Minnesota Uniform Credentialing Application
Initial

Applicant Name *(as shown on your state license):*

Last	First	Middle	Suffix	Title

CREDENTIALING CONTACT INFORMATION

Name _____ **Phone Number** _____

Address _____ **Fax Number** _____

_____ **E-mail** _____

_____

Instructions

The initial credentialing application and attachments should be filled out completely and accurately and must be legible or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **ALL SIGNATURES AND DATES MUST BE CLEARLY LEGIBLE.**

Checklist (please complete):
Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- ☐ Drug Enforcement Administration Registration with correct address (if applicable)
- ☐ ECFMG certificate (if educated outside of U.S. or Canada)
- ☐ Disclosure Explanation Form and supporting documentation (if applicable)
- ☐ Professional liability insurance documentation (as defined on page 12)
- ☐ If not a U.S. citizen, copy of official document(s) indicating authorization to work in the United States
- ☐ Curriculum Vitae (all application items must be completed)
- ☐ Advanced Practice Registered Nurses: Board certification

In addition, please verify that you have:

- ☐ Provided complete street address, phone, fax and e-mail addresses wherever indicated, including education/training, past employment, hospital and ambulatory surgery center affiliations, and professional/peer references
- ☐ Designated dates by month, day and year time frames
- ☐ Explained all gaps of greater than three months in chronology wherever indicated, including education/training and past employment
- ☐ Provided list of all insurance policies you have held for the past 5 years (Page 12)
- ☐ Answered all of the Disclosure Questions on Page 14 and completed the Disclosure Explanation Form for any affirmative answers
- ☐ Signed and dated the Attestation Signature and Date statement (Page 14)
- ☐ Signed and dated the Authorization and Release (Page 18)

All Information Must Be Printed in Black Ink or Electronically Generated

Practitioner Name: _____
Last First Middle Suffix Title

Practitioner NPI: _____

Practitioner Race and Ethnicity

Race and ethnicity (for health plan use only):

The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Race (Select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify): _____
- ☐ Prefer Not to Say

Ethnicity

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer Not to Say

*Providing race, ethnicity and/or language information on the credentialing application is entirely optional and refusal to provide this information will **not** subject you to adverse treatment. We do not discriminate or base credentialing decisions on an applicant's race, ethnicity, and language.*

If provided on the credentialing application, the health plan may utilize race, ethnicity and/or language information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Check here if you do not wish for your race and ethnicity to be displayed in provider directories: ☐

Personal Data

Applicant Name *(as shown on your state license):*

Last First Middle Suffix Title

All Former Aliases: _____ Spouse Name (optional): _____

Gender: ☐ M - Male ☐ F - Female ☐ X - Unspecified or Another Gender Identity ☐ U - Undisclosed

U.S. Citizen: ☐ Yes ☐ No Birthplace City: _____ State: _____ Country: _____

Date of Birth: _____ Social Security Number: _____ NPI: _____ CAQH ID: _____

Current Home Address: _____
Street

_____
City/State/Country Zip Code

Local Home Address (if different from above): _____
Street

_____
City/State/Country Zip Code

Preferred Mailing Address: ☐ Office ☐ Home Practitioner's Preferred E-mail address: _____

Cell Phone Number: _____ Home Phone Number: _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages: _____

Military - Are you currently on active military duty? ☐ Yes ☐ No

Primary or Pending Practice Location

Primary Practice Location/Clinic Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐ No

Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

Billing Information

Billing Name: _____ Contact Person: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

E-mail address: _____

Additional Current or Future Practice Location(s) **Applicant Name:**

Please make additional copies as necessary

1. Other Practice Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Credentialing Contact: _____ Phone Number: _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐ No

Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

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2. Other Practice Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Credentialing Contact: _____ Phone Number: _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐ No

Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

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3. Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Credentialing Contact: _____ Phone Number: _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐

No Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

Additional space is provided on the Education/Training Addendum, page 19.

Check the appropriate box and complete the following information for each level of education that is relevant to your Medical/Graduate/ Professional Education.

(Month, day, year required) ☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ **Check here if you have additional Medical/Graduate/Professional Education on attached Education/Training Addendum (page 19)**

ECFMG - Applicable to International Medical Graduates

ECFMG Number: _____ Date Issued: _____
(month/day/year)

Internship/Post-Graduate/Professional Training (if applicable)

Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty (transitional, rotating, 5th pathway, etc.): _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after Education/Training. Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

☐ **Check here if you have additional information noted on attached Education/Training Addendum (page 19)**

Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: ________________ Institution Name: ________________

To: ________________ Type of Program/Specialty: ________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ________________

If not successfully completed, explain: ________________

Program Director: ________________

Address: ________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________

From: ________________ Institution Name: ________________

To: ________________ Type of Program/Specialty: ________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ________________

If not successfully completed, explain: ________________

Program Director: ________________

Address: ________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________

From: ________________ Institution Name: ________________

To: ________________ Type of Program/Specialty: ________________

Completed Training: ☐ Yes ☐ No If no, expected completion date: ________________

If not successfully completed, explain: ________________

Program Director: ________________

Address: ________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Residency Training. Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: ________________ Explain: ________________

Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Professional and Academic/Faculty Affiliations

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Fellowship Training/ Academic Affiliations. Additional space is provided on the Education/Training Addendum, page 19.

(Month, day, year required)

From: _____ Explain: _____

_____ _____

_____ _____

_____ _____

Additional space is provided on the Chronological Employment/Practice History Addendum, page 20.

Chronological listing of employment/practice history since completion of your post-graduate training.
List ***all*** experience, including military service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. **LEAVE NO GAPS IN CHRONOLOGY**.

(Month, day, year required)

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________ | Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________ | Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________ | Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

☐ **Check here if you have additional employment history on attached Chronological Employment/Practice History Addendum (page 20)**

Time Gaps: Explain gaps/interruptions of <u>greater than three (3) months</u> before, during, or after medical/professional practice. Additional space is provided on the Chronological Employment/Practice History Addendum, page 20.
(Month, day, year required)

From: ______________ Explain: ______________________________

To: ______________ ______________________________

From: ______________ Explain: ______________________________

To: ______________ ______________________________

☐ **Check here if you have additional time gap information on attached Chronological Employment/Practice History Addendum (page 20)**

Pertinent to Primary or Pending Practice Location listed on page 3

If no hospital admitting privileges, describe method/coverage for continuity of care. Provide covering physician's name, if applicable.

_____

(Month, day, year required)

From: _____ Facility Name: _____

To: _____ Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

Other Hospital and Ambulatory Surgery Center Affiliations - Present and past affiliations beginning with most recent.

Additional space is provided on the Hospital/ASC Affiliation Addendum, page 21.

(Month, day, year required)

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

☐ **Check here if you have additional affiliations on attached Hospital/ASC Affiliation Addendum (page 21)**

Additional space is provided on the Specialty and Licensure Addendum, page 22.

***If not certified**, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any.*

_____

Primary Specialty:

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Secondary Specialty:

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty:

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty:

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

☐ **Check here if you have additional specialty on attached Specialty and Licensure Addendum (page 22)**

Licensure - List all past, current and pending professional licenses.

Additional space is provided on the Specialty and Licensure Addendum, page 22.

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending

☐ **Check here if you have additional licensure on attached Specialty and Licensure Addendum (page 22)**

NOTE: Address on DEA certificate(s) must be in the state(s) where you will be practicing as applicable to this application.

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice ☐ DEA certificate pending; date application submitted to DEA: _____

☐ Other _____

If you do not have a DEA with an address in the state in which you will be practicing, you must provide the name of the practitioner at your facility with a valid DEA certificate in that state that will write all controlled substance prescriptions on your behalf until you have a valid DEA certificate in that state.

_____

_____

State Controlled Substance Certification/Registration (If applicable - not applicable to MN, WI, ND).

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Life Support Certification

Do you have any current life support certifications (BLS, ACLS, ATLS, PALS, NRP, etc.): ☐ Yes ☐ No

If Yes: Type of Certification Expiration Date(s)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Insurance Carrier for Primary and/or Pending Practice Location and 5-year insurance history.

Enclose a copy of professional liability insurance coverage (e.g., certificate of insurance, face sheet, or verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

Coverage dates:

(Month, day, year required)

Start: _____ Current Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Certificate Pending Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships.
Specify dates of coverage for each policy. *If additional space is required, complete the Liability Addendum, page 23.*
Additional documentation of insurance coverage may be required.
For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.
(Month, day, year required)

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

☐ **Check here if you have additional Liability Insurance on attached Liability Insurance Addendum (page 23)**

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.)**. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible, from the same subspecialty). **Provide current and complete addresses, phone, fax and e-mail**. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Please complete and sign this form, attesting to its accuracy. If any of the following questions are answered in the affirmative, provide an explanation by completing the **Disclosure Explanation Form** on the following page.

1. □ Yes □ No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. □ Yes □ No Has your **professional license or registration** ever been investigated or is it currently being investigated? *If so, provide details to include the reason for the investigation and the results on the following page.*

3. □ Yes □ No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. □ Yes □ No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. □ Yes □ No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. □ Yes □ No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. □ Yes □ No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. □ Yes □ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

9. □ Yes □ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. □ Yes □ No Are there any **charges pending or are you currently charged with**, or have you ever pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?

11. □ Yes □ No Have you ever been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in **sexual harassment, sexual misconduct, stalking, or any other similar behavior or crime**, or are you aware of any current allegations or charges pending of the same? *Allegations include, but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.*

12. □ Yes □ No Have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?

13. □ Yes □ No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. □ Yes □ No Have you ever practiced within your profession without **professional liability insurance?**

15. □ Yes □ No Do you currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? *You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.*

16. □ Yes □ No Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed. I understand that the race, ethnicity, and language information I have provided (or withheld) on this application is optional and will not be used as basis for credentialing decisions or discrimination.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature _____ Date _____

Name _____

CONFIDENTIAL INFORMATION

If you answered **yes** to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). Make additional copies of this form if needed.

Applicable Disclosure Question(s): _____ **Date of Occurrence:** _____

Location of Occurrence: *Facility (if applicable)* _____ **State:** _____

Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative.
*Do **not** include name of patient or any other information that may identify a patient.*

Describe outcome, as applicable. ***Note: If responding to disclosure question #12, skip this section and complete next section.***

If you answered yes to Disclosure Question #12, complete the following section.

Describe Outcome of Claim or Lawsuit

Date Filed: _____

CONCLUDED WITH NO PAYMENTS: *(month/year)*

- ☐ Dropped/Closed Date:_____
- ☐ Verdict for you Date:_____
- ☐ Dismissed with prejudice* Date:_____
- ☐ Dismissed without prejudice** Date:_____

CONCLUDED WITH PAYMENTS: *(month/year)*

- ☐ Verdict for Plaintiff Date:_____ Amount $_____
- ☐ Settled Date:_____ Amount $_____

PENDING

- ☐ Filed, pending Date:_____

**Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim*
**Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim*

Represented by Legal Counsel for this lawsuit: ☐ Yes ☐ No - **If yes, provide name and address of counsel.**

Counsel Name _____ Phone _____

Address _____

Insurance company or employer that provided coverage for this claim.

Name _____ Policy# _____

Address _____ Phone _____

I hereby certify that all the information on this form is complete, true and accurate.

Applicant Signature _____ Date _____

Print Name _____ Phone_____

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does ***not*** include documents protected by organizational policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

To check the status of your application, contact the applicable organization or go to the organization's website.

The signature blocks below are to be signed ONLY if a previously completed application is being reviewed and updated.

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign only **one** of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note:
It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date____________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Medicare/Medicaid and Other Government Reimbursement Programs Penalty Statement:

This statement is required by Medicare/Medicaid and other government reimbursement programs.

Penalty statement according to the Federal Register dated August 31, 1984 and effective October 1, 1984.

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/MEDICAID AND OTHER GOVERNMENT REIMBURSEMENT PROGRAM PAYMENTS"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient's attending physician by virtue of his or her signature on the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature: _____ Date: _____

Name: _____

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet any applicable licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature: _____ Date: _____

Name: _____

Signature/DEA Verification

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature: _____ Date: _____

Name: _____ DEA Number: _____

Office Address: _____ Specialty: _____

_____

Phone Number: _____

Pharmacies are required to maintain signatures and DEA numbers on file for all practitioners who prescribe.

Authorization and Release

Please read the below information carefully before signing.

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at _____hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, 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 and authorize such third parties to release such information to the Entity and its Agents.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be 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 actions 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 are contemplated and/or in preparation.

3. **Release from Liability**. I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand that communication regarding my application may occur via email.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature _____ **Date** _____

Name _____

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Please make additional copies of this Addendum as necessary.

Check the appropriate box and complete the following information for each level of education that is relevant to your Medical/Graduate/ Professional Education.

(Month, day, year required) ☐ Undergraduate ☐ Masters ☐ PhD ☐ Medical ☐ Dental ☐ Other Post-Graduate

From _____ Institution Name: _____

To _____ Degree Received: _____ Area of Study: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Training (Internship/Residency/Fellowship/Professional) Addendum

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during or after Education/Training.

(Month, day, year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

Please make additional copies of this Addendum as necessary.

(Month, day, year required)

From: ________________ Organization Name: ________________________________

To: ________________ Title/Position: ________________________________

Reason for Leaving: ________________________________

Employment Contact ________________ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ________________________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________________________

From: ________________ Organization Name: ________________________________

To: ________________ Title/Position: ________________________________

Reason for Leaving: ________________________________

Employment Contact ________________ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ________________________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________________________

From: ________________ Organization Name: ________________________________

To: ________________ Title/Position: ________________________________

Reason for Leaving: ________________________________

Employment Contact ________________ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ________________________________
Street City/State/Country Zip Code

Phone Number: ________________ Fax Number: ________________

E-mail address: ________________________________

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after medical/professional practice.

(Month, day, year required)

From: ________________ Explain: ________________________________

To: ________________ ________________________________

From: ________________ Explain: ________________________________

To: ________________ ________________________________

From: ________________ Explain: ________________________________

To: ________________ ________________________________

Please make additional copies of this Addendum as necessary.

(Month, day, year required)

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 8)**

Please make additional copies of this Addendum as necessary.

Specialty/Subspecialty Certification

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

State Licensure

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending

Please make additional copies of this Addendum as necessary.

Please list all insurance policies you have held in the past 5 years, including policies covering Residency and Fellowships. Specify dates of coverage for each policy.

For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.

(Month, day, year required)

Start: ________________ Insurance Carrier Name: ______________________________

Expire: ________________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________

Start: ________________ Insurance Carrier Name: ______________________________

Expire: ________________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________

Start: ________________ Insurance Carrier Name: ______________________________

Expire: ________________ Address: ______________________________

Street City/State/Country Zip Code

Phone Number: ______________________ Fax Number: ______________________

E-mail address: ______________________________

Name in which policy issued: ______________________________

Policy number (if applicable): ______________________________

Amount of coverage (per occurrence): ______________________________

Amount of coverage (per aggregate): ______________________________