

**SECTION II
OFFICE INFORMATION**

Primary Office Street Address _____

City/State/Zip _____

Office Phone(s) (_____)_____ (_____)_____ Office Fax (_____)_____

Office Email _____ Office Manager _____

Billing Address _____

City/State/Zip _____ County _____

Type of Practice (L.L.C., Corp., etc.): _____

Group/Corporate Name _____ Fed Tax ID# _____

Medicare # _____ Medicaid # _____

EPSDT Certified? Yes No If Yes, EPSDT # _____

Please list other licensed/certified professional members of your practice:

Please list health care providers who cover in your absence:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice?	Y N	Accept new Medicare patients?	Y N
Accept new patients from referral only?	Y N	Accept Medicaid patients?	Y N
Accept Medicare patients?	Y N	Accept new Medicaid patients?	Y N

Does the office: (Circle One)

Have 24-hour phone coverage?	Y N	Have public transportation access?	Y N
Have capability for electronic billing?	Y N	Meet Americans with Disabilities Act	
Does this location have TDD?	Y N	accessibility standards?	Y N

Please complete this page if you have an additional office

Office Street Address _____

City/State/Zip _____

Office Phone(s) (_____) _____ (_____) _____ Office Fax (_____) _____

Office Email _____ Office Manager _____

Billing Address _____

City/State/Zip _____ County _____

Type of Practice (L.L.C., Corp., etc.): _____

Group/Corporate Name _____ Fed Tax ID# _____

Medicare # _____ Medicaid # _____

EPSDT Certified? Yes No If Yes, EPSDT # _____

Please list other licensed/certified professional members of your practice:

Please list health care providers who cover in your absence:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice?	Y N	Accept new Medicare patients?	Y N
Accept new patients from referral only?	Y N	Accept Medicaid patients?	Y N
Accept Medicare patients?	Y N	Accept new Medicaid patients?	Y N

Does the office: (Circle One)

Have 24-hour phone coverage?	Y N	Have public transportation access?	Y N
Have capability for electronic billing?	Y N	Meet Americans with Disabilities Act	
Does this location have TDD?	Y N	accessibility standards	Y N

Please complete this page if you have an additional office

Office Street Address _____

City/State/Zip _____

Office Phone(s) (_____) _____ (_____) _____ Office Fax (_____) _____

Office Email _____ Office Manager _____

Billing Address _____

City/State/Zip _____ County _____

Type of Practice (L.L.C., Corp., etc.): _____

Group/Corporate Name _____ Fed Tax ID# _____

Medicare # _____ Medicaid # _____

EPSDT Certified? Yes No If Yes, EPSDT # _____

Please list other licensed/certified professional members of your practice:

Please list health care providers who cover in your absence:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you currently: (Circle One)

Accept new patients into your practice?	Y N	Accept new Medicare patients?	Y N
Accept new patients from referral only?	Y N	Accept Medicaid patients?	Y N
Accept Medicare patients?	Y N	Accept new Medicaid patients?	Y N

Does the office: (Circle One)

Have 24-hour phone coverage?	Y N	Have public transportation access?	Y N
Have capability for electronic billing?	Y N	Meet Americans with Disabilities Act	
Does this location have TDD?	Y N	accessibility standards	Y N

**SECTION III
EDUCATION**

List all, including undergraduate, completed or not, beginning with the most recent. Attach separate sheet, if necessary. Psychologist, please indicate whether APA approved program.

School Name _____
Degree Awarded _____ Program Title _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ APA approved? Yes No

School Name _____
Degree Awarded _____ Program Title _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ APA approved? Yes No

School Name _____
Degree Awarded _____ Program Title _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ APA approved? Yes No

**SECTION IV
TRAINING**

Internships/Residencies/Fellowships/Preceptorships. List all, completed or not, beginning with the most recent. Attach a separate sheet if necessary. Psychologist, indicate whether APA approved program.

Institution _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ Program Completed? Yes No
Type of Training/Specialty _____
Program Director _____ APA approved? Yes No

Institution _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ Program Completed? Yes No
Type of Training/Specialty _____
Program Director _____ APA approved? Yes No

Institution _____
Mailing Address _____
Dates Attended (MM/YY) From _____ to _____ Program Completed? Yes No
Type of Training/Specialty _____
Program Director _____ APA approved? Yes No

**SECTION V
PROFESSIONAL LICENSURE**

List all Current Professional Licenses. Please attach copies.

State	Type	Number	Issue Date	Expiration Date

List all Past Professional Licenses:

State	Type	Number	Issue Date	Expiration Date

**SECTION VI
CERTIFICATIONS/REGISTRATION**

Please attach copies of any of the following certifications, if held. Attach a separate sheet if necessary.

Federal DEA Registration Number _____

Date Issued _____ Expiration Date _____

State CDS Number _____ State _____

Date Issued _____ Expiration Date _____

CPR Certified? Yes No Expiration Date _____

If Yes, List Classifications: _____

International Graduates: Are you ECFMG Certified? Yes No

USMLE/ECFMG Number: _____ Issue Date: _____

Nursing Professionals: Please list any certifications held:

Certification	Received From	Expiration (MM/YY)

SECTION VII
SPECIALTY INFORMATION

Primary Specialty _____ Qualified Certified Not Applicable

Board Name _____ Date of Initial Certification _____

Board Certification expires? Yes No If yes, Date of Expiration? _____

Have you been recertified? Yes No N/A If Yes, Date of Recertification _____

If Qualified, when does status expire? (MM/YY) _____

If Qualified, date exam is scheduled: _____

Board certification results pending? Yes No

Do you wish to be listed in the organization directory under this specialty? Yes No

Would you like to be classified as a: Primary Care Provider Specialist Both
 Hospitalist Not Applicable

Sub-Specialty _____ Qualified Certified Not Applicable

Board Name _____ Date of Initial Certification _____

Board Certification expires? Yes No If yes, Date of Expiration? _____

Have you been recertified? Yes No N/A If Yes, Date of Recertification _____

If Qualified, when does status expire? (MM/YY) _____

If Qualified, date exam is scheduled: _____

Board certification results pending? Yes No

Do you wish to be listed in the organization directory under this specialty? Yes No

Would you like to be classified as a: Primary Care Provider Specialist Both
 Hospitalist Not Applicable

Sub-Specialty _____ Qualified Certified Not Applicable

Board Name _____ Date of Initial Certification _____

Board Certification expires? Yes No If yes, Date of Expiration? _____

Have you been recertified? Yes No If Yes, Date of Recertification _____

If Qualified, when does status expire? (MM/YY) _____

If Qualified, date exam is scheduled: _____

Board certification results pending? Yes No

Do you wish to be listed in the organization directory under this specialty? Yes No

Would you like to be classified as a: Primary Care Provider Specialist Both
 Hospitalist Not Applicable

SECTION VIII
BEHAVIORAL HEALTH PROVIDERS/PRACTITIONERS

If you practice Behavioral Health, please complete this section. Please attach copies of any certifications held.

Employee Assistance Program Affiliates Only:

Do you have a minimum of 1400 hours of experience in a direct substance related disorder treatment program, agency or facility offering in-service and clinical supervision? The 1400 hours can span no more than 2 years. Yes No

Do you have a minimum of 3 graduate level hours or 40 clock hours or 4 CEUs or a combination thereof of documented education/training in S/A related disorders? Yes No

Do you have a minimum of 1 year, clinically supervised full time work experience under a masters level or higher S/A provider? Please note part time may occur within 2 years and total experience hours must be achieved within no more than 4 years. Yes No

Do you have 4 years full time EAP experience as an EAP clinician with 10 or more EAP cases over a 1-year period? Yes No

Are you a licensed or certified addictions counselor at the state or national level? Yes No
If Yes: state level national level

Are you CEAP certified? Yes No

Psychologists Only:

Are you a Member of the National Register of Health Service providers (NHR)? Yes No

Are you a Diplomate of the American Board of Professional Neuropsychology? Yes No

Are you a Diplomate of the American Board of Professional Psychology? Yes No

All Behavioral Health Practitioners:

Do you offer emergency appointments (within 24 hours of call)? Yes No

Do you treat younger children (age 0-5)? Yes No

Do you treat older children (age 6 to 12)? Yes No

Do you treat adolescents (age 13-17)? Yes No

Do you treat adults (age 18-65)? Yes No

Do you treat geriatric patients (age 65 and older)? Yes No

Do you provide family therapy? Yes No

Do you provide group therapy? Yes No

Do you provide crisis evaluation/intervention services? Yes No

Are you available to see clients at least 4 full days a week? Yes No

What is the average waiting time to obtain an appointment? _____

**SECTION IX
DENTAL PROVIDERS/PRACTITIONERS**

If you are a Dental Provider, please complete this section. Please attach copies of any licenses held.

Licensure Status (please check all that apply and indicate licensure information in Section V):

General dental license Limited dental license Teacher's dental license
Inactive dental license Other: _____

Are you recognized as a Specialist by the Dental Board? Yes No

If Yes, please specify: _____

Do you hold a permit to administer general anesthesia? Yes No

Do you hold a permit to administer conscious sedation? Yes No

Do you utilize nitrous oxide in your practice? Yes No

**SECTION X
VISION PROVIDERS/PRACTITIONERS**

If you are a vision provider, please complete this section. Please attach copies of any certifications held.

Which of the following are you certified to use or prescribe:

- Topical Ocular Diagnostic Pharmaceutical Agents
- Therapeutic Pharmaceutical Agents
- Diagnostic Pharmaceutical Agents

Does your office have an on-site lab? Yes No

SECTION XI
HEALTH CARE FACILITY AFFILIATIONS

List all health care facilities where you currently have privileges, beginning with the most recent. Please attach a separate sheet if necessary.

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) Yes No

Is this your Primary Facility? Yes No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) Yes No

Is this your Primary Facility? Yes No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) Yes No

Is this your Primary Facility? Yes No

Facility Name _____

Street Address _____

City/State/Zip _____

Staff Category _____ Status of Privileges _____

Dates of Affiliation From _____ to _____

Any past or present restriction of privileges? (If Yes, explain in Section XVI) Yes No

Is this your Primary Facility? Yes No

**SECTION XII
WORK HISTORY**

List professional work history for the last five (5) years, beginning with the most recent, not mentioned previously, including academic appointments. Explain any gaps of six months or more in Section XVI.

Practice/Employer _____

Contact Name _____ Phone _____

Mailing Address _____

Dates of Employment From _____ to _____

Reason for Leaving _____

Practice/Employer _____

Contact Name _____ Phone _____

Mailing Address _____

Dates of Employment From _____ to _____

Reason for Leaving _____

Practice/Employer _____

Contact Name _____ Phone _____

Mailing Address _____

Dates of Employment From _____ to _____

Reason for Leaving _____

Practice/Employer _____

Contact Name _____ Phone _____

Mailing Address _____

Dates of Employment From _____ to _____

Reason for Leaving _____

SECTION XIII
PROFESSIONAL LIABILITY INSURANCE COVERAGE

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name _____

Carrier Address _____

Agent Name _____ Policy Number _____

Policyholder _____

Amount of Coverage _____

Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From _____ to _____

Type of Coverage Claims Made Occurrence

Carrier Name _____

Carrier Address _____

Agent Name _____ Policy Number _____

Policyholder _____

Amount of Coverage _____

Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From _____ to _____

Type of Coverage Claims Made Occurrence

Carrier Name _____

Carrier Address _____

Agent Name _____ Policy Number _____

Policyholder _____

Amount of Coverage _____

Coverage amount per Occurrence Coverage amount per Aggregate

Dates of Coverage From _____ to _____

Type of Coverage Claims Made Occurrence

**SECTION XIV
MALPRACTICE CLAIMS HISTORY**

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent. Attach additional sheets if necessary.

None

Date of Occurrence _____ Date Claim Filed _____

Professional liability carrier involved _____

You were: Primary Defendant Co-Defendant

Other Defendants (if any): _____

Describe the allegations against you: _____

Describe the alleged injury to the patient _____

Claimant/Plaintiff Filed Suit in Court? Yes No If Yes, Date Filed _____

State Court Case Number _____ State _____ County _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the Claim/Case:

- Pending Settled Arbitrated Awarded
 In Appeal Adjudicated Withdrawn Other _____

Please provide additional information/explanation (e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XVI.

Date of Occurrence _____ Date Claim Filed _____

Professional liability carrier involved _____

You were: Primary Defendant Co-Defendant

Other Defendants (if any): _____

Describe the allegations against you: _____

Describe the alleged injury to the patient _____

Claimant/Plaintiff Filed Suit in Court? Yes No If Yes, Date Filed _____

State Court Case Number _____ State _____ County _____

Federal Court (U.S. District Court) Case Number _____ District _____

Present status of the Claim/Case:

- Pending Settled Arbitrated Awarded
 In Appeal Adjudicated Withdrawn Other _____

Please provide additional information/explanation (e.g. the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment) in Section XVI.

SECTION XV
ADDITIONAL QUESTIONS

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? Yes No

2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? Yes No

3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? Yes No

4. Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, or placed on probation? Yes No

5. Have you ever been placed on probation or asked to resign from an internship, residency or other training program? Yes No

6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violation? Yes No

7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? Yes No

8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled)? Yes No

9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No

10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? Yes No

11. Are you engaged in the illegal use of drugs? Yes No

12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? Yes No
13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? Yes No
14. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)? Yes No
15. Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly? Yes No

If so, please provide the following information:

Name of Organization

Type of Organization

Mailing Address of Organization

Telephone Number

Tax ID Number

Percent of Business Owned/Invested by You

Nature of Business Investment
(owner, partner, investor, etc.)

IF YOU ANSWERED “YES” TO ANY OF THE ABOVE, PLEASE PROVIDE AN EXPLANATION FOR EACH AFFIRMATIVE RESPONSE IN SECTION XVI.

**SECTION XVII
PROFESSIONAL REFERENCES**

Please list three (3) peers who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. None of your references should be relatives by blood or marriage.

1. _____
Name _____
Phone

Mailing Address

2. _____
Name _____
Phone

Mailing Address

3. _____
Name _____
Phone

Mailing Address

**SECTION XVIII
ADDITIONAL DOCUMENTATION**

Please attach copies of the following documents (if applicable):

- 1. Current State Licenses**
- 2. State Controlled Dangerous Substance Certificate**
- 3. Current Federal DEA Registration**
- 4. ECFMG Certificate**
- 5. Board Certification Certificate**
- 6. Current Professional Liability Insurance Face Sheets**
- 7. Therapeutic Pharmaceutical Agents/Diagnostic Pharmaceutical Agents Licenses**
- 8. Any other Certificates held**

SECTION XIX
AUTHORIZATION TO RELEASE INFORMATION
AND AFFIRMATION

Please make additional copies of this page for each Carrier to whom you apply. Please insert the appropriate name in the space provided.

I authorize _____ (“Carrier”) and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release the Carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the Carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the Carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Carrier.

Applicant Signature

Date

Applicant’s Printed Name

()
Phone

Mailing Address