28302

Universal Physician Credentialing Application

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IDENTIFYING INFORMATION

○ MD ○ DO ○ DDS ○ DPM

Last Name

First Name

Middle Name

Maiden Name/Other Name by Which You Have Been Known

Social Security Number - -

Sex
○ Male
○ Female

Marital Status
○ Married ○ Widowed
○ Single ○ Divorced

Name of Spouse

UPIN

Place of Birth

Date of Birth / /

Residence Phone Number ( ) -

Residence Address

City

State

Zip Code -

Preferred Mailing Address:

Office #1 ○ Office #2 ○ Office #3 ○

Office Address (If maintaining more than one office , list each office and address)
If not currently at this address - expected starting date.

Start Date / /

Primary Office Address

Street Address & Suite #

City

State

Zip Code -

Phone Number ( ) -

Fax Number ( ) -

Answering Service Number ( ) -

Pager Number ( ) -

Secondary Office Address

Street Address & Suite #

City

State

Zip Code -

Phone Number ( ) -

Fax Number ( ) -

Answering Service Number ( ) -

Pager Number ( ) -

Additional Office Address

Street Address & Suite #

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Additional Office Address - continued

City

State

Zip Code

Phone Number

Fax Number

Answering Service Number

Pager Number

Practice Information

Group Name

Clinic Manager

Billing Address & Suite #

City

State

Zip Code

Phone Number

Fax Number

Identifying Information Physicians Who Share Call If Outside Your Group

On Call Physician Name #1

Address

City

State

Zip Code

Daytime Phone Number

After Hours Number

On Call Physician Name #2

Address

City

State

Zip Code

Daytime Phone Number

After Hours Number

Primary Specialty

Subspecialty

Subspecialty

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Is your practice limited to a speciality or subspecialty? If so, please indicate: ○ Yes ○ No

Limited Specialty

Other interests in practice, research, etc:

Total years in practice.

Premedical Education

College or University

Start Date / / Stop Date / / Graduation Date / /

Address

City State Zip Code -

Degree

College or University

Start Date / / Stop Date / / Graduation Date / /

Address

City State Zip Code -

Degree

Medical Education

Medical School

Start Date / / Stop Date / / Graduation Date / /

Address

City State Zip Code -

Degree

Medical School

Start Date / / Stop Date / / Graduation Date / /

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Medical Education - continued

Address

City State Zip Code -

Degree

Post graduate education

List name and type (Internship, Residency, Fellowship, Preceptorship) of all postgraduate educational programs in chronological order with dates, location, chiefs of staff, and speciality. **List first postgraduate program first.** If there is a time gap, please explain on a separate sheet of paper and make reference to this section.

Internship

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

If currently in residency, expected date of completion: / /

Residency

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Residency - continued

Training Program

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Fellowship

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Preceptorship

Institution

Start Date / / Stop Date / / Chief of Staff

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Preceptorship - continued

Address

City State Zip Code -

Training Program

Additional Postgraduate Education (Both hospital & non-hospital based)(Attach copies of ALL postgradual certificates)

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Institution

Start Date / / Stop Date / / Chief of Staff

Address

City State Zip Code -

Training Program

Armed Services / Public Health List all medical and surgical dates and locations. Attach copy of your DD214

Military Branch ○ U.S. Air Force ○ U.S. Marines ○ U.S. Army ○ U.S. Navy

Type of Discharge ○ Dishonorable ○ Honorable ○ General ○ Other than Honorable

Start Date / / End Date / / Reserve Status ○ Yes ○ No Rank at time of discharge

Public Health Institution

Start Date / / Stop Date / /

Address

City State Zip Code -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

Armed Services / Public Health - continued

Public Health Institution

Start Date / / Stop Date / /

Address

City State Zip Code -

PROFESSIONAL PRACTICE

Chronological listing of medical practice since medical training, including office and clinic. Include nature of and principal associates (solo, partnership, group) including office address and inclusive dates. If additional space is required, attach sheet of paper and make reference to this section.

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

PROFESSIONAL PRACTICE - continued

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

Practice Type

Address

City State Zip Code -

Start Date / / End Date / / Country

ACADEMIC APPOINTMENTS

Institution

Address

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

ACADEMIC APPOINTMENTS - continued

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

Title | Rank

Institution

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

Title | Rank

Institution

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

Title | Rank

Institution

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

ACADEMIC APPOINTMENTS - continued

Phone Number ( ) -

Fax Number ( ) -

Title

Rank

INSTITUTIONAL APPOINTMENTS

INSTITUTIONAL APPOINTMENTS - continuedList in chronological order **ALL past and present** hospital and health care facility afflilitions since completition of post graduate education. This includes all hospitals, corporations, military assignements, or government agencies. **Complete name and address must be included**. If additional space is required please attach a seperate sheet of paper and

Institution

Address

City

State

Zip Code -

Start Date / /

End Date / /

Country

Phone Number ( ) -

Fax Number ( ) -

Institution

Address

City

State

Zip Code -

Start Date / /

End Date / /

Country

Phone Number ( ) -

Fax Number ( ) -

Institution

Address

City

State

Zip Code -

Start Date / /

End Date / /

Country

Phone Number ( ) -

Fax Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

INSTITUTIONAL APPOINTMENTS - continued

Institution

Address

City | State | Zip Code -

Start Date / / | End Date / / | Country

Phone Number ( ) - | Fax Number ( ) -

Institution

Address

City | State | Zip Code -

Start Date / / | End Date / / | Country

Phone Number ( ) - | Fax Number ( ) -

Institution

Address

City | State | Zip Code -

Start Date / / | End Date / / | Country

Phone Number ( ) - | Fax Number ( ) -

Institution

Address

City | State | Zip Code -

Start Date / / | End Date / / | Country

Phone Number ( ) - | Fax Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

LICENSES, REGISTRATIONS MEDICAL/DENTAL (active & inactive)

List **ALL** states where you hold or have held a medical license. Attach copies of **ALL** current license. If additional space is required, please attach a seperate sheet and make reference to this section.

State Agency

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City | State | Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

LICENSES, REGISTRATIONS MEDICAL/DENTAL- continued (active & inactive)

State Agency

Address

City | State | Zip Code

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

OTHER PROFESSIONAL LICENSES HELD

State Agency

Address

City | State | Zip Code

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City | State | Zip Code

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City | State | Zip Code

Start Date / / End Date / / Country

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

OTHER PROFESSIONAL LICENSES HELD - continued

Phone Number ( ) - Fax Number ( ) -

State Agency

Address

City State Zip Code -

Start Date / / End Date / / Country

Phone Number ( ) - Fax Number ( ) -

Are you a foreign medical graduate? If yes have you passed the FLEX or ECFMG exams? ○ **Yes** ○ **No**

ECFMG Number **Please attach a copy of your ECFMG Certificate**

DRUG ENFORCEMENT ADMINISTRATION (attach copies)

Federal DEA Number **Current** ○ **Yes** ○ **No**

State DEA Number **Current** ○ **Yes** ○ **No**

Do you write prescriptions for controlled substances? ○ **Yes** ○ **No**

MEMBERSHIP IN PROFESSIONAL SOCIETIES

List all professional fellowships, memberships, and societies, past and present, including state and county medical societies with dates. If additional space is required, please attach a seperate sheet and make reference to this section.

Professional Association

Address

City State Zip Code -

Start Date / / End Date / /

Phone Number ( ) - Fax Number ( ) -

Professional Association

Address

City State Zip Code -

Start Date / / End Date / / Phone Number - -

Fax Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

MEMBERSHIP IN PROFESSIONAL SOCIETIES - continued

Professional Association

Address

City | State | Zip Code

Start Date / / End Date / /

Phone Number ( ) - Fax Number ( ) -

Professional Association

Address

City | State | Zip Code

Start Date / / End Date / /

Phone Number ( ) - Fax Number ( ) -

Professional Association

Address

City | State | Zip Code

Start Date / / End Date / /

Phone Number ( ) - Fax Number ( ) -

Professional Association

Address

City | State | Zip Code

Start Date / / End Date / /

Phone Number ( ) - Fax Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

MEMBERSHIP IN PROFESSIONAL SOCIETIES - continued

Professional Association

Address

City | State | Zip Code

Start Date / / | End Date / /

Phone Number ( ) - | Fax Number ( ) -

Professional Association

Address

City | State | Zip Code

Start Date / / | End Date / /

Phone Number ( ) - | Fax Number ( ) -

HEALTH DELIVERY SYSTEMS

List all HMO's, PPO's, IPX's, etc to which you belong or to which you are making application. If additional space is required, please attach a seperate sheet and make reference to this section.

Health Plan

Product

Start Date / / | End Date / /

Health Plan

Product

Start Date / / | End Date / /

Health Plan

Product

Start Date / / | End Date / /

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

HEALTH DELIVERY SYSTEMS

Health Plan

Product

Start Date / / End Date / /

Health Plan

Product

Start Date / / End Date / /

Health Plan

Product

Start Date / / End Date / /

Health Plan

Product

Start Date / / End Date / /

Health Plan

Product

Start Date / / End Date / /

Health Plan

Product

Start Date / / End Date / /

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

STATUS OF LICENSES AND MEMBERSHIPS

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished. **(If yes provide a full explanation on a seperate sheet and make reference to this section.)**

Select all that apply

- ○ Medical license in any state
- ○ Other professional registration/license
- ○ DEA Registration
- ○ Academic appointment
- ○ Membership on any hospital or healthcare facility medical staff
- ○ Clinical privileges
- ○ Prerogatives or rights on any medical staff
- ○ Other institutional affiliations or status
- ○ Professional society membership
- ○ Fellowship/board certification
- ○ Any other type of professional sanction
- ○ Medicare/Medicaid status
- ○ Professional liability insurance
- ○ Are you currently charged with/ever been convicted of a felony or misdemeanor?
- ○ Have you ever withdrawn a credentialing application before a decision was made by a governing body?

LIABILITY INSURANCE (attach copy of certificate)

Insurance Carrier/Agent

Policy Number

Amount of Coverage $, ,

Start Date / /

End Date / /

Select all that apply

- ○ Are there any professional liability claims pending against you?
- ○ Have you had any professional liability cases brought against you in the past 5 years?
- ○ Have you ever been denied professional liability insurance
- ○ Has your liability coverage ever been cancelled?
- ○ Has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?
- ○ Has any monetary settlement been made or agreed to by you or insurance carrier?
- ○ Have any professional liability claims been filed against you?
- ○ Have you reported any malpractice claims to your insurance carrier?
- ○ Have you received any letters of intent to sue?

If you selected any of the above, please provide details on a seperate sheet of paper and make reference to this section.

- ○ Is your current carrier the same carrier with whom you have been insured for the last five years?

Give names, addresses and policy numbers of any other insurance carrier during that time on a seperate attached sheet.

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

BOARD CERTIFICATIONS (attach copies of all certifications)

Certified By

Date Certified / / Expiration Date / /

Y N
○ ○ Present member in good standing?
Y N
○ ○ Does this board require recertification?
Y N
○ ○ If not certified, have you applied for certification examination?
Y N
○ ○ If no, do you intend to apply for certification examination?
Y N
○ ○ If not certified, are you eligible to apply for certification examination?
Y N
○ ○ Have you ever taken and failed a certification examination?

Certified By

Date Certified / / Expiration Date / /

Y N
○ ○ Present member in good standing?
Y N
○ ○ Does this board require recertification?
Y N
○ ○ If not certified, have you applied for certification examination?
Y N
○ ○ If no, do you intend to apply for certification examination?
Y N
○ ○ If not certified, are you eligible to apply for certification examination?
Y N
○ ○ Have you ever taken and failed a certification examination?

Certified By

Date Certified / / Expiration Date / /

Y N
○ ○ Present member in good standing?
Y N
○ ○ Does this board require recertification?
Y N
○ ○ If not certified, have you applied for certification examination?
Y N
○ ○ If no, do you intend to apply for certification examination?
Y N
○ ○ If not certified, are you eligible to apply for certification examination?
Y N
○ ○ Have you ever taken and failed a certification examination?

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

PROFESSIONAL REFERENCES

Name a least four (4) peers who have direct knowledge of your current clinical abilities, ethical character, health status and professional relationships and who will provide specific written comments on these matters if requested. Their experience of your practice must be recent, **WITHIN FIVE YEARS.**
IMPORTANT: Only one reference may be a current associate, and at least one must be within your subspeciality, if applicable, and please do not use persons listed elsewhere in this application. DO NOT LIST TRAINING DIRECTORS OR FELLOW TRAINEES>

Professional Reference

Address

City State Phone Number ( ) -

Professional Reference

Address

City State Phone Number ( ) -

Professional Reference

Address

City State Phone Number ( ) -

Professional Reference

Address

City State Phone Number ( ) -

Professional Reference

Address

City State Phone Number ( ) -

Professional Reference

Address

City State Phone Number ( ) -

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.

ADDITIONAL INFORMATION - foreign languages

Language

Language fluently written ○ Yes ○ No

Language fluently spoken ○ Yes ○ No

Language

Language fluently written ○ Yes ○ No

Language fluently spoken ○ Yes ○ No

Are you trained in signing for the English language? ○ Yes ○ No

Are you trained in signing for any other language? ○ Yes ○ No

How many credit hours of continuing medical education have you completed during the past **TWO** years?

How many category I hours?

Do you have valid AMA Physician's Recognition Aware? ○ Yes ○ No

Expiration Date / /

Submit Reset

Please enter the last four (4) digits of your Social Security Number in the space provided at the right above.