



Texas Standardized Credentialing Application

(Please type or print)

Section I

Personal Information

Name – Last		First	Middle	(Jr., Sr., etc.)	Social Security Number	
Other Name Used (Maiden/Other)	Years Associated with Former Name (yyyy - yyyy)	Other Name Used	Years Associated with Former Name (yyyy - yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
HOME Mailing Address			City	State	ZIP Code	Home Telephone Number
Date of Birth (mm/dd/yyyy)	Place of Birth	Citizenship	If not American Citizen, Status and Visa Number		Are you eligible to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently on active military duty or on military reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No						
US Military Service/Public Health <input type="checkbox"/> N/A <input type="checkbox"/> Yes	Dates of Service From (mm-dd-yyyy) – To (mm-dd-yyyy)		Last Location	Branch of Service		

Practice Location Information

Type of Service Provided: <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialty Care			Type of Professional (Physician, Nurse, Physical Therapist, Counselor):			
Group Name/Practice Name to Appear in the Directory			Group/Corporate Name as It Appears on W-9, if Different from Group Name/Practice Name			
Primary Office Address - Street			City	State	ZIP Code	
Primary Office Telephone Number	Primary Office Fax Number	Primary Office Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)		

Are you currently practicing at the location above? Yes No If No, what is your expected start date? _____

Other Office Address - Street			City	State	ZIP Code	
Do you want this site listed in the Directory? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Telephone Number	Fax Number	Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)		

Other Office Address - Street			City	State	ZIP Code	
Do you want this site listed in the Directory? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Telephone Number	Fax Number	Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)		

Correspondence Office Address - Street			City	State	ZIP Code	
Telephone Number	Fax Number	Email Address				

If you have additional offices, please submit an attachment containing the above information and check this box

License and Other Identification Numbers

License Information – Include all license(s) and certifications in all States where you are currently or have previously been licensed

License	State(s) of Registration	Original Date of Issue	Do you currently practice in this state?	License/Certificate Number	Expiration Date	N/A
License						
License						
License						
DEA Registration Certificate						
DPS Registration Certificate						
Other DPS/DEA (specify)						

UPIN	National Provider Identifier (when available)	Are you a participating Medicare Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Provider Number(s)	Are you a participating Medicaid Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid Provider Number(s)
International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, ECFMG Number		ECFMG Issue Date	

Education

School Issuing Professional Degree (Medical, Dental, Chiropractic, etc.)	Degree	Attendance Dates
Address(es)	City	State/Country

If you attended additional schools, please submit attachment containing the above information and check this box

Post-graduate Education <input type="checkbox"/> Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Residency <input type="checkbox"/> Teaching Appointment	Specialty	Start Date (month/year)	End Date (month/year)	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Institution	Address	City	State/Country	Zip Code
Program Director		Current Program Director (if known)		
Post-graduate Education <input type="checkbox"/> Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Residency <input type="checkbox"/> Teaching Appointment	Specialty	Start Date (month/year)	End Date (month/year)	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Institution	Address	City	State/Country	Zip Code
Program Director		Current Program Director (if known)		
Post-graduate Education <input type="checkbox"/> Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Residency <input type="checkbox"/> Teaching Appointment	Specialty	Start Date (month/year)	End Date (month/year)	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Institution	Address	City	State/Country	Zip Code
Program Director		Current Program Director (if known)		

If you completed additional training, please submit attachment containing the above information and check this box

Other Graduate Level Education for Which a Degree Was Obtained – Type of Program (Psychology, Public Health, Business, etc.)	Institution Name	Address	
City	State/Country	Degree Obtained (BS, MS, PhD, etc.)	Date of Graduation (month/year)

Professional/Specialty Information

Primary Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Certifying Board	
Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)	Do you wish to be listed in the directory under this specialty? HMO <input type="checkbox"/> Yes <input type="checkbox"/> No PPO <input type="checkbox"/> Yes <input type="checkbox"/> No POS <input type="checkbox"/> Yes <input type="checkbox"/> No
If not Board certified, indicate any of the following that apply: <input type="checkbox"/> I have taken exam, results pending for _____ (board) <input type="checkbox"/> I am intending to sit for the Boards on _____ (date) <input type="checkbox"/> I am not planning to take Boards			
Secondary Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Certifying Board	
Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)	Do you wish to be listed in the directory under this specialty? HMO <input type="checkbox"/> Yes <input type="checkbox"/> No PPO <input type="checkbox"/> Yes <input type="checkbox"/> No POS <input type="checkbox"/> Yes <input type="checkbox"/> No

If not Board certified, indicate any of the following that apply:
 I have taken exam, results pending for _____ (board)
 I am intending to sit for the Boards on _____ (date)
 I am not planning to take Boards

Additional Specialty	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Certifying Board
Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)
Do you wish to be listed in the directory under this specialty? HMO <input type="checkbox"/> Yes <input type="checkbox"/> No PPO <input type="checkbox"/> Yes <input type="checkbox"/> No POS <input type="checkbox"/> Yes <input type="checkbox"/> No		

If not Board certified, indicate any of the following that apply:
 I have taken exam, results pending for _____ (board)
 I am intending to sit for the Boards on _____ (date)
 I am not planning to take Boards

Provide Additional Areas of Professional Practice Interest or Focus (HIV/AIDS, etc.)

Hospital Affiliations

Do you have hospital privileges? Yes No
If you do not admit patients, what admitting arrangements do you have? _____

If you have privileges, please answer the section below. Include all hospitals where you have privileges.

Primary Hospital Where You Have Admitting Privileges		Address		City	State	ZIP Code	Telephone Number
Start Date	Full Unrestricted Privileges <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Privileges (Provisional, Limited, Conditional, etc.):		Are Privileges Temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?	
Other Hospital Where You Have Privileges		Address		City	State	ZIP Code	Telephone Number
Start Date	Full Unrestricted Privileges <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Privileges (Provisional, Limited, Conditional, etc.):		Are Privileges Temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?	
Other Hospital Where You Have Privileges		Address		City	State	ZIP Code	Telephone Number
Start Date	Full Unrestricted Privileges <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Privileges (Provisional, Limited, Conditional, etc.):		Are Privileges Temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?	
Additional Hospital Where You Have Privileges		Address		City	State	ZIP Code	Telephone Number
Start Date	Full Unrestricted Privileges <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Privileges (Provisional, Limited, Conditional, etc.):		Are Privileges Temporary? <input type="checkbox"/> Yes <input type="checkbox"/> No		Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?	

If you have additional hospital affiliations, please submit attachment containing the information above and check this box

List all other hospitals where you have previously had privileges:

Hospital Name	Address	City	State	ZIP Code	Dates of Affiliation
Reason for Discontinuance					
Hospital Name	Address	City	State	ZIP Code	Dates of Affiliation
Reason for Discontinuance					

If you have other previous hospital affiliations, please submit attachment containing the information above and check this box

Work History

Include chronological work history since completion of training (may submit Curriculum Vitae).

Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Reason for Discontinuance					
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Reason for Discontinuance					
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Reason for Discontinuance					
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Reason for Discontinuance					

For additional work history, please submit attachment containing the above information and check this box

Please provide an explanation of any gaps greater than six months in each work history.

Date	Explanation
Date	Explanation

References

Please provide three references from peers in the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of the applicant's abilities.

Name	Address	City	State	ZIP Code
Name	Address	City	State	ZIP Code
Name	Address	City	State	ZIP Code

Professional Liability Insurance Coverage

Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Current Malpractice Insurance Carrier or Self-Insured Entity	Effective Date	Expiration Date
Address	City	State	ZIP Code Telephone Number
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Shared Length of Time With Carrier
Name of Previous Malpractice Insurance Carrier if With Current Carrier Less Than 5 Years		Effective Date	Expiration Date
Address	City	State	ZIP Code Telephone Number
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Shared Length of Time With Carrier

List names of colleague(s) providing regular coverage and his or her specialty(ies).

See attached list of hospital staff within my department utilized for call coverage.

Name	Provider Specialty
Name	Provider Specialty
Name	Provider Specialty

List full names of all partners in your practice (attach list for large group)

Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)

DO NOT USE

Other Practice Information (specify for each site)

For additional office sites, please submit attachment containing the information below and check this box

<p>Office Address: Type of Practice: <input type="checkbox"/> Solo <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Multi-Specialty Group</p> <p>Office Manager or Business Office Staff Contact: Name: _____ Phone Number: _____ Fax Number: _____</p> <p>Credentialing Contact (if different from above): Name: _____ Phone Number: _____ Fax Number: _____ Email: _____ Address: _____ City: _____ State: _____ ZIP Code: _____</p> <p><u>Billing Information:</u> Billing company's name (if applicable): _____ Billing representative's name: _____ Address: _____ City: _____ State: _____ ZIP Code: _____ Phone Number: _____ Fax Number: _____ Email: _____ Department Name if Hospital Based: _____ Who check should be payable to: _____ Do you have capability for electronic billing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Office Business Hours (hours patients are seen):</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Day(s)</th> <th>No Office Hours</th> <th>Morning</th> <th>Afternoon</th> <th>Evening</th> </tr> </thead> <tbody> <tr><td>Monday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Tuesday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Wednesday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Thursday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Friday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Saturday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> <tr><td>Sunday</td><td><input type="checkbox"/></td><td></td><td></td><td></td></tr> </tbody> </table> <p>After hours, back office phone number for health plan business use only: _____</p> <p>Do you provide 24 hour/7 day a week phone coverage for this site? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type: <input type="checkbox"/> Answering service <input type="checkbox"/> Voice mail with instructions to call answering service <input type="checkbox"/> Voice mail with other instructions</p> <p>Do you accept new patients into the practice? <input type="checkbox"/> Yes <input type="checkbox"/> No Accept all new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No Accept existing patients with change of payor? <input type="checkbox"/> Yes <input type="checkbox"/> No Accept new patients from physician referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Accept new Medicare patients? <input type="checkbox"/> Yes <input type="checkbox"/> No Accept new Medicaid patients? <input type="checkbox"/> Yes <input type="checkbox"/> No If this information varies by health plan, please provide explanation: _____</p>	Day(s)	No Office Hours	Morning	Afternoon	Evening	Monday	<input type="checkbox"/>				Tuesday	<input type="checkbox"/>				Wednesday	<input type="checkbox"/>				Thursday	<input type="checkbox"/>				Friday	<input type="checkbox"/>				Saturday	<input type="checkbox"/>				Sunday	<input type="checkbox"/>				<p>Office Address: Type of Practice: <input type="checkbox"/> Solo <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Multi-Specialty Group</p> <p>Office Manager or Business Office Staff Contact: Name: _____ Phone Number: _____ Fax Number: _____</p> <p>Credentialing Contact (if different from above): Name: _____ Phone Number: _____ Fax Number: _____ Email: _____ Address: _____ City: _____ State: _____ ZIP Code: _____</p> <p><u>Billing Information:</u> Billing company's name (if applicable): _____ Billing representative's name: _____ Address: _____ City: _____ State: _____ ZIP Code: _____ Phone Number: _____ Fax Number: _____ Email: _____ Department Name if Hospital Based: _____ Who check should be payable to: _____ Do you have capability for electronic billing? 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Sunday	<input type="checkbox"/>																																																																																

Office Address:
 Are there any practice limitations? Yes No
 If Yes, indicate limitations below:
 Sex: Male only Female Only N/A
 Patient age limitations (please list ages): N/A _____

 List other limitations: _____

Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers, dental hygienists or other non-physician providers care for patients in your practice? Yes No
 If yes, provide the following information for each staff member:
 Name: _____
 Professional Designation: _____
 State License Number: _____
 Name: _____
 Professional Designation: _____
 State License Number: _____
 (Please attach a list of any additional mid-level practitioners)

Non-English languages spoken by health care provider: _____
 Non-English languages spoken by office personnel: _____

Are interpreters available? Yes No
 If yes, specify languages: _____

Does this office meet ADA accessibility standards?
 Yes No

Does this site provide handicapped accessibility for each of the following:
 Building Yes No
 Parking Yes No
 Restroom Yes No
 Other: _____

Does this site have other services for the disabled? Yes No
 If yes, indicate type:
 Text Telephony - TTY Yes No
 American Sign Language - ASL Yes No
 Mental/Physical Impairment Services Yes No
 Other: _____

Is this site accessible by public transportation? Yes No
 If yes, indicate type:
 Bus Yes No
 Subway Yes No
 Regional Train Yes No
 Other: _____

Does this site provide childcare services? Yes No

Does this office qualify as a minority business enterprise?
 Yes No

Do you or does someone in your office have the following certifications? (indicate for each office location):

Provider	Office Staff
BLS - Basic Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	BLS - Basic Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
ALSO - Advanced Life Support in OB? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	ALSO - Advanced Life Support in OB? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
ATLS - Advanced Trauma Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	ATLS - Advanced Trauma Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____

Office Address:
 Are there any practice limitations? Yes No
 If Yes, indicate limitations below:
 Sex: Male only Female Only N/A
 Patient age limitations (please list ages): N/A _____

 List other limitations: _____

Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? Yes No
 If yes, provide the following information for each staff member:
 Name: _____
 Professional Designation: _____
 State License Number: _____
 Name: _____
 Professional Designation: _____
 State License Number: _____
 (Please attach a list of any additional mid-level practitioners)

Non-English languages spoken by health care provider: _____
 Non-English languages spoken by office personnel: _____

Are interpreters available? Yes No
 If yes, specify languages: _____

Does this office meet ADA accessibility standards?
 Yes No

Does this site provide handicapped accessibility for each of the following:
 Building Yes No
 Parking Yes No
 Restroom Yes No
 Other: _____

Does this site have other services for the disabled? Yes No
 If yes, indicate type:
 Text Telephony - TTY Yes No
 American Sign Language - ASL Yes No
 Mental/Physical Impairment Services Yes No
 Other: _____

Is this site accessible by public transportation? Yes No
 If yes, indicate type:
 Bus Yes No
 Subway Yes No
 Regional Train Yes No
 Other: _____

Does this site provide childcare services? Yes No

Does this office qualify as a minority business enterprise?
 Yes No

Do you or does someone in your office have the following certifications? (indicate for each office location):

Provider	Office Staff
BLS - Basic Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	BLS - Basic Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
ALSO - Advanced Life Support in OB? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	ALSO - Advanced Life Support in OB? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____
ATLS - Advanced Trauma Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____	ATLS - Advanced Trauma Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____

Office Address:		Office Address:	
Provider	Office Staff	Provider	Office Staff
CPR – Cardio-Pulmonary Resuscitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	CPR – Cardio-Pulmonary Resuscitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	CPR – Cardio-Pulmonary Resuscitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	CPR – Cardio-Pulmonary Resuscitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:
ACLS - Advanced Cardiac Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	ACLS - Advanced Cardiac Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	ACLS - Advanced Cardiac Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	ACLS - Advanced Cardiac Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:
PALS – Pediatric Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	PALS – Pediatric Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	PALS – Pediatric Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	PALS – Pediatric Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:
NALS – Neonatal Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	NALS – Neonatal Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	NALS – Neonatal Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:	NALS – Neonatal Advanced Life Support? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:
Other: _____ Expiration Date:	Other: _____ Expiration Date:	Other: _____ Expiration Date:	Other: _____ Expiration Date:

Does this site provide any of the following services on site (indicate for each office location):			
Laboratory Services? <input type="checkbox"/> Yes <input type="checkbox"/> No Certificate of participation from CLIA or another accrediting/certifying program (AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE) program (If yes, please list):	Radiology Service <input type="checkbox"/> Yes <input type="checkbox"/> No X-ray certification? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include Type: _____	Laboratory Services? <input type="checkbox"/> Yes <input type="checkbox"/> No Certificate of participation from CLIA or another accrediting/certifying program (AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE) program (If yes, please list):	Radiology Service <input type="checkbox"/> Yes <input type="checkbox"/> No X-ray certification? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include Type: _____
EKG's? <input type="checkbox"/> Yes <input type="checkbox"/> No	Care of minor lacerations? <input type="checkbox"/> Yes <input type="checkbox"/> No	EKG's? <input type="checkbox"/> Yes <input type="checkbox"/> No	Care of minor lacerations? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pulmonary function testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy injections? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary function testing? <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	Office gynecology (routine pelvic/pap?) <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy skin testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office gynecology (routine 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	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	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	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 tests? <input type="checkbox"/> Yes <input type="checkbox"/> No	IV hydration/treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac stress tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Physical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Office Procedures Provided (including surgical procedures): _____		Additional Office Procedures Provided (including surgical procedures): _____	
Is anesthesia administered in your office? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what category of anesthesia do you use? Specify the class or category. _____		Is anesthesia administered in your office? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what category of anesthesia do you use? Specify the class or category. _____	
Who administers it? _____		Who administers it? _____	

Required Attachments or Supplemental Information
Please attach hard copy or scanned documents of the following:
• Copy(ies) of DEA Controlled Substances Registration Certificate(s)
• Copy(ies) of state DPS Controlled Substances Registration Certificate(s)
• Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
• Copy(ies) of W-9(s) for verification of each tax identification number used
• Copy of workers compensation certificate of coverage, if applicable
• Copy of CLIA certification, if applicable
• Copy of radiology certifications, if applicable
• Copy of DD214, if applicable

Disclosure Questions

Section II

PLEASE ANSWER EACH QUESTION AND INCLUDE AN EXPLANATION FOR ANY QUESTION ANSWERED YES.

Licensure

1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever received a reprimand or been fined by any state licensing board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges at any hospital or healthcare institution 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 records 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. 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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Education, Training and Board Certification

6. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have any of your board certifications or eligibility ever been revoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

DEA or DPS

10. Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Medicare, Medicaid or other Governmental Program Participation

11. 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 health care plans or programs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Other Sanctions or Investigations

12. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Professional Liability Insurance Information and Claims History

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Malpractice Claims History

19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case on the attached form located at the end of the Disclosure Questions (list all separately).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For any malpractice actions, please complete addendum and check this box <input type="checkbox"/>		

Criminal/Civil History *

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Have you ever been court-martialed for actions related to your duties as a medical professional?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*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. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.

Date of Occurrence: _____		
Date Claim Was Filed: _____		
Claim/Case Status: _____		
Professional Liability Carrier Involved: _____		
Address: _____		
Phone Number: _____		
Policy Number: _____		
Amount of Award or Settlement and Amount Paid: _____		
Method of Resolution: <input type="checkbox"/> Dismissed <input type="checkbox"/> Settled (with prejudice) <input type="checkbox"/> Settled (without prejudice) <input type="checkbox"/> Judgment for defendant(s) <input type="checkbox"/> Judgement for plaintiff(s) <input type="checkbox"/> Mediation or Arbitration		
Description of Allegations: _____		

Were you primary defendant or co-defendant? _____		
Number of Other Co-defendants _____		
Your Involvement in Case (attending, consulting, etc.) _____		
Description of Alleged Injury to the Patient: _____		

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Please provide information below for any Disclosure Questions in Section II answered Yes.

Question Number	Please Explain

Applicant's Initials and Date

Standard Authorization, Acknowledgement, Attestation and Release Form

Section III

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with _____ (indicate managed care company(s) or hospital(s) to which you are applying) (hereinafter, 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.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

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 obtain and inspect information, which includes both oral and written statements, records, and documents, concerning my application for Participation as part of the investigation of this application. I agree to allow the Entity and/or its Agent(s) to inspect 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, Acknowledgement, Attestation and Release.

Applicant's Initials and Date

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, Acknowledgement, 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, Acknowledgement, 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, to the extent permitted by law, this Authorization, Acknowledgement, 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, Acknowledgement, 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 true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). 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, Acknowledgement, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Acknowledgement, Attestation and Release shall be as effective as the original.

Signature _____

Name _____
(Please print or type.)

Social Security Number _____

Date _____