



**ATTACHMENTS**

**Attach forms A-F as needed to support “yes” responses in Section G: Professional History and copies of the following:**

<input type="checkbox"/> Curriculum Vitae
<b>CONFIDENTIAL INFORMATION:</b> <input type="checkbox"/> All Current Professional Licenses <input type="checkbox"/> Current Federal DEA License, If Applicable <input type="checkbox"/> Current State Controlled Substance License(s), If Applicable <input type="checkbox"/> Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate <input type="checkbox"/> Current CLIA Certificate, If Applicable <input type="checkbox"/> Current W-9s, If Applicable

**AFFIRMATION OF INFORMATION**

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Date

**\*\* PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM. \*\***

**CHAPTER A:  
PRACTICE AND PROFESSIONAL INFORMATION**

**SECTION A. GENERAL INFORMATION**


Name: \_\_\_\_\_  
Last First MI Degree

List other names by which you have been known: \_\_\_\_\_  
Last First MI

If you have been known by other names, please explain why your name changed:  
\_\_\_\_\_  
\_\_\_\_\_

Birth Date: \_\_\_\_\_  
(mm/dd/yy)

Sex:  Male  Female

U.S. Citizen?  Yes  No 

If no, do you have a legal right to reside permanently and work in the U.S.?  Yes  No

Resident Visa No: _____	<i><b>CONFIDENTIAL INFORMATION</b></i>
Social Security Number: _____	
Emergency Contact Person: _____	
Last First MI	
Telephone Number: ( ) _____	

Mailing Address: \_\_\_\_\_  
Street City State Zip

Daytime Phone: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Check here if you have appended additional information for this section:

*(Please continue next page)*

**SECTION B. PROFESSIONAL INFORMATION**

Illinois Professional License Number: \_\_\_\_\_

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
\_\_\_\_\_

**Current Professional License(s) in Other States**

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
\_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
\_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ (mm/dd/yy)

License Unlimited? Yes  No  → If No, please explain limitation: \_\_\_\_\_  
\_\_\_\_\_

Check here if you have appended additional information for this section:

**Current Federal DEA License Number: \_\_\_\_\_ CONFIDENTIAL INFORMATION**

DEA License Number Expiration Date: \_\_\_\_\_ License Unlimited? Yes  No

If No, please explain limitation: \_\_\_\_\_  
\_\_\_\_\_

Check here if you have appended additional information for this section:

**Current State Controlled Substance Number(s):**

State: _____	<b>CONFIDENTIAL INFORMATION</b>	CS License #: _____	Expiration Date: _____
			(mm/dd/yy)
State: _____		CS License #: _____	Expiration Date: _____
			(mm/dd/yy)
State: _____		CS License #: _____	Expiration Date: _____
			(mm/dd/yy)

**Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.**

\_\_\_\_\_  
\_\_\_\_\_

Medicare Unique Provider ID# (UPIN): \_\_\_\_\_

National Provider Identification Number (NPI): \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_

X-Ray Certification: State: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ (mm/dd/yy)

Check here if you have appended additional information for this section:

**COMPLETE FOR EACH SPECIALTY**

**Specialty I:** \_\_\_\_\_

Are you Board Certified in Specialty I? Yes  No

If Yes, name of Certifying Board: \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes  No

If Certifying Boards taken, give date: \_\_\_\_\_ Certification Expiration Date, if Any: \_\_\_\_\_  
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: \_\_\_\_\_  
(mm/yy)

**Specialty/Subspecialty II:** \_\_\_\_\_

Are you Board Certified in Specialty II? Yes  No

If Yes, name of Certifying Board: \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes  No

If Certifying Boards taken, give date: \_\_\_\_\_ Certification Expiration Date, if Any: \_\_\_\_\_  
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: \_\_\_\_\_  
(mm/yy)

*(Please continue next page)*

**Specialty/Subspecialty III:** \_\_\_\_\_

Are you Board Certified in Specialty III? Yes  No

If Yes, name of Certifying Board: \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes  No

If Certifying Boards taken, give date: \_\_\_\_\_ Certification Expiration Date, if Any: \_\_\_\_\_  
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: \_\_\_\_\_  
(mm/yy)

**Specialty/Subspecialty IV:** \_\_\_\_\_

Are you Board Certified in Specialty IV? Yes  No

If Yes, name of Certifying Board: \_\_\_\_\_

Date of Certification: \_\_\_\_\_ Date of Recertification (if applicable): \_\_\_\_\_  
(mm/yy) (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes  No

If Certifying Boards taken, give date: \_\_\_\_\_ Certification Expiration Date, if Any: \_\_\_\_\_  
(mm/yy) (mm/yy)

If not taken, date scheduled to take Specialty Boards: \_\_\_\_\_  
(mm/yy)

Check here if you have appended additional information for this section:

**CURRENT PROFESSIONAL LIABILITY INSURANCE**

**CONFIDENTIAL INFORMATION:**

Carrier: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Policy Number: \_\_\_\_\_ Original Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_

Retroactive Date: \_\_\_\_\_  
(mm/dd/yy)

What type of coverage do you have?  Claims Made  Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  
 Yes  No

**MEMBERSHIP STATUS – USE FOR SECTIONS C AND D**

**Please use the following key to indicate membership status in Sections C (Hospital Membership – Current and Pending) and D (Ambulatory Surgery Center Practice) below.**

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

**SECTION C. HOSPITAL MEMBERSHIP - CURRENT AND PENDING**

**Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending.** (Include additional sheets if more than three hospitals.)

**A. Primary Hospital**

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ **To Present**  
From (mm/yy)

Department/Division: \_\_\_\_\_ Medical Staff Office FAX #: ( ) \_\_\_\_\_

Department Telephone #: ( ) \_\_\_\_\_

Any Limitations in Your Area of Specialty at this Hospital? \_\_\_\_\_

**B. Other Hospital**

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ **To:** \_\_\_\_\_  
From (mm/yy) To (mm/yy)

Department/Division: \_\_\_\_\_ Medical Staff Office FAX #: ( ) \_\_\_\_\_

Department Telephone #: ( ) \_\_\_\_\_

Any Limitations in Your Area of Specialty at this Hospital? \_\_\_\_\_

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**C. Other Hospital**

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_

From (mm/yy) To (mm/yy)

Department/Division: \_\_\_\_\_ Medical Staff Office FAX #: ( ) \_\_\_\_\_

Department Telephone #: ( ) \_\_\_\_\_

Any Limitations in Your Area of Specialty at this Hospital? \_\_\_\_\_

\_\_\_\_\_

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Check here if you have appended additional information for this section:

*(Please continue next page)*



**SECTION D. AMBULATORY SURGERY CENTER PRACTICE**

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 7. (Include additional sheets if more than three ambulatory surgery centers.)

**A. Primary Ambulatory Surgery Center**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

**B. Other Ambulatory Surgery Center**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

**C. Other Ambulatory Surgery Center**

ASC Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Membership Status: \_\_\_\_\_ Dates: \_\_\_\_\_ To: \_\_\_\_\_  
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section:

*(Please continue next page)*

**SECTION E. WORK HISTORY**

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service) in the last four (4) years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

**Current work place:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ to Present  
(mm/yy)

**Previous work place:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ to: \_\_\_\_\_  
(mm/yy) (mm/yy)

**Previous work place:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ to: \_\_\_\_\_  
(mm/yy) (mm/yy)

**Previous work place:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ to: \_\_\_\_\_  
(mm/yy) (mm/yy)

**Previous work place:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation: \_\_\_\_\_

Time in this employment: From: \_\_\_\_\_ to: \_\_\_\_\_  
(mm/yy) (mm/yy)

**SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING UPDATE**

**Please provide an update of your medical education and clinical training over the past four years. Do not duplicate internship, residency, and fellowship information previously reported. (Attach additional sheets if necessary.)**

**FIRST UPDATE**

Fellowship                   Residency                   Other

Institution Name: \_\_\_\_\_

Department Chair or Program Director: \_\_\_\_\_  
Last Name                                  First Name                                  MI                                  Degree

Mailing Address: \_\_\_\_\_  
Street    City    State                                  Zip

Telephone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_

Dates attended: From: \_\_\_\_\_ To: \_\_\_\_\_  
mm/yy                                  mm/yy

Type of internship:  Rotating           Straight → If straight, please list specialty: \_\_\_\_\_

Did you successfully complete this program?  Yes     No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  Yes     No

(Attach an explanation of a "Yes" answer.) ←

**SECOND UPDATE**

Fellowship                   Residency                   Other

Institution Name: \_\_\_\_\_

Department Chair or Program Director: \_\_\_\_\_  
Last Name                                  First Name                                  MI                                  Degree

Mailing Address: \_\_\_\_\_  
Street    City    State                                  Zip

Telephone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_

Dates attended: From: \_\_\_\_\_ To: \_\_\_\_\_  
mm/yy                                  mm/yy

Type of internship:  Rotating           Straight → If straight, please list specialty: \_\_\_\_\_

Did you successfully complete this program?  Yes     No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  Yes     No

(Attach an explanation of a "Yes" answer.) ←

**Check here if you have appended additional information for this section:**

**SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL**

**ADVERSE OR OTHER ACTIONS**

**Submit with all applications. Please answer the following questions to the best of your knowledge with a “yes” or “no.” If you answer “yes” to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each “yes” answer.**

**Please provide information on your professional history over the past four (4) years.**

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?  Yes  No
2. Have you been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers?  Yes  No
3. Have you lost any board certification(s), and/or failed to recertify?  Yes  No
4. Have you been examined by a Certifying Board but failed to pass?  Yes  No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?  Yes  No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?  Yes  No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?  Yes  No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?  Yes  No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?  Yes  No
10. Have you been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?  Yes  No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?  Yes  No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?  Yes  No
13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?  Yes  No

### PROFESSIONAL LIABILITY ACTIONS

**If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.**

1. Have any professional liability judgments ever been entered against you?  Yes  No
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?  Yes  No
3. Are there any currently pending professional liability suits, actions and/or claims filed against you?  Yes  No
4. Has any person or entity been sued for your clinical actions?  Yes  No

### LIABILITY INSURANCE

**If you answer yes to this question please complete FORM C.**

Have you been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?  Yes  No

### CRIMINAL ACTIONS

**If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.**

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?  Yes  No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?  Yes  No

**MEDICAL CONDITION**

**If you answer yes to this question please complete FORM E.**

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?  Yes  No

**CHEMICAL SUBSTANCES OR ALCOHOL ABUSE**

**If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.**

- 1. Are you currently engaged in illegal use of any legal or illegal substances?  Yes  No
- 2. Do you currently overuse and/or abuse alcohol or any other controlled substances?  Yes  No
- 3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?  Yes  No  
 Not Applicable
- 4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?  Yes  No

**INVESTMENTS**

In the last five (4) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?  Yes  No

**If Yes, please provide explanation:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(Please continue next page)*

**CHAPTER B:  
BUSINESS INFORMATION**

**SECTION H. PRIMARY SITE INFORMATION**

Please provide the following information for the primary site at which you practice.

**Primary  
Site**

\_\_\_\_\_  
Group/Business Name

\_\_\_\_\_  
Building Name

\_\_\_\_\_  
Office Address – Number and Street – Suite

\_\_\_\_\_  
City County State Zip

( ) \_\_\_\_\_  
Main Telephone Number Office Administrator – Last First MI

( ) \_\_\_\_\_  
Beeper Number FAX Number E-mail

( ) \_\_\_\_\_  
Emergency Number Answering Service

Are you currently accepting new patients at this location?  Yes  No

**If yes**, describe any restrictions (e.g., appointment type, patient type): \_\_\_\_\_  
\_\_\_\_\_

Please provide the number of active patients enrolled with you at this site: \_\_\_\_\_

Please provide the number of patient visits you have at this site per year: \_\_\_\_\_

**List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.**

Special Skills of Practitioner: \_\_\_\_\_

Special Skills of Staff: \_\_\_\_\_

Languages Spoken by Practitioner: \_\_\_\_\_

Languages Written by Practitioner: \_\_\_\_\_

Languages Spoken by Staff: \_\_\_\_\_

Languages Written by Staff: \_\_\_\_\_

*(Please continue next page)*

**Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.**

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays  
**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays  
**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays  
**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

*(Please continue next page)*



**SECTION I. ADDITIONAL SITE INFORMATION**

Please provide the following information for each additional site at which you practice.

<b>Site #</b>	Group/Business Name								
	Building Name								
	Office Address – Number and Street – Suite								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;">City</td> <td style="width: 30%; border-bottom: 1px solid black;">County</td> <td style="width: 15%; border-bottom: 1px solid black;">State</td> <td style="width: 20%; border-bottom: 1px solid black;">Zip</td> </tr> <tr> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>	City	County	State	Zip	( )			
City	County	State	Zip						
( )									
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;">Main Telephone Number</td> <td style="width: 30%; border-bottom: 1px solid black;">Office Administrator – Last</td> <td style="width: 15%; border-bottom: 1px solid black;">First</td> <td style="width: 20%; border-bottom: 1px solid black;">MI</td> </tr> <tr> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>	Main Telephone Number	Office Administrator – Last	First	MI	( )	( )		
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( )	( )								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;">Beeper Number</td> <td style="width: 30%; border-bottom: 1px solid black;">FAX Number</td> <td style="width: 35%; border-bottom: 1px solid black;">E-mail</td> </tr> <tr> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>	Beeper Number	FAX Number	E-mail	( )	( )			
Beeper Number	FAX Number	E-mail							
( )	( )								
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border-bottom: 1px solid black;">Emergency Number</td> <td style="width: 55%; border-bottom: 1px solid black;">Answering Service</td> </tr> <tr> <td style="border-bottom: 1px solid black;">( )</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>	Emergency Number	Answering Service	( )					
Emergency Number	Answering Service								
( )									

Are you currently accepting new patients at this location?     Yes     No

**If yes**, describe any restrictions (e.g., appointment type, patient type): \_\_\_\_\_  
 \_\_\_\_\_

Please provide the number of active patients enrolled with you at this site: \_\_\_\_\_

Please provide the number of patient visits you have at this site per year: \_\_\_\_\_

**List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.**

- Special Skills of Practitioner: \_\_\_\_\_
- Special Skills of Staff: \_\_\_\_\_
- Languages Spoken by Practitioner: \_\_\_\_\_
- Languages Written by Practitioner: \_\_\_\_\_
- Languages Spoken by Staff: \_\_\_\_\_
- Languages Written by Staff: \_\_\_\_\_

*(Please continue next page)*

**Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.**

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays

**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays

**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Degree  
Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_  
Street City State Zip  
Availability:  Days  Nights  Weekends  Holidays

**CONFIDENTIAL INFORMATION:** Tax ID #: \_\_\_\_\_

**End Recredentialing and Business Data Gathering Form.  
Attach Forms A-F As Required.**

**FORM A – ADVERSE AND OTHER ACTIONS**

**DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered “yes”: Question Number: \_\_\_\_

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Provide an explanation of any actions taken. Please include the date the action was taken.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Provide the current status of the issue.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. If known: Contact: \_\_\_\_\_

Department/Committee: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Telephone: ( ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM B – PROFESSIONAL LIABILITY ACTIONS**

**DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
Last First MI

A. Plaintiff's Name: \_\_\_\_\_  
Last First MI

If court case, Case Name & Case Number: \_\_\_\_\_  
\_\_\_\_\_

B. Your Involvement in the Care (Attending, Consulting, Etc.): \_\_\_\_\_

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): \_\_\_\_\_

D. Allegations, including Patient Outcome, if Available: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Date of Incident (mm/yy): \_\_\_\_\_ F. Date Filed (mm/yy): \_\_\_\_\_

G. Date Case Closed (mm/yy): \_\_\_\_\_

Resolution Case:  Dismissed  Judgment  Arbitration  Other  
 Settlement out of Court  Pending  Mediation

H. Amount Paid on Your Behalf (if any): \$ \_\_\_\_\_

I. Professional Liability Insurer Name (if one was involved): \_\_\_\_\_

J. Insurer Telephone Number: ( ) \_\_\_\_\_ K. Policy Number: \_\_\_\_\_

L. Insurer Address (Street, City, State, Zip Code): \_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM C – LIABILITY INSURANCE**

**DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
Last First MI

**A. History of Professional Liability Insurance (Please check One)**

- Canceled Voluntarily
- Non-Renewed
- Canceled Involuntarily
- Application Denied

B. Carrier Name: \_\_\_\_\_

C. Carrier Telephone Number: ( ) \_\_\_\_\_

D. Policy Number: \_\_\_\_\_

E. Carrier Address (Street, City, State, Zip Code):  
\_\_\_\_\_  
\_\_\_\_\_

F. Dates of Coverage: From (mm/yy): \_\_\_\_\_ To (mm/yy): \_\_\_\_\_

G. Circumstances Involved: \_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## FORM D – CRIMINAL ACTIONS

**DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
   Last    First    MI

A. Date of Incident (mm/yy): \_\_\_\_\_

B. Date of Complaint or Conviction (mm/yy): \_\_\_\_\_

C. Date of Resolution (mm/yy): \_\_\_\_\_

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): \_\_\_\_\_

E. Allegation(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Details of Incident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

G. Actions Taken Against You: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

H. Current Status of Situation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I. Medical Practice Privileges Affected as a Result of This Situation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM E – MEDICAL CONDITION**

**DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
Last
First
MI

A. Describe this medical condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

C. What is the current status of your condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name				Telephone Number
Last	First	MI	Degree	( )
Last	First	MI	Degree	( )

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE**

**DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.**

Applicant Name: \_\_\_\_\_  
  Last  First  MI

Describe the substance you use:  
\_\_\_\_\_

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

\_\_\_\_\_  
\_\_\_\_\_

B. Monitored by State Board Mandate (Name and Address)      C. Monitored Voluntarily (Name and Address)

_____	_____
_____	_____
_____	_____

D. Other information about the current status of your use of substances:  
\_\_\_\_\_  
\_\_\_\_\_

E. Abstinent since (mm/yy): \_\_\_\_\_

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
                    Street  City  State      Zip

Telephone: (     ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_