Managed Care Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone 405.271.6868
http://hrds.health.ok.gov

Uniform Credentialing Application

63 O.S. 2011, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"), unless the credentialing entity to which you are applying advises you otherwise. Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to:__________________________

____

Date:______________________________

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION. THE COMPLETED APPLICATION MAY BE SUBMITTED TO HOSPITALS, AMBULATORY SURGERY CENTERS, MANAGED CARE ORGANIZATIONS, AND OTHER ENTITIES REQUIRING CREDENTIALS VERIFICATION.

PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH

SECTION 1: PERSONAL INFORMATION

Name ____
Last First Middle Suffix

Professional Degree ______________________ Gender: ☐ Male ☐ Female

Other Name By Which You Have Been Known ______________________

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Other Name By Which You Have Been Known ______________________

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ NPID (formerly UPIN)______________

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ ______________________
Place of Birth Citizenship

____
Visa Type Visa Number (provide copy) Expiration Date

____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: ______________________
Street Address

____
Suite Number City State Zip Code

( ) ______________ ( ) ______________ ( ) ______________
Phone Number Fax Number Emergency or Pager Number

( ) ____
Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: ______________________

This Section continues on next page.

-Section 2 Continued-

Office Street Address: ____________________
Street Address

____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Mailing Address: ____________________
Street Address

____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Billing Address (If Different From Claims Payment Address): ____________________
Street Address

____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Claims Payment Address (If Different From Office Billing Address): ____________________
Street Address

____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Make Checks Payable To: ____________________

SECTION 3: CURRENT PROFESSIONAL PRACTICE

0%

Primary Specialty (or field of practice) Subspecialty % Of Time

0%

Secondary Specialty Subspecialty % Of Time

Do you wish to be listed as:
☐ Primary Care Provider ☐ Specialist ☐ Hospitalist ☐ On-Call ☐ Other (specify)__________

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

☐ Yes ☐ No Are you accepting new patients?
☐ Yes ☐ No Are you willing, in the future to accept new patients?
☐ Yes ☐ No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

☐ Yes ☐ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?
☐ Yes ☐ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name:

Street Address Suite Number

City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Answering Service Number

Name:

Street Address Suite Number

City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Answering Service Number

List any restrictions on your practice (i.e. patient age and gender):

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(2) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(3) ____

Institution Degree Awarded

____

Mailing Address City State Zip Code

Telephone Number: (________) ____________________________

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

Foreign Medical Graduates:

ECFMG #______________________

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) ____________________

Was program successfully completed: ☐ Yes ☐ No

____
Specialty Institution Your Program Director

____ ( )
Address City State Zip Code Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(2) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) ____________________

Was program successfully completed? ☐ Yes ☐ No

____
Specialty Institution Your Program Director

____ ( )
Address City State Zip Code Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(3) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) ____________________

Was program successfully completed? ☐ Yes ☐ No

____
Specialty Institution Your Program Director

____ ( )
Address City State Zip Code Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(4) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) ____________________

Was program successfully completed? ☐ Yes ☐ No

____
Specialty Institution Your Program Director

____ ( )
Address City State Zip Code Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) ____ ( )
Institution and Address City State Zip Code Phone Number

______________________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(2) ____ ( )
Institution and Address City State Zip Code Phone Number

______________________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(3) ____ ( )
Institution and Address City State Zip Code Phone Number

______________________From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) ____ ☐ Primary ☐ Secondary
Facility Name

____ ( )
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________
Dates of Appointment (mo/day/year) Staff Category

____
Reason for Discontinuance Department or Service

(2) ____ ☐ Primary ☐ Secondary
Facility Name

____ ( )
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________
Dates of Appointment (mo/day/year) Staff Category

____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) ______________________________ ☐ Primary ☐ Secondary

Facility Name

______________________________ ( )

Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________

Dates of Appointment (mo/day/year) Staff Category

____

Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) ______________________________

Name and Nature of Affiliation

______________________________ ( )

Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________

Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) ______________________________

Name and Nature of Affiliation

______________________________ ( )

Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________

Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) ______________________________

Name and Nature of Affiliation

______________________________ ( )

Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ ______________

Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

____

Location Branch of Service

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

____

Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

Oklahoma ______ ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______ ______ ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______ ______ ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______ ______ ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______________________ ___ ___-___ ___-___ ___ ___ ___
USMLE/ECFMG Number Certification Date

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

______ DEA ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______ DEA ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

Oklahoma BNDD ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

______ CDS ______ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

BOARD CERTIFICATION

Are you Board Certified? ☐ Yes ☐ No ______________________
Name of Board

___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
Date Initially Certified Date Most Recently Recertified Date Certification Expires

☐ Yes ☐ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification ____________ Name of Board ____________

___ ___ - ___ ___ - ___ ___ ___ ___ Date Initially Certified

___ ___ - ___ ___ - ___ ___ ___ ___ Date Most Recently Recertified

___ ___ - ___ ___ - ___ ___ ___ ___ Date Certification Expires

Subspecialty or Added Qualification ____________ Name of Board ____________

___ ___ - ___ ___ - ___ ___ ___ ___ Date Initially Certified

___ ___ - ___ ___ - ___ ___ ___ ___ Date Most Recently Recertified

___ ___ - ___ ___ - ___ ___ ___ ___ Date Certification Expires

BOARD QUALIFICATIONS

☐ Yes ☐ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

☐ Yes ☐ No Are you planning to take the exam?

☐ Yes ☐ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral ___ ___ - ___ ___ - ___ ___ ___ ___

Written ___ ___ - ___ ___ - ___ ___ ___ ___

Other ___ ___ - ___ ___ - ___ ___ ___ ___

Subspecialty or Added Qualification ____________ Name of Board ____________

Date Qualified ___ ___ - ___ ___ - ___ ___ ___ ___ Date Qualification Expires ___ ___ - ___ ___ - ___ ___ ___ ___

Classifications:

☐ Yes ☐ No Are you certified in CPR? Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Basic Life Support (BLS) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Advanced Cardiac Life Support (ACLS) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Health Care Provider (CoreC) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Advanced Trauma Life Support (ATLS) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Neonatal Advanced Life Support (NALS) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Pediatric Advanced Life Support (PALS) Expires ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Yes ☐ No Other____________________________ Expires ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify)________________

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No Reference Lab? ☐ Yes ☐ No On Site? ☐ Yes ☐ No

CLIA ID # ______________________ CLIA Waiver # ______________________

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?

If yes, please list:______________________

☐ Yes ☐ No Other:______________________

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You ______________________

Your Staff ______________________

Other Resources ______________________

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name ______________________ Specialty ______________________ Telephone (_____) ______________

Name ______________________ Specialty ______________________ Telephone (_____) ______________

Name ______________________ Specialty ______________________ Telephone (_____) ______________

Name ______________________ Specialty ______________________ Telephone (_____) ______________

☐ Yes ☐ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify)________________

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No   Reference Lab? ☐ Yes ☐ No   On Site? ☐ Yes ☐ No

CLIA ID # ____________________   CLIA Waiver # ____________________

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?
If yes, please list:____________________
☐ Yes ☐ No Other:____________________

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You ____________________

Your Staff ____________________

Other Resources ____________________

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name ____________________ Specialty ____________________ Telephone (   ) __________

Name ____________________ Specialty ____________________ Telephone (   ) __________

Name ____________________ Specialty ____________________ Telephone (   ) __________

Name ____________________ Specialty ____________________ Telephone (   ) __________

☐ Yes ☐ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
☐	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
☐	Current Federal DEA Registration Certificate
☐	Emergency Care Training Certificates (CPR, etc., if certified)
☐	Photo Identification
☐	Curriculum Vitae
☐	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) ____

Signature ______________________________ Date ________________

NOTE:
Practitioners are reminded that each organization will require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

____
____
____
____
____
____
____
____
____
____

Section 8 — Disclosure Questions

Disclosure Questions

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

Allied Health Providers

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

LICENSURE

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

2. ◯ YES ◯ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ◯ YES ◯ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*

4. ◯ YES ◯ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*

5. ◯ YES ◯ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ◯ YES ◯ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*

7. ◯ YES ◯ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*

8. ◯ YES ◯ NO Have any of your board certifications or eligibility ever been revoked?*

9. ◯ YES ◯ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ◯ YES ◯ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ◯ YES ◯ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ◯ YES ◯ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

13. ◯ YES ◯ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*

14. ◯ YES ◯ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*

15. ◯ YES ◯ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*

16. ◯ YES ◯ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ◯ YES ◯ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*

18. ◯ YES ◯ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

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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?*

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