

Minnesota Uniform Credentialing Application

Initial

Physician/Dentist/Allied Health Professional

Application is submitted by:

Name: _____
Last First Middle Suffix Title

PRIMARY PRACTICE LOCATION CREDENTIALING CONTACT NAME	
Name _____	Phone Number _____
Address _____	Fax Number _____
_____	E-mail _____

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, 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. Please mark all non-applicable sections with N/A.

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)
- Diploma and ECFMG certificate (if educated outside of U.S. or Canada)
- Malpractice Litigation and Professional Complaints Form (if applicable)
- Malpractice liability insurance documentation (as defined on page 8)
- Curriculum Vitae (all application items must be completed)
- Allied Health Professionals: License/registration and/or certification (if applicable)

In addition, please verify that you have:

- Provided complete street addresses wherever indicated, including past employment, hospital affiliations and references
- Designated dates by month and year time frames
- Explained all gaps of greater than three months in chronology (Page 6)
- Answered all of the Disclosure Questions on Pages 10 and 11 and enclosed explanations for affirmative answers
- Signed and dated the Attestation Signature and Date statement (Page 11)
- Signed and dated the Authorization and Release (Page 13)

<p>This Box to be Completed by Allied Health Professionals Only</p> <p>Profession/Title _____</p> <p>Sponsoring/Collaborative Physician _____ (If applicable)</p>
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All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Personal Data

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s): _____ Spouse Name (optional): _____

Marital Status (optional): Married Single Divorced Widowed Gender: Male Female

Date of Birth: ____/____/____ Birthplace (city/state/country): _____ U.S. Citizen: Yes No

Social Security Number: _____ UPIN or NPI: _____

Medicaid Number: _____ State _____ Medicare Number: _____ State _____

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 E-mail address: _____

Pager 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: _____

Primary or Pending Practice Location

Primary Practice Location: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ E-mail Address: _____

Credentialing Contact: _____ Phone Number: _____

Expected Start Date: _____ Do you intend to practice as: Primary Care Specialist Urgent Care

Is over 50 percent of your practice primary care? Yes No

Primary Specialty: _____ Subspecialty: _____

Specialty/Subspecialty 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: _____

Additional Practice Location(s)

Practice Name: _____ **Phone Number:** _____

Address: _____
Street City/State/Country Zip Code

Credentialing Contact: _____ **Phone Number:** _____

Currently practicing at this location? Yes No **Start Date:** _____

If yes, will you continue to practice at this location? Yes No **If no, last date of employment:** _____

Specialty/Subspecialty in which care will be provided: _____

Other Practice Name: _____ **Phone Number:** _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ **Fax Number:** _____

Federal Tax ID Number (if different from primary): _____

Credentialing Contact: _____ **Phone Number:** _____

Currently practicing at this location? Yes No **Start Date:** _____

If yes, will you continue to practice at this location? Yes No **If no, last date of employment:** _____

Specialty/Subspecialty in which care will be provided: _____

Other Practice Name: _____ **Phone Number:** _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ **Fax Number:** _____

Federal Tax ID Number (if different from primary): _____

Credentialing Contact: _____ **Phone Number:** _____

Currently practicing at this location? Yes No **Start Date:** _____

If yes, will you continue to practice at this location? Yes No **If no, last date of employment:** _____

Specialty/Subspecialty in which care will be provided: _____

Other Practice Name: _____ **Phone Number:** _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ **Fax Number:** _____

Federal Tax ID Number (if different from primary): _____

Credentialing Contact: _____ **Phone Number:** _____

Currently practicing at this location? Yes No **Start Date:** _____

If yes, will you continue to practice at this location? Yes No **If no, last date of employment:** _____

Specialty/Subspecialty in which care will be provided: _____

Medical/Graduate/Professional Education

From ____/____/____ Institution Name: _____

To ____/____/____ Degree Received: MD DO DDS DC DPM Ph.D Other: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From ____/____/____ Institution Name: _____

To ____/____/____ Degree Received: MD DO DDS DC DPM Ph.D Other: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

ECFMG - Applicable to International Medical Graduates

ECFMG Number: _____ Date Issued: _____ (mo/yr) Valid Through: _____ (mo/yr)

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

From: ____/____/____ Institution Name: _____

To: ____/____/____ Internship Type/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 (if known): _____ Fax Number (if known): _____

Residency/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)

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 (if known): _____ Fax Number (if known): _____

Residency/Post-Graduate/Professional Training - continued

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 (if known): _____ Fax Number (if known): _____

Fellowship/Post-Graduate/Professional Training (If additional space is required, attach a separate sheet.)

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 (if known): _____ Fax Number (if known): _____

Professional and Academic/Faculty Affiliations

From: ____/____/____ Institution Name: _____
To: ____/____/____ Appointment Held/Position: _____
Address: _____
Street City/State/Country Zip Code
Phone Number (if known): _____ Fax Number (if known): _____

From: ____/____/____ Institution Name: _____
To: ____/____/____ Appointment Held/Position: _____
Address: _____
Street City/State/Country Zip Code
Phone Number (if known): _____ Fax Number (if known): _____

From: ____/____/____ Institution Name: _____
To: ____/____/____ Appointment Held/Position: _____
Address: _____
Street City/State/Country Zip Code
Phone Number (if known): _____ Fax Number (if known): _____

Chronological Employment/Practice History

Chronological listing [month/year] of employment/practice history **since completion of your post-graduate training**. List all experience, including armed 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. If additional space is required, attach a separate sheet.

From: ___/___/___ Organization Name/Activity: _____

To: ___/___/___ Reason for Leaving: _____

Contact Name _____

	If no, attach sheet listing address and phone number of someone who can verify your
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Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Organization Name/Activity: _____

To: ___/___/___ Reason for Leaving: _____

Contact Name _____

Clinic Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing address and phone number of someone who can verify your
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Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Organization Name/Activity: _____

To: ___/___/___ Reason for Leaving: _____

Contact Name _____

Clinic Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing address and phone number of someone who can verify your
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Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Organization Name/Activity: _____

To: ___/___/___ Reason for Leaving: _____

Contact Name _____

Clinic Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing address and phone number of someone who can verify your
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Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

Explain gaps/interruptions of greater than three (3) months to practice of medicine/professional practice (if additional space is required, attach a separate sheet):

From: ___/___/___ Explain : _____

To: ___/___/___ _____

From: ___/___/___ Explain : _____

To: ___/___/___ _____

Primary Hospital Affiliation (pertinent to Primary or Pending Practice Location listed on page 2)

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

From: ____/____/____ Facility Name: _____

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

Application Pending Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

Other Hospital Affiliations - Present and past affiliations beginning with most recent. (Additional space is provided on the Hospital Affiliation Addendum, page 15. You may make extra copies of page 15 or attach a separate sheet for additional affiliations.)

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

Specialty/Subspecialty Certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___	___/___/___

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. _____

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

State	License Number	Date Issued	Expiration Date	License Status
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive

Drug Enforcement Administration Registration

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 _____

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

Issued By: _____ Number: _____ Expiration Date: ___/___/___

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

Coverage dates:

From: ___/___/___ Insurance Carrier Name: _____

To: ___/___/___ Address _____
Street City/State/Country Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): _____

Professional/Peer References

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgement, 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.) Limit to one **(1) current office associate. 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. 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: _____

Life Support Certification

Do you have any current life support certifications (BLS, CPR, ACLS, ATLS, etc.)? Yes No

If Yes: Type of Certification	Expiration Date(s)
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

Disclosure Questions for Initial Credentialing

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

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 and, if so, what were the results?

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 been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

11. Yes No Have you ever been found liable, guilty or responsible for **sexual impropriety** or misconduct or sexual harassment \ with a patient, co-worker, or other?

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 judgements? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.** You may be asked for additional information by individual organizations.

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 have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

16. Yes No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

17. Yes No Are you currently using illegal 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. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 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.)

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 hospital 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.

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.

Signature _____ Date _____

Name _____

(please print or type)

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

Application Update

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 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 _____

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 _____

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 _____

Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership and/or participation status (hereinafter, referred to as "Participation") at Clinical Resource Group, Inc. (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 and agree that the Entity may communicate with me via e-mail over the Internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

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 (please print or type) _____

***Application Addendum
To Initial and Reappointment Applications***

Medicare/Champus Penalty Statement: This statement is required by Medicare/Champus

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

“NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/CHAMPUS 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.

Signature: _____ Date: _____

Name: _____
(please print or type)

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 the 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.

Signature: _____ Date: _____

Name: _____
(please print or type)

Signature/DEA Verification

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

Signature: _____ Date: _____

Name: _____ (please print or type) DEA Number: _____

Office Address: _____ Specialty: _____

Phone Number: _____

Malpractice Litigation and Professional Complaints
Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. If is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

Name(s) of plaintiff(s) or complainants(s)

Month/Year of incident

Where incident occurred

Describe the nature of incident (Complaint, Allegation)

Provide a narrative description of your participation/level of care

Outcome of incident

Pending Dropped/Settled/Closed - no payment Date Closed ___/___/___ Verdict for you - no payment

Dropped/Settled/Closed with payment, amount: _____ Dismissed with prejudice

Verdict for plaintiff, amount: _____ Dismissed without prejudice

Represented by Legal Counsel for this claim/malpractice lawsuit? Yes No If yes, give the name and address of counsel.

Name: _____

Address: _____

Phone Number: _____

Insurance company that provided coverage for this claim:

Name: _____

Address: _____

Phone Number: _____ Policy Number: _____

Signature _____ Date _____

Print Name _____ Phone Number _____

Hospital Affiliation Addendum
(Please make as many extra copies as necessary.)

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____

From: ____/____/____ Facility Name: _____

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

Department Name: _____

Department Chairperson: _____

Address _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known) _____