology, Pediatric Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2	Dentist
13	Dentist, Dental Public Health
14	Dentist, Endodontics
438	Dentist, General Practice
16	Dentist, Oral and Maxillofacial Pathology
439	Dentist, Oral and Maxillofacial Radiology
20	Dentist, Oral and Maxillofacial Surgery
15	Dentist, Orthodontics and Dentofacial Orthopedics
17	Dentist, Pediatric Dentistry
18	Dentist, Periodontics
19	Dentist, Prosthodontics

DPM

3	Podiatrist
231	Podiatrist, Foot & Ankle Surgery
230	Podiatrist, Foot Surgery
227	Podiatrist, Primary Podiatric Medicine
226	Podiatrist, Public Medicine
228	Podiatrist, Radiology
229	Podiatrist, Sports Medicine

DC

1	Chiropractor
5	Chiropractor, Internist
6	Chiropractor, Neurology
7	Chiropractor, Nutrition
8	Chiropractor, Occupational Medicine
9	Chiropractor, Orthopedic
10	Chiropractor, Radiology
801	Chiropractor, Rehabilitation Specialization
11	Chiropractor, Sports Physician
12	Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501	Acupuncturist
503	Audiologist
504	Audiologist, Assistive Technology Practitioner
505	Audiologist, Assistive Technology Supplier
531	Christian Science Practitioner
727	Clinical Nurse Specialist
728	Clinical Nurse Specialist, Acute Care
729	Clinical Nurse Specialist, Adult Health
730	Clinical Nurse Specialist, Chronic Care
731	Clinical Nurse Specialist, Community Health/Public Health
732	Clinical Nurse Specialist, Critical Care Medicine
733	Clinical Nurse Specialist, Emergency
734	Clinical Nurse Specialist, Ethics
735	Clinical Nurse Specialist, Family Health
736	Clinical Nurse Specialist, Gerontology
737	Clinical Nurse Specialist, Holistic
738	Clinical Nurse Specialist, Home Health
739	Clinical Nurse Specialist, Informatics
740	Clinical Nurse Specialist, Long-Term Care
741	Clinical Nurse Specialist, Medical-Surgical
742	Clinical Nurse Specialist, Neonatal
743	Clinical Nurse Specialist, Neuroscience
744	Clinical Nurse Specialist, Occupational Health
745	Clinical Nurse Specialist, Oncology
746	Clinical Nurse Specialist, Oncology, Pediatrics
747	Clinical Nurse Specialist, Pediatrics
748	Clinical Nurse Specialist, Perinatal
749	Clinical Nurse Specialist, Perioperative
750	Clinical Nurse Specialist, Psychiatric/Mental Health
751	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754	Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755	Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756	Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757	Clinical Nurse Specialist, Rehabilitation
759	Clinical Nurse Specialist, School
758	Clinical Nurse Specialist, Transplantation
760	Clinical Nurse Specialist, Women's Health
513	Counselor
514	Counselor, Addiction (Substance Use Disorder)
515	Counselor, Mental Health
516	Counselor, Professional
533	Dietitian, Registered
536	Dietitian, Registered, Nutrition, Metabolic
534	Dietitian, Registered, Nutrition, Pediatric
535	Dietitian, Registered, Nutrition, Renal
651	Licensed Practical Nurse
517	Marriage & Family Therapist
547	Massage Therapist
549	Midwife, Certified
652	Midwife, Certified Nurse
551	Naturopath
553	Neuropsychologist
653	Nurse Anesthetist, Certified Registered
654	Nurse Practitioner
655	Nurse Practitioner, Acute Care
656	Nurse Practitioner, Adult Health
658	Nurse Practitioner, Community Health
657	Nurse Practitioner, Critical Care Medicine
659	Nurse Practitioner, Family

Code Lists

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
807 Pharmacist, Geriatric
575 Pharmacist, Nuclear
576 Pharmacist, Nutrition Support
808 Pharmacist, Oncology
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychiatric
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, HealthService
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
810 Registered Nurse, Registered Nurse First Assistant
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anesthetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards

044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopaedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards

113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards

118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards

140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

KAPER-1 (04/2009)
Part B, Section 1

For Health Care Providers Desiring Initial Hospital or Health Care Facility Privileges

NOTE: Submission and approval of a pre-application for privileges may be required by a health care facility prior to the facility's processing a completed KAPER-1 (04/2009), Part B, Section 1. Therefore, a provider desiring initial health care facility privileges is advised to contact the facility for information relating to any pre-application requirements.

Commonwealth of Kentucky
Instructions - Form (04/2009), Part B, Section 1

A. Uniform Application for Evaluation (Credentialing) Form. Following is the form KAPER-1 (04/2009), Part B, Section 1, developed pursuant to KRS 304.17A-535(5) for evaluation (credentialing) of a health care provider. The form is available on the Web site of the Kentucky Department of Insurance at http://insurance.ky.gov. Prior to completing this form, a health care provider who desires initial evaluation (credentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (04/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the health care provider who desires evaluation (credentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (04/2009), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments.
For a Physician, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (04/2009), Part B, Section 1, in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this license, a copy of the application for this license will be accepted until a copy of the license is available for submission.);
2. Current federal drug enforcement agency (DEA) certificate for each state of practice. (If medical, dental or other health care provider, including a psychologist, has applied for, but not received this number, a copy of the application for a DEA number will be accepted until the DEA number is available for submission.);
3. Current state substance registration certificate, if applicable. (If medical, dental or other health care provider, including a psychologist, has applied for but not received this certificate, a copy of the application for this certificate will be accepted until a copy of the state substance registration certificate is available for submission.);
4. Proof of current professional liability insurance, including name, inception and expiration dates and amount of coverage (If medical, dental or other health care provider, including a psychologist, has applied for but not received professional liability insurance, a photocopy of the application for professional liability insurance will be accepted until the proof of current professional liability insurance is available for submission.);
5. Board certification/eligibility verification information;
6. Curriculum vitae (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

For an Allied Health Professional, unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (04/2009), Part B, Section 1, in the following order:

1. Current professional license or evidence of licensure (If multiple professional licenses are held by the allied health professional, a copy of each license and/or registration should be attached; for example, registered nurse (RN);
2. Current federal drug enforcement agency (DEA) certificate, if applicable for allied health professional specialty (If allied health professional has applied for but not been issued a DEA number, a copy of the application requesting this number may be submitted until a copy of the actual DEA number is available for submission.);
3. Current state substance registration certificate, if applicable (If allied health professional has applied for but not been issued a state substance registration certificate, a copy of the application requesting this certificate may be submitted until a copy of the actual certificate is available for submission.);
4. Statement of sponsoring health care provider (e.g., physician) or collaborative practice agreement, if applicable;
5. Proof of current professional liability insurance, including allied health professional name, inception and expiration date, and amount of coverage (If allied health professional has applied for but not been issued professional liability insurance, a copy of the application requesting coverage may be submitted until a copy of the approval of coverage is available for submission.);
6. Curriculum vitae or resume (All time periods from receipt of degree to present must be accounted for);
7. Current photograph;
8. Photo identification (ID). Additionally, photo ID should be presented in person at the hospital or health care organization where participation is desired; and
9. Separate pages or supplemental forms, if any, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: _____
Last Suffix First Middle Maiden Name Degree

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____
_____ Fax: _____
_____

Primary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Secondary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Billing Office Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Contact: _____ Credentialing Email: _____

Preferred Mailing Address: ☐ Primary Office ☐ Residence ☐ Other (please specify) _____

Phys. Email Address: _____ Prac. Admin's Email: _____ Office Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse: _____

(If not a US citizen, please complete the next three fields)

Visa Status: _____ Alien Reg. #: _____ Exp. Date: _____

Language Spoken: _____

ECFMG #: (if applicable): ☐ - ☐☐☐ - ☐☐☐ - ☐ Pager #: _____ ☐ Alpha ☐ Digital ☐ Voice

Medicare #: _____ Cellular #: _____

Medicaid #: _____ Answering service #: _____

UPIN: _____ Are you taking new patients? _____

EIN: _____ Taxonomy Code: _____

NPI #: _____

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc.: _____

Name others with whom you are or will be associated in practice: _____

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice (if applicable): _____

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

II. EDUCATIONAL DATA

(All periods of time must be accounted for from entrance into medical school to the present)

Please indicate if your name at any educational institution is different than the name listed on your application. ☐ **Yes** ☐ **No**
If YES, please identify other name(s): _____

A. Schools

Undergraduate College/University: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ _____ / _____
From (mm/yy) To (mm/yy)

Medical/Dental/Other College: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____ _____ / _____
From (mm/yy) To (mm/yy)

B. Internships

Name: _____ _____ _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ _____ _____ / _____
Type of Internship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than two internships were begun or completed. Please supply the same information on a separate sheet and attach.

C. Residencies

Name: _____ _____ _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ _____ _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ _____ _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than three residencies were begun or completed. Please supply the same information on a separate sheet and attach.

D. Fellowship and/or Other Postgraduate Training

Name: _____ _____ _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ _____ _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: _____ _____ _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than three fellowships were begun or completed. Please supply the same information on a separate sheet and attach.

E. Other Professional Training

School: _____ _____ _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

School: _____ _____ _____ / _____
Chairman/Chief of Service From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

☐ Check if more than two training programs were begun or completed. Please supply the same information on a separate sheet and attach.

III. TEACHING APPOINTMENTS

Name: _____ _____ _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

Name: _____ _____ _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

IV. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

☐ CPR	☐ Yes	☐ No	Date of Expiration _____
☐ ACLS	☐ Yes	☐ No	Date of Expiration _____
☐ ATLS	☐ Yes	☐ No	Date of Expiration _____
☐ PALS	☐ Yes	☐ No	Date of Expiration _____
☐ NRP	☐ Yes	☐ No	Date of Expiration _____

Please attach copies of all certificates.

V. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

	State:	License #:	Date Issued:	Expiration Date:	Status:		License Obtained by:	
KY State:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #2:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #3:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #4:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #5:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #6:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #7:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #8:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

VI. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VII. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VIII. PROFESSIONAL LIABILITY DATA

(This application cannot be processed without proof of amount of professional liability)

Name of Carrier: _____

Address: _____

City: _____ State: _____ ZIP: _____

Policy #: _____ Amount of Coverage: _____

Date of Inception: _____ Date of Expiration: _____

Name of Agency: _____

☐ CLAIMS MADE ☐ OCCURRENCE (Check One)

Please list any other professional liability carriers you have used within the last five (5) years: _____

_____

Answer the following questions:

1.	Has your professional liability insurance coverage been terminated by action of the insurance company?	☐ N/A	☐ Yes	☐ No
2.	Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?	☐ N/A	☐ Yes	☐ No
3.	Has your present professional liability insurance carrier excluded any specific procedures from your coverage?	☐ N/A	☐ Yes	☐ No
4.	Have any professional liability suits or claims been filed against you?	☐ N/A	☐ Yes	☐ No
5.	Have any professional liability suits or claims been filed against you which are presently pending?	☐ N/A	☐ Yes	☐ No
6.	Have any judgments or settlements been made against you in professional liability cases?	☐ N/A	☐ Yes	☐ No
7.	If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund?	☐ N/A	☐ Yes	☐ No
8.	If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act?	☐ N/A	☐ Yes	☐ No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: _____

List the allegations: _____

_____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

_____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

_____

Amount of jury award or amount awarded by the court: _____

IX. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)

2. If yes, list full name of certifying board and date which you obtained certification/recertification:
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____

3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
   _____ Date: _____

4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____

5. List date of next required recertification (if applicable): _____

6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

X. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1.	Are there any actions that have been initiated or are any pending against you by any state licensing board? ☐ Pending ☐ Resolved		☐ Yes	☐ No
2.	Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed?		☐ Yes	☐ No
3.	Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s).		☐ Yes	☐ No
4.	Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?	☐ N/A	☐ Yes	☐ No
5.	Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed?	☐ N/A	☐ Yes	☐ No
6.	If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged?	☐ N/A	☐ Yes	☐ No
7.	Have you been named as a defendant or convicted of a felony or misdemeanor?		☐ Yes	☐ No
8.	Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility?		☐ Yes	☐ No
9.	Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?		☐ Yes	☐ No
10.	Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility?		☐ Yes	☐ No
11.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?		☐ Yes	☐ No

XI. PERSONAL HEALTH STATUS

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1.	Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
2.	Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
3.	Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No

XII. PROFESSIONAL SOCIETIES

Membership in local, state, or national medical societies

Dates

Name: ______________________________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________________
City: ______________ State: __________ ZIP: __________

Name: ______________________________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________________
City: ______________ State: __________ ZIP: __________

Name: ______________________________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________________
City: ______________ State: __________ ZIP: __________

Name: ______________________________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________________
City: ______________ State: __________ ZIP: __________

1. I would like to use this application for membership in the ______________ County Medical Society and the KMA. A separate dues statement will be sent.

2. I am already a member of my local medical society. Please specify society: ______________________________

XIII. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________________

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

B. Affiliations

List in chronological order all professional affiliations since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

Name: ______________________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ______________________________ Type of Privileges/Position: ______________________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: ________________ Fax: ________________ Email (if available): ______________________
Reason for leaving: ____

XIV. PEER REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, and ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/St/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

XV. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT STATEMENT

The following statement is required (by Medicare/Champus regulation) to be signed by each physician when he/she joins the Medical Staff. This must be signed and dated in the physician's own handwriting using his/her legal signature (initials are not accepted).

According to federal guidelines, stamped signatures and typed dates are not acceptable.

MEDICARE/CHAMPUS

"Notice to physicians: Medicare/Champus payment to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in 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 law."

I certify that I have received the above statement.

Signature: _____ Date: _____

Type or Printed Name: _____

KAPER-1 (01/2009)
Part B, Section 2

For Health Care Providers Desiring Reevaluation for Hospital or Health Care Facility Privileges

Commonwealth of Kentucky
Instructions - KAPER-1 (01/2009), Part B, Section 2

A. Uniform Application for Reevaluation (Recredentialing) Form. Following is the KAPER-1 (01/2009), Part B, Section 2 developed pursuant to KRS 304.17A-545(5) for reevaluation (recredentialing) of health care providers. The form is available on the Web site of the Kentucky Department of Insurance at http://insurance.ky.gov. Prior to completing this form, a health care provider who desires reevaluation (recredentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the provider, who desires reevaluation (recredentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (01/2009), Part B, Section 2 in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable;
2. Current federal drug enforcement agency (DEA) certificate for each state of practice;
3. Current state substance registration certificate, as applicable;
4. Proof of current professional liability insurance, including name, limits of liability and expiration dates. Additionally, if an affirmative response is entered for any question in Section VII of this section, provide a written explanation on an additional page of this attachment;
5. Proof of continuing medical education (CME) or continuing education unit (CEU) credits obtained in the past two (2) years; and
6. Separate pages, as applicable, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: _____
Last Suffix First Middle Maiden Name Degree

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____
_____ Fax: _____
_____

Primary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Secondary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Billing Office Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Contact: _____ Credentialing Email: _____

Preferred Mailing Address: ☐ Primary Office ☐ Residence ☐ Other (please specify) _____

Phys. Email Address: _____ Prac. Admin's Email: _____ Office Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse: _____

(If not a US citizen, please complete the next three fields)

Visa Status: _____ Alien Reg. #: _____ Exp. Date: _____

Language Spoken: _____

ECFMG #: ☐ - ☐☐☐ - ☐☐☐ - ☐ Pager #: _____ ☐ Alpha ☐ Digital ☐ Voice
(if applicable):

Medicare #: _____ Cellular #: _____

Medicaid #: _____ Answering service #: _____

UPIN: _____ Are you taking new patients? _____

EIN: _____ Taxonomy Code: _____

NPI #: _____

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc.: _____

Name others with whom you are or will be associated in practice: _____

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice (if applicable): _____

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

II. TEACHING APPOINTMENTS

Name: _____ _____ _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

III. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last two (2) years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

☐ CPR	☐ Yes	☐ No	Date of Expiration	_____
☐ ACLS	☐ Yes	☐ No	Date of Expiration	_____
☐ ATLS	☐ Yes	☐ No	Date of Expiration	_____
☐ PALS	☐ Yes	☐ No	Date of Expiration	_____
☐ NRP	☐ Yes	☐ No	Date of Expiration	_____

Please attach copies of all certificates.

IV. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

	State:	License #:	Date Issued:	Expiration Date:	Status:		License Obtained by:	
KY State:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #2:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #3:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #4:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #5:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #6:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #7:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #8:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

V. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VI. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VII. PROFESSIONAL LIABILITY DATA

Answer the following questions as they apply to the last two (2) years:

1.	Has your professional liability insurance coverage been terminated by action of the insurance company?		☐ Yes	☐ No
2.	Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?		☐ Yes	☐ No
3.	Has your present professional liability insurance carrier excluded any specific procedures from our coverage?		☐ Yes	☐ No
4.	Have any professional liability suits or claims been filed against you?		☐ Yes	☐ No
5.	Have any professional liability suits or claims been filed against you which are presently pending?		☐ Yes	☐ No
6.	Have any judgments or settlements been made against you in professional liability cases?		☐ Yes	☐ No
7.	If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund?	☐ N/A	☐ Yes	☐ No
8.	If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act?	☐ N/A	☐ Yes	☐ No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: _____

List the allegations: _____

_____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

_____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

_____

Amount of jury award or amount awarded by the court: _____

VIII. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)

2. If yes, list full name of certifying board and date which you obtained certification/recertification:
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____

3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
   _____ Date: _____

4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____

5. List date of next required recertification (if applicable): _____

6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

IX. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1.	Are there any actions that have been initiated or are any pending against you by any state licensing board? ☐ Pending ☐ Resolved		☐ Yes	☐ No
2.	Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed?		☐ Yes	☐ No
3.	Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s).		☐ Yes	☐ No
4.	Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?	☐ N/A	☐ Yes	☐ No
5.	Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed?	☐ N/A	☐ Yes	☐ No
6.	If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged?	☐ N/A	☐ Yes	☐ No
7.	Have you been named as a defendant or convicted of a felony or misdemeanor?		☐ Yes	☐ No
8.	Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility?		☐ Yes	☐ No
9.	Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?		☐ Yes	☐ No
10.	Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility?		☐ Yes	☐ No
11.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?		☐ Yes	☐ No

X. PERSONAL HEALTH STATUS

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1.	Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
2.	Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
3.	Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No

XI. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: ____________ Fax: ____________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: ____________ Fax: ____________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: ____________ Fax: ____________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: ____________ Fax: ____________ Email (if available): ______________________

Reason for leaving: ______________________

B. Affiliations

List in chronological order all professional affiliations within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________________ ____________ / ____________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: ____________ Fax: ____________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ______________________
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ______________________

XII. PEER REFERENCES

Name two peers who have personal knowledge of your current clinical abilities, ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: ______________________
Address: ______________________
City/St/ZIP: ______________________ Country: __________
Phone: __________ Fax: __________ Email (if available): ______________

Reference: ______________________
Address: ______________________
City/St/ZIP: ______________________ Country: __________
Phone: __________ Fax: __________ Email (if available): ______________

XIII. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____ **Date:** _____