



**Kentucky Application  
for  
Provider Evaluation and  
Reevaluation**

**November 2019**

**KAPER-1 (11/2019)**

## Kentucky Department of Insurance

### Kentucky Application for Provider Evaluation and Reevaluation – 11/2019

**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 (11/2019) 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 (11/2019), 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 (11/2019), 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(11/2019), Part B is also used by the CHFS pursuant to KRS 216B.155.

The KAPER-1 (11/2019) 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-1 (11/2019), 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-1 (11/2019), Part A**

**A. Uniform Kentucky Application for Evaluation (Credentialing) and Reevaluation (recredentialing) Form.** Following is the KAPER-1 (11/2019), 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-1 (11/2019), 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-1 (11/2019), 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-1 (11/2019), 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 (11/2019), 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-1 (11/2019), Part A is submitted to an insurer, a cover letter signed and dated by the health care provider requesting consideration of evaluation or reevaluation 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-1 (11/2019), 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

M ✓ •

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

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?\* NO (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

M M D D Y Y Y Y

DATE STARTED USING OTHER NAME

M M D D Y Y Y Y

DATE STOPPED USING OTHER NAME

#### 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.

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**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

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

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

LICENSE EXPIRATION DATE

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

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

LICENSE EXPIRATION DATE

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

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

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

\* 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.

**UNDERGRADUATE SCHOOL**

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

ADDRESS

CITY STATE ZIP/POSTAL CODE

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE TELEPHONE FAX

COUNTRY CODE

TELEPHONE

FAX

START DATE

START DATE

END DATE (GRADUATION DATE)

END DATE (GRADUATION DATE)

DEGREE AWARDED

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\*

START DATE\*

END DATE (GRADUATION DATE)\*

END DATE (GRADUATION DATE)\*

DEGREE AWARDED

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

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRESS

ADDRESS

CITY COUNTRY CODE POSTAL CODE

CITY

COUNTRY CODE

POSTAL CODE

START DATE\*

START DATE\*

END DATE (GRADUATION DATE)\*

END DATE (GRADUATION DATE)\*

DEGREE AWARDED

DEGREE AWARDED

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

**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.

\* 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.

	<b>INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)</b>	<b>SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)</b>
<b>NUMBER</b>	<b>STREET</b>	<b>SUITE/BUILDING</b>
<b>CITY</b>	<b>STATE</b>	<b>ZIP/POSTAL CODE</b>
<b>COUNTRY CODE</b>	<b>TELEPHONE</b>	<b>FAX</b>
<b>DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)</b>		

List each department separately, if applicable.  List Internship/Residency, Fellowship and Other programs separately.	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"><input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b></td> <td style="width:15%;"><input type="checkbox"/> <b>FELLOWSHIP</b></td> <td style="width:15%;"><input type="checkbox"/> <b>OTHER</b></td> <td style="width:20%; text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="width:20%; text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;"><b>START DATE</b></td> <td style="text-align: center;"><b>END DATE</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>NAME OF DIRECTOR</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td><input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b></td> <td><input type="checkbox"/> <b>FELLOWSHIP</b></td> <td><input type="checkbox"/> <b>OTHER</b></td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;"><b>START DATE</b></td> <td style="text-align: center;"><b>END DATE</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>NAME OF DIRECTOR</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td><input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b></td> <td><input type="checkbox"/> <b>FELLOWSHIP</b></td> <td><input type="checkbox"/> <b>OTHER</b></td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;"><b>START DATE</b></td> <td style="text-align: center;"><b>END DATE</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b></td> </tr> <tr> <td colspan="5" style="height: 20px;"></td> </tr> <tr> <td colspan="5"><b>NAME OF DIRECTOR</b></td> </tr> </table>	<input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b>	<input type="checkbox"/> <b>FELLOWSHIP</b>	<input type="checkbox"/> <b>OTHER</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				<b>START DATE</b>	<b>END DATE</b>						<b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b>										<b>NAME OF DIRECTOR</b>										<input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b>	<input type="checkbox"/> <b>FELLOWSHIP</b>	<input type="checkbox"/> <b>OTHER</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				<b>START DATE</b>	<b>END DATE</b>						<b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b>										<b>NAME OF DIRECTOR</b>										<input type="checkbox"/> <b>INTERNSHIP/RESIDENCY</b>	<input type="checkbox"/> <b>FELLOWSHIP</b>	<input type="checkbox"/> <b>OTHER</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				<b>START DATE</b>	<b>END DATE</b>						<b>DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</b>										<b>NAME OF DIRECTOR</b>				
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\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

**Section 4 Practice Location Information (Continued)**

**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 PAYEE 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 box above, please provide the E-mail Address of the Payee Contact.

**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.





\* 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**

<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
LAST NAME															SPECIALTY CODE			COVERING COLLEAGUE (Y/N)?
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
LAST NAME															SPECIALTY CODE			COVERING COLLEAGUE (Y/N)?
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
LAST NAME															SPECIALTY CODE			COVERING COLLEAGUE (Y/N)?
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.

**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**

<input type="text"/>															<input type="text"/>			
LAST NAME															SPECIALTY CODE			
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.
<input type="text"/>															<input type="text"/>			
LAST NAME															SPECIALTY CODE			
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.
<input type="text"/>															<input type="text"/>			
LAST NAME															SPECIALTY CODE			
<input type="text"/>															<input type="text"/>			<input type="checkbox"/>
FIRST NAME															PROVIDER TYPE (CODE PG 36)			M.I.

**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?

<input type="text"/>														
<input type="text"/>														
<input type="text"/>														
<input type="text"/>														
<input type="text"/>														

\* 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.

M M Y Y Y Y M M Y Y Y Y FULL, UNRESTRICTED PRIVILEGES? YES NO ARE PRIVILEGES TEMPORARY? YES NO

AFFILIATION START DATE AFFILIATION END DATE

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.

M M Y Y Y Y M M Y Y Y Y FULL, UNRESTRICTED PRIVILEGES? YES NO ARE PRIVILEGES TEMPORARY? YES NO

AFFILIATION START DATE AFFILIATION END DATE

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.



**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 6**

**Professional Liability Insurance Carrier**

**Professional Liability Insurance Carrier**

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

SELF-INSURED?\* YES  NO

CARRIER OR SELF-INSURED NAME\*

NUMBER\* STREET\* SUITE/BUILDING

CITY\* STATE\* ZIP CODE\*

MMYYYY EFFECTIVE DATE\* MMYYYY EXPIRATION DATE YYY TYPE OF COVERAGE?\* INDIVIDUAL  SHARED

ORIGINAL EFFECTIVE DATE\*  
MMYYYY

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.

SELF-INSURED?\* YES  NO

CARRIER OR SELF-INSURED NAME

NUMBER\* STREET\* SUITE/BUILDING

CITY\* STATE\* ZIP CODE\*

MMYYYY EFFECTIVE DATE\* MMYYYY EXPIRATION DATE YYY TYPE OF COVERAGE?\* INDIVIDUAL  SHARED

ORIGINAL EFFECTIVE DATE\* EFFECTIVE DATE\* EXPIRATION DATE

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



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

KAPER-1 (11/2019)



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**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?\*

**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\*

3094

# 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

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

FEDERAL DEA NUMBER

DEA ISSUE DATE

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

CDS CERTIFICATE NUMBER

CDS ISSUE DATE

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE

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

LICENSE EXPIRATION DATE

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

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

LICENSE EXPIRATION DATE

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 Relevant Education Supplemental Form

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

<b>Section 2</b>	<b>Education and Training</b>
------------------	-------------------------------

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO											
M M Y Y Y Y					M M Y Y Y Y						
START DATE					END DATE (GRADUATION DATE)						

**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								
M M Y Y Y Y		M M Y Y Y Y		M M Y Y Y Y							
COUNTRY CODE		START DATE		END DATE (GRADUATION DATE)		DEGREE AWARDED					
DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO											

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)											
NUMBER			STREET				SUITE/BUILDING				
CITY						STATE		ZIP/POSTAL CODE			
TELEPHONE			FAX								
M M Y Y Y Y		M M Y Y Y Y		M M Y Y Y Y							
COUNTRY CODE		START DATE		END DATE (GRADUATION DATE)		DEGREE AWARDED					
DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> 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	M M Y Y Y Y		
			START DATE	END DATE		
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)						
NAME OF DIRECTOR						
INTERNSHIP/ RESIDENCY	FELLOWSHIP	OTHER	M M Y Y Y Y	M M Y Y Y Y		
			START DATE	END DATE		
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)						
NAME OF DIRECTOR						
INTERNSHIP/ RESIDENCY	FELLOWSHIP	OTHER	M M Y Y Y Y	M M Y Y Y Y		
			START DATE	END DATE		
DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)						
NAME OF DIRECTOR						



# 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 \_\_\_\_\_

<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>
<b>LAST NAME</b>	<input type="text"/>	<input type="checkbox"/>	<b>SPECIALTY CODE</b>	<input type="checkbox"/>	<b>COVERING COLLEAGUE (Y/N)?</b>
<b>FIRST NAME</b>	<input type="text"/>	<b>M.I.</b>	<input type="text"/>	<input type="text"/>	<b>PROVIDER TYPE (CODE PG 36)</b>

3098

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

# 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.

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

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 BILLING INFORMATION

LAST NAME\*

FIRST NAME\*  M.I.

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FRIDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SATURDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	SUNDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	AFTER HOURS BACK OFFICE TELEPHONE				

### 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  INSTRUCTIONS TO CALL ANSWERING SERVICE  VOICE MAIL WITH OTHER INSTRUCTIONS

### Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?\*  YES  NO

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

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?\*  YES  NO

ACCEPT ALL NEW PATIENTS?\*  YES  NO

ACCEPT NEW MEDICARE PATIENTS?\*  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  FEMALE  NONE  U N L Y

3101

\* 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 3 of 5

**Additional Practice Location**

(Continued)

**IMPORTANT**

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

**Mid-Level Practitioners**

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)

--

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

# 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

	<input type="text"/>				
	LANGUAGE CODE				

INTERPRETERS AVAILABLE?\*  YES  NO

LANGUAGES INTERPRETED

	<input type="text"/>				
	LANGUAGE CODE				

**Accessibilities**

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?\*  YES  NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

BUILDING?* <input type="checkbox"/> YES <input type="checkbox"/> NO	TEXT TELEPHONY (TTY)* <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCESSIBLE BY PUBLIC TRANSPORTATION?* <input type="checkbox"/> YES <input type="checkbox"/> NO
PARKING?* <input type="checkbox"/> YES <input type="checkbox"/> NO	AMERICAN SIGN LANGUAGE* <input type="checkbox"/> YES <input type="checkbox"/> NO	BUS* <input type="checkbox"/> YES <input type="checkbox"/> NO
RESTROOM?* <input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="checkbox"/> YES <input type="checkbox"/> NO	SUBWAY* <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="text"/>	<input type="text"/>	REGIONAL TRAIN* <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER HANDICAPPED ACCESS	OTHER DISABILITY SERVICES	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? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY INJECTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGY SKIN TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? <input type="checkbox"/> YES <input type="checkbox"/> NO
DRAWING BLOOD? <input type="checkbox"/> YES <input type="checkbox"/> NO	AGE APPROPRIATE IMMUNIZATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	FLEXIBLE SIGMOIDOSCOPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYMPANOMETRY/AUDIOMETRY SCREENING? <input type="checkbox"/> YES <input type="checkbox"/> NO
ASTHMA TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	OSTEOPATHIC MANIPULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IV HYDRATION/TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	CARDIAC STRESS TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO
PULMONARY FUNCTION TESTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	PHYSICAL THERAPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	CARE OF MINOR LACERATIONS? <input type="checkbox"/> YES <input type="checkbox"/> 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)

→ **LOCATION\* #**

**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.

**LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
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**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
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.

--	--	--	--

**AFFILIATION START DATE**

--	--	--	--

**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



# 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										END DATE																																																																															
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										END DATE																																																																															
REASON FOR DEPARTURE (IF APPLICABLE)																																																																																																			

# Work History Supplemental Form

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

Std. App. v.5.0







# 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	030	Licensed Practical Nurse
021	Alcohol/Drug Counselor	031	Marriage/Family Therapist
022	Audiologist	032	Massage Therapist
023	Biofeedback Technician	033	Naturopath
024	Certified Registered Nurse Anesthetist	034	Neuropsychologist
025	Christian Science Practitioner	035	Midwife
026	Clinical Nurse Specialist	036	Nurse Midwife
027	Clinical Psychologist	037	Nurse Practitioner
028	Clinical Social Worker	038	Nutritionist
029	Dietician	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	008	Pending	015	Temporary
002	Canceled	009	Probation	016	Terminated
003	Denied	010	Provisional	017	Time Limited
004	Expired	011	Restricted	018	Unrestricted
005	Inactive	012	Revoked	019	Other
006	Lapsed	013	Suspended		
007	Limited	014	Surrendered		

## Country Codes

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

# Code Lists

## Country Codes (continued)

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

## Language Codes

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

# 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 Angeles  
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

60 Duke University School of Medicine  
61 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

67 Dartmouth Medical School

### New Jersey

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

### New Mexico

70 University of New Mexico School of Medicine

### Nevada

71 University of Nevada School of Medicine

### New York

72 Albany Medical College  
73 Albert Einstein College of Medicine  
74 Columbia University College of Physicians and Surgeons  
333 Columbia University School of Dental and Oral Surgery  
75 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  
79 State University of New York College of Medicine  
80 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  
86 Northeastern Ohio Universities College of Medicine  
803 Ohio College of Podiatric Medicine  
338 Ohio State University College of Dentistry  
87 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

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

### Pennsylvania

92 Jefferson Medical College of Thomas Jefferson University

515 Lake Erie College of Osteopathic Medicine  
93 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

98 Ponce School of Medicine  
99 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	287	Internal Medicine, Hematology	Spine	
246	Allergy & Immunology, Allergy	288	Internal Medicine, Hematology & Oncology	416	Orthopaedic Surgery, Orthopaedic Trauma
291	Allergy & Immunology, Clinical & Laboratory Immunology	450	Internal Medicine, Hepatology	803	Orthopaedic Surgery, Pediatric Orthopaedic Surgery
249	Anesthesiology	299	Internal Medicine, Infectious Disease	457	Orthopaedic Surgery, Sports Medicine
235	Anesthesiology, Addiction Medicine	451	Internal Medicine, Interventional Cardiology	119	Orthopedic
258	Anesthesiology, Critical Care Medicine	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	331	Otolaryngology
126	Anesthesiology, Pain Medicine	325	Internal Medicine, Medical Oncology	458	Otolaryngology, Otolaryngic Allergy
363	Clinical Pharmacology	309	Internal Medicine, Nephrology	459	Otolaryngology, Otolaryngology/ Facial Plastic Surgery
367	Colon & Rectal Surgery	378	Internal Medicine, Pulmonary Disease	332	Otolaryngology, Otology & Neurotology
263	Dermatology	390	Internal Medicine, Rheumatology	357	Otolaryngology, Pediatric Otolaryngology
292	Dermatology, Clinical & Laboratory	802	Internal Medicine, Sleep Medicine	417	Otolaryngology, Plastic Surgery within the Head & Neck
	Dermatological Immunology	397	Internal Medicine, Sports Medicine	804	Otolaryngology, Sleep Medicine
444	Dermatology, Dermatological Surgery	433	Laboratories, Clinical Medical Laboratory	480	Pain Medicine, Interventional Pain Medicine
266	Dermatology, Dermatopathology	481	Legal Medicine	337	Pain Medicine
264	Dermatology, MOHS-Micrographic Surgery	278	Medical Genetics, Clinical Biochemical Genetics	338	Pathology, Anatomic Pathology
443	Dermatology, Pediatric Dermatology	261	Medical Genetics, Clinical Cytogenetic	340	Pathology, Anatomic Pathology & Clinical Pathology
268	Emergency Medicine	277	Medical Genetics, Clinical Genetics (M.D.)	250	Pathology, Blood Banking & Transfusion Medicine
445	Emergency Medicine, Emergency Medical Services	280	Medical Genetics, Clinical Molecular Genetics	344	Pathology, Chemical Pathology
427	Emergency Medicine, Medical Toxicology	455	Medical Genetics, Molecular Genetic Pathology	302	Pathology, Clinical Pathology/Laboratory Medicine
348	Emergency Medicine, Pediatric Emergency Medicine	454	Medical Genetics, Ph.D. Medical Genetics	262	Pathology, Cytopathology
395	Emergency Medicine, Sports Medicine	306	Neonatal-Perinatal Medicine	265	Pathology, Dermatopathology
446	Emergency Medicine, Undersea and Hyperbaric Medicine	308	Neopathology	273	Pathology, Forensic Pathology
391	Facial Plastic Surgery	409	Neurological Surgery	290	Pathology, Hematology
272	Family Practice	330	Neuromusculoskeletal Medicine & OMM	298	Pathology, Immunopathology
447	Family Practice, Addiction Medicine	440	Neuromusculoskeletal Medicine, Sports Medicine	305	Pathology, Medical Microbiology
237	Family Practice, Adolescent Medicine	317	Nuclear Medicine	461	Pathology, Molecular Genetic Pathology
448	Family Practice, Adult Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	312	Pathology, Neuropathology
282	Family Practice, Geriatric Medicine	315	Nuclear Medicine, Nuclear Cardiology	358	Pathology, Pediatric Pathology
396	Family Practice, Sports Medicine	316	Nuclear Medicine, Nuclear Imaging & Therapy	244	Pediatrics
225	General Practice	321	Obstetrics & Gynecology	805	Pediatric Anesthesiology
479	Hospitalist	260	Obstetrics & Gynecology, Critical Care Medicine	239	Pediatrics, Adolescent Medicine
301	Internal Medicine	326	Obstetrics & Gynecology, Gynecologic Oncology	295	Pediatrics, Clinical & Laboratory Immunology
449	Internal Medicine, Addiction Medicine	286	Obstetrics & Gynecology, Gynecology	462	Pediatrics, Developmental – Behavioral Pediatrics
236	Internal Medicine, Adolescent Medicine	303	Obstetrics & Gynecology, Maternal & Fetal Medicine	354	Pediatrics, Medical Toxicology
248	Internal Medicine, Allergy & Immunology	320	Obstetrics & Gynecology, Obstetrics	356	Pediatrics, Neurodevelopmental Disabilities
255	Internal Medicine, Cardiovascular Disease	271	Obstetrics & Gynecology, Reproductive Endocrinology	345	Pediatrics, Pediatric Allergy & Immunology
294	Internal Medicine, Clinical & Laboratory Immunology	328	Ophthalmology		
253	Internal Medicine, Clinical Cardiac Electrophysiology	441	Oral & Maxillofacial Surgery		
257	Internal Medicine, Critical Care Medicine	411	Orthopaedic Surgery		
267	Internal Medicine, Endocrinology, Diabetes & Metabolism	412	Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery		
275	Internal Medicine, Gastroenterology	456	Orthopaedic Surgery, Foot and Ankle Orthopaedics		
285	Internal Medicine, Geriatric Medicine	406	Orthopaedic Surgery, Hand Surgery		
		415	Orthopaedic Surgery, Orthopaedic Surgery of the		

# Code Lists

## Specialty Codes - MD/DO Only

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

## 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	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
438 Dentist, General Practice	227 Podiatrist, Primary Podiatric Medicine	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	226 Podiatrist, Public Medicine	8 Chiropractor, Occupational Medicine
439 Dentist, Oral and Maxillofacial Radiology	228 Podiatrist, Radiology	9 Chiropractor, Orthopedic
20 Dentist, Oral and Maxillofacial Surgery	229 Podiatrist, Sports Medicine	10 Chiropractor, Radiology
15 Dentist, Orthodontics and Dentofacial Orthopedics		801 Chiropractor, Rehabilitation Specialization
17 Dentist, Pediatric Dentistry		11 Chiropractor, Sports Physician
18 Dentist, Periodontics		12 Chiropractor, Thermography
19 Dentist, Prosthodontics		

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

# Code Lists

## Specialty Codes - Allied Providers (continued)

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

# Code Lists

## Specialty Boards - Allied Providers

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

## 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 (11/2019)**

## **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 (11/2019), 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 (11/2019), Part B, Section 1**

**A. Uniform Application for Evaluation (Credentialing) Form.** Following is the form KAPER-1 (11/2019), 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 (11/2019), 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 (11/2019), 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 (11/2019), 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); 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 (11/2019), 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: \_\_\_\_\_  
St ZIP ZIP+ City Country

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email (if available): \_\_\_\_\_

Degree: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)

Medical/Dental/Other College: \_\_\_\_\_

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

City/State/ZIP: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City Country

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email (if available): \_\_\_\_\_

Degree: \_\_\_\_\_

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

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email (if available): \_\_\_\_\_

Name: \_\_\_\_\_  
Department Chief Type of Appointment

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

City/State/ZIP: \_\_\_\_\_ / \_\_\_\_\_  
St ZIP ZIP+ From (mm/yy) City 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?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> 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: \_\_\_\_\_
- 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?  Yes  No  
 Pending  Resolved
- 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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: \_\_\_\_\_  
St ZIP ZIP+ City 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 (11/2019)**  
**Part B, Section 2**

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

**Commonwealth of Kentucky**  
**Instructions - KAPER-1 (11/2019), Part B, Section 2**

**A. Uniform Application for Reevaluation (Recredentialing) Form.** Following is the KAPER-1 (11/2019), 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 (11/2019), 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 (11/2019), 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 (11/2019), 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

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: \_\_\_\_\_ St \_\_\_\_\_ ZIP \_\_\_\_\_ ZIP+ \_\_\_\_\_ / \_\_\_\_\_ City \_\_\_\_\_  
 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?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> 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?
2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?
3. Has your present professional liability insurance carrier excluded any specific procedures from our coverage?
4. Have any professional liability suits or claims been filed against you?
5. Have any professional liability suits or claims been filed against you which are presently pending?
6. Have any judgments or settlements been made against you in professional liability cases?
7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund?
8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act?

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:
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?  Yes  No  
 Pending  Resolved
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:** \_\_\_\_\_