For Credentialing Staff Use Only

Specialty_______________________________________

Date Application Received___________________________

Date Application Signature___________________________

Attach a recent 2" x 2" passport size photograph for the master file and each facility marked on this application

PERSONAL DATA

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

1. Name____

2. Other Name(s) Previously Used_________________________________ Effective __________________

3. Social Security Number__________________ 4. UPIN# **NA** 5. Medicaid _____________

6. Medicare#__________________7.NPI (National Provider Identifier)______________________________

8. Tax ID# __________________Name Affiliated with Tax ID#_____________________________________

    8A. Other Tax ID's (Attach separate sheet if applicable)

9. Place of Birth ______________________________ Date of Birth _________________________________

10. Gender_____________________ 10. Citizenship____

11. If Not US Citizen: Visa #________________ Status_______________ Expiration Date________________

12. Name of Spouse/Significant Other

    ____

13. Local Residence

    ____

    Complete Address

    ____

    Telephone Number E-Mail Address

14. Date of Relocation to NV (If Applicable)____________ Date Expected to Begin Practice______________

    Specialty______________________________ Staff Status Requested______________________________

    Current Address (if different from above)

    ____

15. Alternate Care of Hospitalized Patients: If you do not apply for admitting privileges, list the name/names of physicians or groups with whom you have established a current hospital admission coverage agreement:

NA

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

OFFICE INFORMATION

16. Local Primary Practice/Group Name____

____

Complete Office Address

____

Office Phone FAX Number E-Mail

Preferred Method of Contact _____ Phone _____ FAX _____ E-Mail

16A. Other Practice Locations (Please attach a separate sheet)

17. Office/Credentialing Contact Name & Address____

____

Title Phone Number FAX Number E-Mail Address

18. Secondary/Billing Office Address____

____

Office Phone FAX Number E-Mail

19. Practitioner's Beeper/Cell Number____________________ Answering Service Number_______________

20. Practitioner Call Coverage____

21. Are you currently accepting new patients into your practice? _____ YES _____NO
(If NO, your name may not appear in the Managed Care directory)

22. Office Hours ____________Monday ____________Tuesday ____________Wednesday

____________Thursday ____________Friday ____________Saturday ____________Sunday

23. Describe after-hours patient care operation.____

24. Any practice restrictions? (Specify)____

25. Office accessible to disabled pursuant to ADA guidelines? _____YES _____NO

26. Languages (other than English) Spoken in Your Office

A. By Provider____

B. By Staff____

27. Do you wish to have these languages listed in a Provider Directory? _____YES _____NO

28. Do you accept Medicare assignment? _____YES _____NO

29. Is your office within twenty (20) minutes of the facilities at which you have privileges? ____YES ____NO

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

30. Office Laboratory services provided? **NA**
31. Office Radiology services provided? **NA**

32. Additional office testing available? **NA**

33. Surgical facilities/services provided at the office? **NA**

34. Do you wish to be listed (for Managed Care) as _____PCP _____Specialist _____Both **NA**

PROFESSIONAL LICENSES

Attach copies of license(s)

35. Nevada Medical/Dental/AHP license #___________Date Issued____________ Date Expires __________

Other State Licenses:

State	Number	Issue Date	Expiration Date

DEA AND NEVADA STATE PHARMACY REGISTRATION

Attach copies of certificates

36. Federal DEA Registration #________________________ Date Expires___________________________

Nevada State Pharmacy #__________________________ Date Expires___________________________

Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date

37. Other Training or Certification (Check and complete all that apply, attach copies for hospitals only)

TYPE	Date of Certification	Expiration Date
CPR	___________________	___________________
ACLS	___________________	___________________
ATLS	___________________	___________________
BLS	___________________	___________________
NALS	___________________	___________________
PALS	___________________	___________________
OTHER	___________________	___________________

EDUCATION/TRAINING

39. Pre-Medical/Dental/AHP Education

____
Facility Name

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Degree Earned

40. Medical/Dental/AHP Education

____
Facility Name

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Degree Earned

41. **Internship** (if applicable) Type____(Specialty)

____
Facility Name

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Program Director

42. **Residency** (if applicable) Type_______________________________________(Specialty)

____
Facility Name

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Program Director

OTHER POST GRADUATE EDUCATION

List in chronological order and include copies of certificates

48. ____
Facility Name Specialty & Degree Awarded

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Program Director

49. ____
Facility Name

____
Mailing Address

____
Phone FAX

____
FROM: Mo/Yr TO: Mo/Yr Program Director

BOARD CERTIFICATIONS

Attach copy of certificate(s)

This section pertains to specialty boards that are organized and recognized by the American Board of Medical Specialties or American Osteopathic Association. (AHPs List Board certification as applicable)

50. ____

Name of Specialty Board

____

Mailing Address

Date of Certification ___________________________ Expiration Date______________________________

If **not** certified, indicate current status____

If **not** certified, are you scheduled to take the exam? If so, when?___________________________________

53. Other Board Certification____

MILITARY SERVICE

Attach copy of discharge papers.

54. Have you ever served or are you currently serving in the United States Military? _____ YES _____NO

If YES, Branch of Service____

FROM ________/________ TO ________/________ Type of Discharge___________________________

DD214 (provide copy with application)

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

EMPLOYED FACULTY POSITIONS AND ACADEMIC AFFILIATIONS

List in chronological order. Do not include hospital staff memberships or surgical center affiliations.

55. ____
Facility Name FROM: Mo/Yr TO: Mo/Yr

____
Mailing Address

____
Phone Number FAX Number

____
Position Department

____
Reason for Leaving

56. ____
Facility Name FROM: Mo/Yr TO: Mo/Yr

____
Mailing Address

____
Phone Number FAX Number

____
Position Department

____
Reason for Leaving

57.

____
Facility Name FROM: Mo/Yr TO: Mo/Yr

____
Mailing Address

____
Phone Number FAX Number

____
Position Department

____
Reason for Leaving

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of medical/dental/AHP school. For any time period not covered by an affiliation or training, please provide a written explanation.

58. ____

Affiliated With FROM: Mo/Yr TO: Mo/Yr

____

Person to Contact for Verification

____

Mailing Address

____

Phone Number FAX Number

59. ____

Affiliated With FROM: Mo/Yr TO: Mo/Yr

____

Person to Contact for Verification

____

Mailing Address

____

Phone Number FAX Number

60. ____

Affiliated With FROM: Mo/Yr TO: Mo/Yr

____

Person to Contact for Verification

____

Mailing Address

____

Phone Number FAX Number

61. __ ____

Affiliated With FROM: Mo/Yr TO: Mo/Yr

____

Person to Contact for Verification

____

Mailing Address

____

Phone Number FAX Number

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Attach copy of present policy face sheet and list **ALL** insurance carriers for the past 10 years. Attach additional sheets if necessary.

72. **Present Carrier for Nevada Practice**____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim $___________________Aggregate $____________________

73. **Previous Carrier**____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim $___________________Aggregate $____________________

CONTINUING MEDICAL EDUCATION/CEU

76. Attach documentation of continuing medical education/CEU courses attended during the previous two (2) years, if applicable. Indicate which is specialty specific. Approved documentation includes a copy of CME/CEU Certificates or a list from a recognized professional organization such as AOA, AAFP, AMA, AAOS, etc.

PEER REFERENCES

MD/DO, DDS/DMD, etc.: List the names and complete information of three (3) peer references, other than associates, relatives, prospective associates or training directors with equivalent licensure (MD/DO, DDS/DMD, etc.) who have, within the past three (3) years, *personal knowledge* of your current clinical abilities, ethical character and ability to work with others. At least two of the references should be of your same specialty.

AHPs: List three physicians who are familiar with your clinical abilities and recent practice. Note: references will be evaluated primarily by the extent of direct clinical observation and other work with the applicant. If you are applying for CRNFA privileges, some Entities require each physician to complete a Statement of Physician Sponsorship form (contact Entity for form).

77. ____

Peer Reference Specialty

Complete Mailing Address

Phone Number FAX Number

78.
Peer Reference Specialty

Complete Mailing Address

Phone Number FAX Number

79.
Peer Reference Specialty

Complete Mailing Address

Phone Number FAX Number

PRACTITIONER QUESTIONNAIRE

80. **If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status**.

A.	Has your license to practice medicine in any jurisdiction **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you **ever** been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?	**☐YES ☐ NO**
B.	Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?	**☐YES ☐ NO NA**
C.	Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends **ever** been commenced?	**☐YES ☐ NO NA**
D.	Have you **ever** voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct?	**☐YES ☐ NO NA**
E.	Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced?	**☐YES ☐ NO**

F. Have you **ever** voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? ☐**YES** ☐ **NO**

G. Has your membership or status in any state or local professional society or other comparable medical organization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐ **NO**

H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs **ever** been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐ **NO**

I. Has a letter of concern or reprimand **ever** been issued to you? ☐**YES** ☐ **NO**

J. Have you **ever** been denied professional liability insurance or has your policy **ever** been canceled? ☐**YES** ☐ **NO**

K. (1) Have you **ever** been named in a complaint based on allegations of professional negligence or professional misconduct or have you **ever** received notice of an intent to commence litigation of that type? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** ☐**YES** ☐ **NO**

(2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending**? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** ☐**YES** ☐ **NO**

L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges? ☐**YES** ☐ **NO**

M. Has your specialty board certification or eligibility **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐ **NO**

N. Has your Drug Enforcement Agency or other controlled substances authorization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? ☐**YES** ☐ **NO**

O. Have you **ever** been convicted of a criminal offense other than a minor traffic violation? ☐YES ☐ NO

P. Are you now or have you **ever** been addicted to a controlled substance or alcohol**? If the answer to this question is yes, please provide the name, address and a full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. An organization may require that you complete a Health Status Form which provides the name and title of the individual/organization (counselor/diversion program/treating provider) who can advocate on behalf of your sobriety status.** ☐YES ☐ NO

Q. Do you currently use illegal drugs? ☐YES ☐ NO

R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care meeting the standards controlling the award of privileges and status that you seek? ☐YES ☐ NO

S. Would you require an accommodation in order for you to exercise medical staff duties or the privileges requested safely and completely? ☐YES ☐ NO

MALPRACTICE CLAIM INFORMATION WORKSHEET

Please duplicate this form and complete for EACH case. Also, for each case that has been settled or dismissed, supply court documentation.

Practitioner Name____

1. Patient Name____
2. Diagnosis____
3. Your involvement in the case (attending, consulting, etc.) ____________________________

   ____

4. Allegation(s) ____

   ____

5. Clinical Case Summary (Include additional pages or inserts if necessary)

   ____

   ____

6. Patient Outcome ____

   ____

7. Other Pertinent Details ____

   ____

8. Date of Incident ________________Date Filed _____________Date Closed_____________
9. Resolution of Case (dismissed, settled out of court, litigated, other)
   NOTE: All cases litigated must include legal documentation.

   ____

   ____

10. Settlement amount paid on your behalf, if any

    ____

11. Professional liability insurer involved:
    A. Name of Insurer ___________________________B. Policy #______________________
    B. Address of Insurer

    ____

    ____

Name:____

Signature________________________________ **Date**________________________________

❒ No claims to report

Regardless of whether you have had any claims, this form must be signed and dated.