

Instructions to Help Eliminate the Need for Returns or Delays

Application

IMPORTANT: *There are several sections throughout the application that have check boxes indicating that nothing has changed. If you check this box, you do not need to fill out the section.*

- If an erroneous entry is made on any part of the application, please draw a single line through the error, write in the correction, and initial and date the change. White out and other similar materials are not acceptable.
- Please make sure copies of all documents required in Section I of the application are attached. The following is a document check list:
 - ✓ Current copy of your license
 - ✓ Current copy of DEA (if applicable)
 - ✓ Current copy of malpractice insurance policy
 - ✓ Current copy of your CV
 - ✓ Copy of Diploma/Certificates form completed postgraduate training (if applicable)
- In every section that is not applicable, you must write “N/A” otherwise the packet will be returned.
- Please make sure to sign and date pages that require you to do so. Digital or stamped signatures are not accepted.

Addendum B

- If you **have not** had any malpractice issues you must check of the “N/A” box at the top of the page and then you must **sign and date page (2) two.**
- If you have had malpractice action(s) in the proceeding (7) seven years you must complete the addendum for the action(s).
- Most physicians create the summary on a separate piece of paper but you are welcome to use page (2) two. **Please remember to sign and date page (2) two.**

Office Verification Form

- Please complete this form in its entirety.



Allied Health Professional Re-Credentialing Application

I. INSTRUCTIONS:

This form should be typed 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. Fill in all blanks and answer all questions. Please provide all addresses including zip codes. Mark "N/A" if no applicable. Please do not use abbreviations when completing the application.

Current copies of the following documents must be submitted with this application:

- California State Medical License, Registration or Certificate
- Face Sheet of Professional Liability Policy or Certification
- DEA Certificate (if applicable)
- Curriculum Vitae
- Board Certification (if applicable)

II. IDENTIFYING INFORMATION

Last Name:		First:	Middle:
Is there any other name under which you have been known? Name (s):			
Home Mailing Address:		City:	
Home Telephone Number:		State:	ZIP:
Home Fax Number:		E-Mail Address:	
Birth Date:	Birth Place (City/State/Country)		
Citizenship (If not US, please include copy of Alien Registration Card):			
Social Security #:		Gender ¹ :	<input type="checkbox"/> Male <input type="checkbox"/> Female
AHP Specialty:			

III. PRACTICE INFORMATION - If nothing has changed, please check here

Practice Name (if applicable):			
Supervising Physician (if applicable):			
Primary Office:			
Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Tax ID Number:			
Office Manager/Administrator:		Phone Number:	
E-mail Address:		Fax Number:	

¹ This information will be used for consumer information purposes only.

Secondary Office:			
Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Tax ID Number:			

IV. EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

If nothing has changed, please check here

College or University Name:			
Address:	City:	State:	Zip:
Degree:	Date of Graduation:		

V. PROFESSIONAL EDUCATION (Attach additional sheets if necessary.)

If nothing has changed, please check here

College or University Name:		Degree Received:	Date of Graduation:
Address:	City:	State:	Zip:
Degree:	Date of Graduation:		

VI. OTHER TRAINING (Internships, Fellowships, Preceptorships, Postgraduate Education)

If nothing has changed, please check here

Institution:	Degree:	Date Completed:	
Address:	City:	State:	Zip:
Institution:	Degree:	Date Completed:	
Address:	City:	State:	Zip:

VII. LICENSES/CERTIFICATIONS/REGISTRATIONS (Remember to attach copies of documents)

California State Medical License Number:	Issue Date:	Expiration Date:
Other State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG (Applies to Foreign Medical Graduates):		Date Issued:
Medicare UPIN/National Physician Identifier (NPI):		

VIII. PROFESSIONAL LIABILITY INSURANCE (Remember to attach copy of professional liability policy or certification face sheet.) (Attach additional sheets if necessary. Reference this Section # and Title)

Current Insurance Carrier:		Policy Number:		Original effective date:	
Address:		City:		State:	
Address:		City:		State:	
Per Claim Amount \$		Aggregate Amount: \$		Expiration Date:	

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Previous Carrier:		Policy #:		From:		To:	
Address:		City:		State:		Zip:	
Address:		City:		State:		Zip:	
Previous Carrier:		Policy #:		From:		To:	
Address:		City:		State:		Zip:	
Address:		City:		State:		Zip:	

IX. MEMBERSHIP IN PROFESSIONAL SOCIETIES (Attach additional sheets if necessary. Reference this section number and Title)

Are you a member of a professional society? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a membership pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you intend to apply for membership? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If a member past or present, or an applicant to any other County, State or National Medical Society, give name:			

X. HOSPITAL/INSTITUTION AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and Title)

Institution Name:		From:		To:	
Address:		City:		State:	
Address:		City:		State:	
Institution Name:		From:		To:	
Address:		City:		State:	
Address:		City:		State:	
Institution Name:		From:		To:	
Address:		City:		State:	
Address:		City:		State:	

XI. PEER REFERENCES

List three (3) professional references, preferably from you specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. **DO NOT PROVIDE PHYSICIAN CELL PHONE NUMBERS. ONLY OFFICE TELEPHONE#.**

NOTE: Reference must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:		Title:		Phone #:	
Address:		City:		State:	
Address:		City:		State:	
Name of Reference:		Title:		Phone #:	

Address:	City:	State:	Zip:
Name of Reference:	Title:	Phone #:	
Address:	City:	State:	Zip:

XII. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

If nothing has changed, please check here

Chronologically list all work history activities since completion of postgraduate training. This information must be complete. A curriculum vitae is sufficient provided it is CURRENT and contains all information requested below. Please explain any gaps in professional history on a separate page.

Current Practice		From:	To:
Address:	City:	State:	Zip:
Contact Name and Title:		Phone #:	Fax #:
Previous Practice:		From:	To:
Address:	City:	State:	Zip:
Contact Name and Title:		Phone#:	Fax #:
Previous Practice:		From:	To:
Address:	City:	State:	Zip:
Contact Name and Title:		Phone#:	Fax #:
Previous Practice:		From:	To:
Address:	City:	State:	Zip:
Contact Name and Title:		Phone#:	Fax #:
Previous Practice:		From:	To:
Address:	City:	State:	Zip:
Contact Name and Title:		Phone#:	Fax #:

XIII. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes No

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes No

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes No

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (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) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes No

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

Yes No

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes No

I. Do you presently use any drugs illegally?

Yes No

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes No

K. 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, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes No

L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes No

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature _____ Date _____

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state² laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 5 and 6.

Print Name Here _____

Signature _____ Date _____

(Stamped Signature Is Not Acceptable)

² The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

California Participating Physician Application
Addendum B
Professional Liability Action Explanation

This Addendum is submitted to: Exclusive Care herein, this Healthcare Organization 1.

N/A []

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Form with fields: Last Name, First, Middle, Street Address, City, State, ZIP.

II. CASE INFORMATION

Form with fields: City, County and State where lawsuit filed; Court case number; Date of alleged incident; Date Suit Filed; Sex of patient; Age of patient; Location of Incident; Your relationship to Patient; Allegation; Insurance company information; Attorney contact information.

1 As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.



Office Verification Form

PLEASE COMPLETE & RETURN WITH APPLICATION

In order for Exclusive Care to maintain the most accurate and up to date information it is very important that the following information is provided.

Provider(s) full name(s) at location:

_____, _____,
_____, _____,
_____, _____,
_____, _____,
_____, _____,

Location(s) _____

Office Hours: _____

Phone number: _____ **Fax number:** _____

Back office number: _____ (Not for public use)

Other clinical staff: (PA, NP, MFT, LCSW)

Signature: _____ **Printed Name:** _____

Date: _____