OREGON PRACTITIONER CREDENTIALING APPLICATION

(Not an Employment Application)

Prior to completing this credentialing application, please read and observe the following:

→ Healthcare Organizations may contract with credentials verification organizations (CVO) to verify the credentials of practitioners. ***Before completing this form, please contact the Organization you are applying to for instructions on how to proceed or should you have any questions.***

→ **Complete the application in its entirety**. Keep a copy of the application on file for future requests. When a request is placed, send a copy of the completed application, **making sure that all information is complete, current and accurate.** Sign and date pages 9 and 10, and mail application to the requesting organization.

→ Each page of the application requires the applicant's name and the date in which the application was last reviewed.

→ Identify the healthcare organization(s) this application is being submitted to in the space provided below.

→ If a section does not apply to you, please write N/A in the first box of the section.

→ Attach copies of the documents requested each time the application is submitted.

I. **INSTRUCTIONS**

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. **Current copies of the following documents must be submitted with this application:**

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (optional)

**** All sections must be completed in their entirety. A curriculum vitae is not an acceptable substitute ****

I am applying to_____

_____

_____

(herein, this/these Healthcare Organization(s)) for _____ (i.e., staff membership, network participation, if applicable).

PRACTITIONER NAME: _____

DATE: _____

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II. SPECIALTY INFORMATION (this information may be included in directory listings)

Primary Specialty:

Do you want to be designated as a primary care provider (PCP)?

☐ YES ☐ NO

Sub-specialties and/or Alternative Care Practices:

III. PRACTITIONER INFORMATION *(Please provide the practitioner's full legal name)*

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):
Is there any other name under which you have been known? Name(s):			
Home Mailing Address:	City:		
	State:	Zip:	
Home Telephone Number: ( )	Birth Date:	Birth Place:	
Social Security Number: (if used for business, please check this box ☐)		Gender: ☐ Male ☐ Female	

IV. PRACTICE INFORMATION

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:	Effective Date at Location: mo/yr	
	County:	State:	Zip:
Primary Office Telephone Number: ( )	Primary Office Fax Number: ( )	Patient Appointment Telephone Number: ( )	
Mailing Address (if different from above): Attn:			
Office Manager:	Office Manager's Telephone Number: ( )	Office Manager's Fax Number: ( )	
Exchange / Answering Service Number:	Pager Number:	E-Mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( )	Credentialing Contact's Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

PRACTICE INFORMATION, continued:

PRACTITIONER NAME: _____

DATE: _____

Secondary Office Street Address:	City:	Effective Date at Location:
	County:	State:	Zip:
Secondary Office Telephone Number: ( )	Secondary Office Fax Number: ( )	Patient Appointment Telephone Number: ( )
Mailing Address (if different from above):		
Office Manager:	Office Manager's Telephone Number: ( )	Office Manager's Fax Number: ( )
Exchange / Answering Service Number:	Pager Number:	E-mail Address:
Credentialing Contact and Address (if different from above):		
Credentialing Contact's Telephone Number: ( )	Credentialing Contact's Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

List other office locations with above information on a separate sheet.

IV. A. **PRACTICE CALL COVERAGE** - Please provide the names of those practitioners who will provide call coverage for your practice or attach separate listing.

_____

_____

_____

_____

_____

V. BILLING OFFICE INFORMATION

Legal Name of Practice:	Billing Office Address:	
Office Manager's Name:	Billing Office Telephone Number: ( )	Billing Office Fax Number: ( )

	Medicare UPIN	Medicare Number	DSHS Number	OMAP Number	NPI Number
OR					
WA					
ID					
CA					

UPIN: Unique Provider Identification Number DSHS: Dept. of Social & Health Services OMAP: OR Medical Assistance Program NPI: Nt'l Provider Identifier

VI. UNDERGRADUATE EDUCATION (attach additional sheets if necessary)

PRACTITIONER NAME: _____

DATE: _____

Complete School Name:	Degree Received:	Graduation Date (mm/dd/yy):
City and State:		

VII. MEDICAL/PROFESSIONAL EDUCATION (attach additional sheets if necessary)

Complete Medical/Professional School Name and Address:			Fax Number, if available:
Degree Received:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

Complete Medical/Professional School Name and Address:			Fax Number, if available:
Degree Received:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

VIII. INTERNSHIP/PGYI (attach additional sheets if necessary) Does Not Apply ☐

Complete Institution Name and Address:		Fax Number, if available:	
Type of Internship / Specialty:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

IX. RESIDENCIES (attach additional sheets if necessary) Does Not Apply ☐

Complete Institution Name and Address:		Fax Number, if available:	
Specialty:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

Complete Institution Name and Address:		Fax Number, if available:	
Specialty:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

X. FELLOWSHIPS (attach additional sheets if necessary) Does Not Apply ☐

Complete Institution Name and Address:		Fax Number, if available:	
Specialty:	Date of Completion:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

XI. HEALTHCARE LICENSURE, REGISTRATIONS & CERTIFICATES (attach additional sheet if necessary)

PRACTITIONER NAME: _____

DATE: _____

Oregon Number:	Type:	Expiration Date:
Washington Number:	Type:	Expiration Date:
Idaho Number:	Type:	Expiration Date:
California Number:	Type:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

XII. **OTHER STATE HEALTHCARE LICENSES, REGISTRATIONS & CERTIFICATES** (include all other ever held - attach additional sheets if necessary)

State / Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		
State/ Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		
State / Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		

XIII. **BOARD CERTIFICATION** ***(This section does not apply to licensure)*** Does Not Apply ☐

Are you board or otherwise professionally certified?

☐ **Yes** If "Yes", please complete below: ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification below, attach additional sheets if necessary. If you participate in a specialty which does not have board certification, please indicate on a separate sheet.

Name and Address of Issuing Board	Specialty	Date Certified/Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No
If so, list and date:

XIV. **OTHER CERTIFICATIONS** (attach certificate if applicable) Does Not Apply ☐

PRACTITIONER NAME: _____
DATE: _____

Examples include: ACLS, BLS, ATLS, PALS, NRP E.G. Fluoroscopy, Radiography, etc.		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XV. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations (B) have applications in process, and (C) have had previous hospital privileges. This includes hospitals, surgery centers, institutions, corporations, military assignments, government agencies or any other healthcare institution. **If more space is needed, attach additional sheets. List only affiliations here; do not list residencies, internships, or fellowships. List employment in Section XVI.** ***If you do not have hospital privileges, please explain on a separate sheet, your plan for continuity of care for any of your patients who require hospitalization.***

A. CURRENT AFFILIATIONS

Facility Name:		Complete Address:
Status (e.g. active, provisional, allied health, etc.):	Appointment Date (mm/yy):	
Facility Name:		Complete Address:
Status:	Appointment Date (mm/yy):	
Facility Name:		Complete Address:
Status:	Appointment Date (mm/yy):	

B. APPLICATIONS IN PROCESS

Facility Name:	City and State:	Submission Date:	Status:
Facility Name:	City and State:	Submission Date:	Status:

C. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS- Attach Additional Sheet if Needed

Name of Facility:		Address:
From (mm/yy):	To (mm/yy):	Reason for Leaving:
Name of Facility:		Address:
From (mm/yy):	To (mm/yy):	Reason for Leaving:
Name of Facility:		Address:
From (mm/yy):	To (mm/yy):	Reason for Leaving:

XVI. PROFESSIONAL PRACTICE / WORK HISTORY (A curriculum vitae is <u>not</u> sufficient)

Chronologically list <u>all</u> work and professional practice history activities since completion of postgraduate training , including military service (attach additional sheets if necessary). This information must be complete.			
Name of Current Practice/Employer:		Telephone Number: ( )	
Contact Name:		Fax Number: ( )	
Mailing Address:	City/State/Zip:	From (mm/yy):	To (mm/yy):
Name of Previous Practice / Employer:		Telephone Number: ( )	
Contact Name:		Fax Number: ( )	
Mailing Address:	City/State/Zip:	From (mm/yy):	To (mm/yy):
Name of Previous Practice / Employer:		Telephone Number: ( )	
Contact Name:		Fax Number: ( )	
Mailing Address:	City/State/Zip:	From (mm/yy):	To (mm/yy):

XVI. A.

Please account for <u>all</u> periods of time from the date of entry into medical/professional school to present not covered elsewhere within this application. Include dates, activity and names where applicable. <u>*Please explain any gaps greater than two months - attach additional sheets if necessary:*</u>

_____

_____

_____

_____

_____

XVII. PEER REFERENCES

List three professional references, including at least one individual from the same discipline with essentially equal qualifications not including relatives, current or pending partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. ***NOTE:*** *References must be from individuals who through recent observation are directly familiar with your work.*

Name of Reference:	Specialty and Relationship:	Telephone Number: ( )
Mailing Address:	City/State/Zip:	Fax Number: ( )
Name of Reference:	Specialty and Relationship:	Telephone Number: ( )
Mailing Address:	City/State/Zip:	Fax Number: ( )
Name of Reference:	Specialty and Relationship:	Telephone Number: ( )
Mailing Address:	City/State/Zip:	Fax Number: ( )

XVIII. PROFESSIONAL LIABILITY

Current Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage: Claims Made ☐ Occurrence ☐
Mailing Address:		
Name of Local Contact:		Contact Telephone Number: ( )
Per claim limit of liability: $	Aggregate amount: $	Effective Date: / Expiration Date:

Please list all of your professional liability carriers within the past five years (attach additional sheets if necessary):

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage: Claims Made ☐ Occurrence ☐
Mailing Address:		
Name of Local Contact:		Contact Telephone Number: ( )
Per claim limit of liability: $	Aggregate amount: $	Effective Date: / Expiration Date:
Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage: Claims Made ☐ Occurrence ☐
Mailing Address:		
Name of Local Contact:		Contact Telephone Number: ( )
Per claim limit of liability: $	Aggregate amount: $	Effective Date: / Expiration Date:
Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage: Claims Made ☐ Occurrence ☐
Mailing Address:		
Name of Local Contact:		Contact Telephone Number: ( )
Per claim limit of liability: $	Aggregate amount: $	Effective Date: / Expiration Date:

XIX. MEDICARE/MEDICAID CONDITIONS OF PARTICIPATION

How do you meet Medicare/Medicaid Conditions of Participation relating to hospitals, JCAHO standards, and conditions for reimbursement to the hospital for services that you have initiated?

- ☐ I am an M.D. or D.O. and, therefore, meet the requirements.
- ☐ I am not applying for any hospital privileges, and therefore these requirements do not apply.
- ☐ I am not an M.D. or a D.O. but am applying for hospital privileges; I have made arrangements to work together with _____M.D./D.O. to meet the requirements for my hospitalized patients.

XX. ATTESTATION QUESTIONS - **This section to be completed by the Practitioner**

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on separate sheet. ***If you attach additional sheets, please sign and date those sheets**.*

PRACTITIONER NAME: _____
DATE: _____

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you been fined or received a letter of reprimand or is any such action pending or under review?	☐ YES ☐ NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	☐ YES ☐ NO
C.	Have you **ever been** denied clinical privileges, membership, contractual participation or employment by any healthcare related organization**, or have your clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished, or not renewed - or is any such action pending or under review?	☐ YES ☐ NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any medical organization ** while under investigation or potential review?	☐ YES ☐ NO
E.	Have you **ever** withdrawn an application for clinical privileges, appointment, membership, employment or participation in any healthcare related organization prior to the organization's final action on your request?	☐ YES ☐ NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished, or not renewed or is any such action pending or under review?	☐ YES ☐ NO
G.	Have you **ever been** denied certification / recertification, or has your eligibility status changed with respect to certification / recertification by a specialty board?	☐ YES ☐ NO
H.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	☐ YES ☐ NO
I.	Have you **ever been** charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation? A. Do you have notice of any such anticipated charges?	☐ YES ☐ NO **A.** ☐ YES ☐ NO
J.	Do you presently use any drugs illegally?	☐ YES ☐ NO
K.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice with or without reasonable accommodation the privileges requested? If reasonable accommodation is required, specify the accommodations required.	☐ YES ☐ NO
L.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement / hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	☐ YES ☐ NO
M.	Has judgment **ever been** entered or money paid in part to settle allegations of negligence / malpractice or any form of action or inaction by you in a professional role, whether or not a lawsuit was filed or the allegations ever proven in court? A. Are there any such claims being asserted against you now? (If yes, full details and reasons are not required at this time.)	☐ YES ☐ NO **A.** ☐ YES ☐ NO
N.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	☐ YES ☐ NO

** (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system)

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this Application, including this Attestation and the Authorization and Release has the same force and effect as the original. I have reviewed this information of the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the provider/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature _____ Date _____

Oregon Practitioner Credentialing Application

AUTHORIZATION AND RELEASE OF INFORMATION FORM

PRACTITIONER NAME: _____

DATE: _____

Modified Releases Will Not Be Accepted

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated Hospital(s) and/or participation status with the Healthcare Organization(s)** indicated on this application (initial credentialing/recredentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matters, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as a part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the Healthcare Organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Signature _____ **Date** _____

I grant permission for the release of the credentials information contained in this practitioner application to the following entities.

Entity Release Name(s):

_____

_____

_____

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance Organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, credentials verification organization (CVO), professional association, medical school faculty position or other health delivery entity or system).