

# Minnesota Uniform Credentialing Application

## Initial

### Physician/Dentist/Allied Health Professional

Applicant Name (as shown on your state license):

\_\_\_\_\_ Last First Middle Suffix Title

#### CREDENTIALING CONTACT INFORMATION

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ Fax Number \_\_\_\_\_  
\_\_\_\_\_ E-mail \_\_\_\_\_  
\_\_\_\_\_

#### This Box to be Completed by Allied Health Professionals Only

Profession/Title \_\_\_\_\_

Sponsoring/Collaborative Physician \_\_\_\_\_  
(Must complete if PA-C or APRN)

#### 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)
- Malpractice Litigation and Professional Complaints Form (if applicable)
- Malpractice liability insurance documentation (as defined on page 11)
- 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)
- Allied Health Professionals: License/registration and/or certification (if applicable)

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 affiliations & 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
- List of all insurance policies you have held for the past 10 years (Page 11)
- Answered all of the Disclosure Questions on Pages 13 and 14 and enclosed explanations for affirmative answers
- Signed and dated the Attestation Signature and Date statement (Page 14)
- Signed and dated the Authorization and Release (Page 16)

**All Information Must Be Printed in Black Ink or Electronically Generated**

**Personal Data**

Name (as shown on your state license):

\_\_\_\_\_  
Last First Middle Suffix Title

All Former Aliases: \_\_\_\_\_ Spouse Name (optional): \_\_\_\_\_

Gender:  Male  Female U.S. Citizen:  Yes  No

Birthplace: City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Race (optional): \_\_\_\_\_ Ethnicity (optional): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ NPI: \_\_\_\_\_

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: \_\_\_\_\_

**Primary or Pending Practice Location**

Primary Practice Location/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ Type II NPI: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Start Date (at this location): \_\_\_\_\_

Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Moonlighting Resident  Hospitalist  
 Hospital Based only  Teaching/Research only  Other (specify) \_\_\_\_\_

Accepting new patients?  Yes  No Directory Suppress?  Yes  No

Primary Specialty in which care will be provided: \_\_\_\_\_

Sub Specialty (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 as many extra copies as necessary)

**1. 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): \_\_\_\_\_ Type II NPI: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Start Date (at this location): \_\_\_\_\_

Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Moonlighting Resident  Hospitalist  
 Hospital Based only  Teaching/Research only  Other (specify) \_\_\_\_\_Accepting new patients?  Yes  No Directory Suppress?  Yes  No

Primary Specialty in which care will be provided: \_\_\_\_\_

Sub Specialty (ies) in which care will be provided: \_\_\_\_\_

**2. 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): \_\_\_\_\_ Type II NPI: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Start Date (at this location): \_\_\_\_\_

Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Moonlighting Resident  Hospitalist  
 Hospital Based only  Teaching/Research only  Other (specify) \_\_\_\_\_Accepting new patients?  Yes  No Directory Suppress?  Yes  No

Primary Specialty in which care will be provided: \_\_\_\_\_

Sub Specialty (ies) in which care will be provided: \_\_\_\_\_

**3. 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): \_\_\_\_\_ Type II NPI: \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Start Date (at this location): \_\_\_\_\_

Practicing as:  Primary Care  Specialist  Urgent Care  Locum Tenens  Moonlighting Resident  Hospitalist  
 Hospital Based only  Teaching/Research only  Other (specify) \_\_\_\_\_Accepting new patients?  Yes  No Directory Suppress?  Yes  No

Primary Specialty in which care will be provided: \_\_\_\_\_

Sub Specialty (ies) in which care will be provided: \_\_\_\_\_

**Education – Medical/Graduate/Professional**

**Applicant Name:** \_\_\_\_\_

(Additional space is provided on the Education – Medical/Graduate/Professional Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Education.)

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

(Month, day and 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 Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

(Month, day and 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 and year required)

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

Check here if you have additional time gap information on attached Education/Training Addendum (page 19)

**Residency/Post-Graduate/Professional Training****Applicant Name:**

(Additional space is provided on the Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

*(Month, day and 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 Post Graduate/Professional Training Addendum, page 19)

*(Month, day and year required)*

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

Check here if you have additional time gap information on attached Post Graduate/Professional Training Addendum (page 19)

**Fellowship/Post-Graduate/Professional Training****Applicant Name:**

(Additional space is provided on the Post-Graduate/Professional Training Addendum, page 19. You may make extra copies of page 19 or attach a separate sheet for additional Training.)

(Month, day and 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 and 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 Post Graduate/Professional Training Addendum, page 19)

(Month, day and year required)

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

Check here if you have additional time gap information on attached Post Graduate/Professional Training Addendum (page 19)



**Primary Hospital Affiliation**

**Applicant Name:** \_\_\_\_\_

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

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

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

*(Month, day and 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 Affiliations - Present and past affiliations beginning with most recent.**

(Additional space is provided on the Hospital Affiliation Addendum, page 21. You may make extra copies of page 21 or attach a separate sheet for additional affiliations.)

*(Month, day and 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 hospital affiliations on attached Hospital Affiliation Addendum (page 21)





**Drug Enforcement Administration Registration**

**Applicant Name:** \_\_\_\_\_

**NOTE: Address on DEA certificate must be in state 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, etc.)?  Yes  No

If Yes: Type of Certification \_\_\_\_\_ Expiration Date(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Liability Insurance**

**Applicant Name:**

**Insurance Carrier for Primary, Pending Practice Location and 10-year insurance history** (Additional space is provided on the Liability Addendum, page 23. You may make extra copies of page 23 or attach a separate sheet for additional Liability Insurance.)

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:**

*(Month, day and 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: \_\_\_\_\_

Amount of coverage (per occurrence): \_\_\_\_\_

Amount of coverage (per aggregate): \_\_\_\_\_

**Please list all insurance policies that you have held in the past 10 years. Include policies covering Residency and Fellowships.**

*(Month, day and 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: \_\_\_\_\_

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: \_\_\_\_\_

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)

**Professional/Peer References**

**Applicant Name:**

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.) 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, 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: \_\_\_\_\_

**Disclosure Questions for Initial Credentialing****Applicant Name:**

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

**Disclosure Questions for Initial Credentialing – continued Applicant Name:**

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 judgments? **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. To check the status of your application, go to the applicable organization website.

***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.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

## *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. To check the status of your application, go to the applicable organization 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.**

**(Please read 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.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_



**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 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.

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

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

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

**Signature/DEA Verification**

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

**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: \_\_\_\_\_

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. It 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.

**Month/Year of incident:** \_\_\_\_\_ **Reported to National Practitioner Data Bank (NPDB):**  Yes  No

**Where incident occurred:** Facility Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Describe the nature of incident (Complaint, Allegation) - Do Not Include Patient Name or Identifiers:**

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

**Provide a narrative description of your participation/level of care:**

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

**Outcome of incident:**

<b>CONCLUDED WITH NO PAYMENTS:</b> (month/year) <input type="checkbox"/> Dropped/Closed      Date: _____ <input type="checkbox"/> Verdict for you      Date: _____ <input type="checkbox"/> Dismissed with prejudice*?      Date: _____ <input type="checkbox"/> Dismissed without prejudice**? Date: _____	<b>CONCLUDED WITH PAYMENTS:</b> (month/year) <input type="checkbox"/> Verdict for plaintiff      Date: _____      Amount \$ _____ <input type="checkbox"/> Settled      Date: _____      Amount \$ _____ <b>PENDING:</b> <input type="checkbox"/> Date of filing      Date: _____
---	---

*\*Dismissed with prejudice - set aside the lawsuit and deny the right to file another suit on that 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 claim/malpractice lawsuit?**  Yes  No If yes, give the name and address of counsel.

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

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

Phone Number: \_\_\_\_\_

**Insurance company or employer that provided coverage for this claim:**

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

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

Phone Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

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

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Education – Medical/Graduate/Professional Addendum**

**Applicant Name:** \_\_\_\_\_

(Please make as many extra copies as necessary)

Undergraduate     Masters     PhD     Medical     Dental     Other Post-Graduate

(Month, day and year required)

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

To \_\_\_\_\_ Degree Received: \_\_\_\_\_ Area of Study: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Internship/Residency/Fellowship/Professional Training Addendum**

(Month, day and 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 and year required)

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

(Please make as many extra copies as necessary)

(Month, day and year required)

From: \_\_\_\_\_ Organization Name: \_\_\_\_\_

To: \_\_\_\_\_ Title/Position: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Employment 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 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 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 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 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 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 and year required)

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

From: \_\_\_\_\_ Explain: \_\_\_\_\_

To: \_\_\_\_\_

**Hospital Affiliation Addendum**

**Applicant Name:**

(Please make as many extra copies as necessary)

(Month, day and 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)



**Liability Insurance Addendum**

**Applicant Name:** \_\_\_\_\_

(Please make as many extra copies as necessary)

**Please list all insurance policies that you have held in the past 10 years. Include policies covering Residency and Fellowships.**

*(Month, day and 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: \_\_\_\_\_  
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: \_\_\_\_\_  
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: \_\_\_\_\_  
Amount of coverage (per occurrence): \_\_\_\_\_  
Amount of coverage (per aggregate): \_\_\_\_\_