

# IOWA STATEWIDE UNIVERSAL PRACTITIONER CREDENTIALING APPLICATION

NAME: \_\_\_\_\_  
Last Name First Name Middle Name Title

- § Type or print responses in ink.
- § Complete this form in its entirety and attach all requested documentation and explanations.
- § A CV or "See CV" may not be used in lieu of completing any answers on this application.
- § If a question does not apply to you, answer with "Non-Applicable" or "N/A".
- § If additional space is necessary to provide answers, attach additional sheet(s) of paper.
- § All dates must be formatted as: Month/Date/Year (MM/DD/YEAR) Type/print "present" in Ending Date year for current status of activity, if applicable.

**THIS APPLICATION MUST BE SIGNED AND DATED WHERE INDICATED**

POSITION/RANK: \_\_\_\_\_ ANTICIPATED START DATE: \_\_\_\_\_  
(Professor, Assist. Professor; if applicable)

PRIMARY PRACTICE SPECIALTY: \_\_\_\_\_ BOARD CERTIFIED: " YES " NO

SECONDARY PRACTICE SPECIALTY(IES): \_\_\_\_\_ BOARD CERTIFIED: " YES " NO

\_\_\_\_\_ BOARD CERTIFIED: " YES " NO

\_\_\_\_\_ BOARD CERTIFIED: " YES " NO

\_\_\_\_\_ BOARD CERTIFIED: " YES " NO

PERSON/ENTITY TO CONTACT REGARDING THIS APPLICATION:

NAME: \_\_\_\_\_

ENTITY/GROUP AFFILIATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ FAX NUMBER: (\_\_\_\_\_) \_\_\_\_\_

E-MAIL: \_\_\_\_\_



**SECTION B: OFFICE/PRACTICE SITE INFORMATION**

Answer the following questions on pages 3-5, specific to you and the practice site listed below. Indicate if this site is the primary or additional site by marking the appropriate box. **Pages 3-5 should be duplicated and completed for every site at which you provide services.**

**PRIMARY**                       **ADDITIONAL/SATELLITE**

Practice Location Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Main Office Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Scheduling Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Main Office Fax: (\_\_\_\_\_) \_\_\_\_\_ Emergency/After-hours Number: (\_\_\_\_\_) \_\_\_\_\_

Reports/test results Phone: (\_\_\_\_\_) \_\_\_\_\_ Reports/Results Fax: (\_\_\_\_\_) \_\_\_\_\_

Your Campus/In-house Address: (If applicable): \_\_\_\_\_

If different than above, provide your specific: Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

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

Beginning practice date at this location: \_\_\_\_/\_\_\_\_/\_\_\_\_

Practice arrangement (Please check all that apply):

- Solo     Specialty Group     Multi-Specialty Group     Employee     Resident     Fellow     Fellow Associate  
 Partner/Associate     Locum Tenens - Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End date: \_\_\_\_/\_\_\_\_/\_\_\_\_

List your office hours (hours available to see patients):

	<i>Sun</i>	<i>Mon</i>	<i>Tues</i>	<i>Wed</i>	<i>Thurs</i>	<i>Fri</i>	<i>Sat</i>
<i>Open</i>							
<i>Close</i>							

Describe your coverage arrangements (24x7):

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

List the name(s) of all provider back-ups:

- Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_

Supervising/Collaborative Physician for non-physician applicant:

- Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ License # \_\_\_\_\_

**SECTION B: OFFICE/PRACTICE SITE INFORMATION - continued**

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

For the following questions check those boxes that apply to you at the *practice location identified on page 3*. (If you have more than one directory listing, photocopy and complete this section for each listing and/or each location):

Directory Listing/Specialty: \_\_\_\_\_

Check all that apply:     Primary Care Provider (PCP)         Co-Care Manager         Specialist  
                                   Both PCP & Specialist         PCP Back-up Only         Specialist serving as a Back-up

Are you (the applicant practitioner) accepting new patients? Yes  No

Special languages spoken/translated by you: \_\_\_\_\_

Identify your specific practice limitations on patients (age, gender, payer, scope of practice) if any:

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

Office handicapped accessible?        Yes  No   
 Office accessible via public transportation?    Yes  No   
 Services available for hearing impaired?    Yes  No

Estimated waiting time in days for appointments: Non-Urgent/Elective \_\_\_\_\_ days    Urgent \_\_\_\_\_ days.

Provide billing and registration numbers (if applicable). These may be individual or group/clinic numbers:

<u>Type</u>	<u>Group Number</u>	<u>Individual Number</u>
Federal Tax Identification Number:		
Medicare Number:		
Medicaid Number:		
Wellmark BCBS Number:		
Delta Dental Number:		
CLIA Certificate Number:		N/A
UPIN Number	N/A	
NPI Number		

Does this practice location bill under a group number listed above?         Yes     No  
 Does this practice location use a group Tax ID number listed above?         Yes     No  
 Does this practice location have the capability to submit claims electronically?     Yes     No

Billing Contact and Account/Billing Address if different than the practice location address identified on Page 3:

Full Name: \_\_\_\_\_  
 Make Checks Payable to: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_

**SECTION B: OFFICE/PRACTICE SITE INFORMATION – continued**

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

Office Manager:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Nurse Coordinator:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Credentialing/Privileging Contact:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

List all MD, DO, DDS, DPM, DC, and OD practitioners at this location (attach additional sheets if necessary):

Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_

List all other licensed practitioners at this location (PA, ARNP, CRNA, PhD, LISW, etc.) (attach additional sheets if necessary):

Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_ License # \_\_\_\_\_



**SECTION D: MALPRACTICE LIABILITY COVERAGE**

By signing and dating this application you are attesting to the current malpractice coverage identified below.

**Current** Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Agent Name: \_\_\_\_\_

\_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Coverage Amounts: \$ \_\_\_\_\_/Occurrence \$ \_\_\_\_\_/Aggregate

Dates of Coverage: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current** Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Agent Name: \_\_\_\_\_

\_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Coverage Amounts: \$ \_\_\_\_\_/Occurrence \$ \_\_\_\_\_/Aggregate

Dates of Coverage: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

List any privileges or procedures which are excluded or restricted under your current policy: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Previous** Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Agent Name: \_\_\_\_\_

\_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Coverage Amounts: \$ \_\_\_\_\_/Occurrence \$ \_\_\_\_\_/Aggregate

Dates of Coverage: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Previous** Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Agent Name: \_\_\_\_\_

\_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Coverage Amounts: \$ \_\_\_\_\_/Occurrence \$ \_\_\_\_\_/Aggregate

Dates of Coverage: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION E: HOSPITAL AND FACILITY PRIVILEGES**

List all hospitals and facilities at which you have held, have pending or currently hold privileges and describe the type(s) of privileges, (do not include privileges during internship, residency or training) (copy and include additional sheets if necessary):

**Hospital/Facility Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

Other: \_\_\_\_\_ Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

Other: \_\_\_\_\_ Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

Other: \_\_\_\_\_ Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

Other: \_\_\_\_\_ Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

Other: \_\_\_\_\_ Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION F: CERTIFICATION**

Please give the following information for each certification you have completed, or are eligible to complete (see below) (copy and include additional sheets if necessary):

**○ NOT APPLICABLE**

**○ CERTIFICATION:**

Board Name/Certificate Type/Issued By: \_\_\_\_\_

Board Specialty: \_\_\_\_\_ Board Sub-specialty: \_\_\_\_\_

Issuing Entity Address (City and State): \_\_\_\_\_

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

Certificate Number: \_\_\_\_\_ Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

**○ CERTIFICATION:**

Board Name/Certificate Type/Issued By: \_\_\_\_\_

Board Specialty: \_\_\_\_\_ Board Sub-specialty: \_\_\_\_\_

Issuing Entity Address (City and State): \_\_\_\_\_

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

Certificate Number: \_\_\_\_\_ Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

**○ CERTIFICATION:**

Board Name/Certificate Type/Issued By: \_\_\_\_\_

Board Specialty: \_\_\_\_\_ Board Sub-specialty: \_\_\_\_\_

Issuing Entity Address (City and State): \_\_\_\_\_

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

Certificate Number: \_\_\_\_\_ Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date(s): \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

**○ ELIGIBLE/ADMISSABLE FOR CERTIFICATION (Attach letter confirming admissibility):**

Board Name/Certificate Type: \_\_\_\_\_

Written Examination: Completed \_\_\_\_/\_\_\_\_/\_\_\_\_ Scheduled \_\_\_\_/\_\_\_\_/\_\_\_\_

Oral Examination: Completed \_\_\_\_/\_\_\_\_/\_\_\_\_ Scheduled \_\_\_\_/\_\_\_\_/\_\_\_\_

Admissibility Dates: From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION G: EDUCATION**

Check the appropriate box and complete the following information for each level of education completed (copy and include additional sheets if necessary):

**Level:**     UNDERGRADUATE     MASTERS     PHD     MEDICAL     DENTAL     OTHER POST-GRADUATE

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Degree Received: \_\_\_\_\_ Area of Study/Major: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

**Level:**     UNDERGRADUATE     MASTERS     PHD     MEDICAL     DENTAL     OTHER POST-GRADUATE

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Degree Received: \_\_\_\_\_ Area of Study/Major: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

**Level:**     UNDERGRADUATE     MASTERS     PHD     MEDICAL     DENTAL     OTHER POST-GRADUATE

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Degree Received: \_\_\_\_\_ Area of Study/Major: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

**Explain any gaps in education:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION H: TRAINING**

Give the following information for each training program completed (copy and include additional sheets if necessary):

**Level (check one):**             **INTERNSHIP**     **RESIDENCY**     **FELLOWSHIP**     **OTHER**

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type/Specialty: \_\_\_\_\_ Year Completed: \_\_\_\_\_ If not completed, please explain below.

Program Supervisor/Director Name: \_\_\_\_\_

**Level (check one):**             **INTERNSHIP**     **RESIDENCY**     **FELLOWSHIP**     **OTHER**

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type/Specialty: \_\_\_\_\_ Year Completed: \_\_\_\_\_ If not completed, please explain below.

Program Supervisor/Director Name: \_\_\_\_\_

**Level (check one):**             **INTERNSHIP**     **RESIDENCY**     **FELLOWSHIP**     **OTHER**

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

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

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

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

Dates Attended: Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type/Specialty: \_\_\_\_\_ Year Completed: \_\_\_\_\_ If not completed, please explain below.

Program Supervisor/Director Name: \_\_\_\_\_

**Explain any incomplete training, any gaps in training, or any gaps between education and training:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION I: PROFESSIONAL HISTORY**

List all professional career experience and mark appropriate box for *type* (include additional sheet(s) if necessary), beginning with current professional activity. **Be sure to explain any chronological gaps below (if applicable).**

**Type:**     PRACTICE/EMPLOYMENT     ACADEMIC/FACULTY     MILITARY     PUBLIC HEALTH     OTHER

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

Position: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Type:**     PRACTICE/EMPLOYMENT     ACADEMIC/FACULTY     MILITARY     PUBLIC HEALTH     OTHER

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

Position: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Type:**     PRACTICE/EMPLOYMENT     ACADEMIC/FACULTY     MILITARY     PUBLIC HEALTH     OTHER

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

Position: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Beginning Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Explain any gaps in professional history:** \_\_\_\_\_

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

**SECTION J: PROFESSIONAL REFERENCES**

Give **four** professional peer references that have personal knowledge of your recent clinical abilities, ethics, health status and can provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional ability. Do not include family or fellow students. Suggested peer references are: professors, practitioners in the same specialty, or department chairs.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Position: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Position: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Position: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

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

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Position: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

Please be sure to carefully read and answer each question below, and explain any “yes” answers on page 15.

\* Note - A special form is attached for Malpractice Claim History on Addendum C ☺ ☺

**SECTION K: QUALITY FOCUSED QUESTIONS**

1. Have you ever voluntarily or involuntarily surrendered or relinquished a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification?.....  YES  NO
2. Have you ever voluntarily or involuntarily had a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification revoked, suspended, limited, denied or refused by an Iowa licensing, state or federal drug administration, certifying board, or by such an entity in any other state(s)?.....  YES  NO
3. Have there been any previously successful or are there any currently pending challenges, complaint(s), sanction(s), disciplinary actions(s), investigations or denials recommended or taken against your state, district or federal professional license(s), registrations (DEA or State Controlled Substance Certificate), board certification or any other certification(s)?.....  YES  NO
4. Have you ever voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?.....  YES  NO
5. Have you ever voluntarily or involuntarily withdrawn a request for an increase in privileges?.....  YES  NO
6. Have you ever been refused membership on a clinical, medical, dental or professional staff (other than for a general closure of that staff to providers of your specialty)?.....  YES  NO
7. Have you ever had a hospital, health care facility, or other health care organization invoke probation, issue a reprimand, impose proctoring (other than proctoring when privileges are initially granted), require a second opinion or initiate an investigation of your professional conduct or competency?.....  YES  NO
8. Are you currently performing or do you plan to perform any procedures for which you have ever been refused or lost privileges?.....  YES  NO
9. Have you ever been the subject of a formal or public citation or warning or ever had a sanction of any kind imposed by any health care institution, health care organization, licensing authority or other governmental entity, or voluntarily or involuntarily resigned under threat of the same?.....  YES  NO
10. Have your employment, medical staff appointment/membership, or clinical privileges ever been challenged or voluntarily or involuntarily suspended, reduced, revoked, refused (denied), relinquished, terminated, limited or lost at any hospital, healthcare plan or other healthcare facility or organization?.....  YES  NO
11. Have you ever been convicted of any crime related to your clinical, medical, dental or professional practice?  YES  NO
12. Regarding Medicare, Medicaid, or any other governmental health-related programs, have you ever been convicted of a crime or been subjected to civil penalties, disciplinary proceedings, investigations, denial of or suspension from participation, or had any type of sanction?.....  YES  NO
13. Do you have any felony, grand jury indictment, or other criminal charges pending?.....  YES  NO
14. Have you ever been convicted of, found guilty of or pled no contest to a felony, grand jury indictment or crime, other than a minor traffic violation?.....  YES  NO
15. Do you presently have a physical, mental or emotional condition (including alcohol or drug dependence) that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients?.....  YES  NO
16. Has your malpractice insurance ever been denied, suspended, limited, not renewed or terminated by a carrier?.....  YES  NO



**TO AVOID DELAY IN THE PROCESSING OF THIS APPLICATION**  
**PLEASE BE SURE TO SIGN AND DATE FOR CERTIFICATION / ATTESTATION / and RELEASE BELOW**  
**AND ANY ADDENDUMS (if applicable).**

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application;
- You may correct any erroneous information found in your credentialing files; and
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted.
- Upon request, you will be informed about the status of your credentialing application.

I represent and warrant that all of the information provided and the responses given on this application are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of information could result in the rejection or termination of my participation in any plan, staff or panel, in addition to penalties provided by law. I hereby authorize the hospital, CVO, credentialing entity or managed care plan, or its delegated agents, staff and representatives to collect and review all records and documents, including records of previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank, that may be material to an evaluation of my professional qualifications and competence. I also understand that certain fields of data on this application contain time-sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize the entity to which this application is submitted, to collect from me and other sources this information on an as-needed basis. I hereby release from liability the entity to which this application is submitted and their delegated agents, staff and representatives for their acts performed without malice in connection with the evaluation of my application and my credentials and qualifications. It is my understanding that the entity to which this application is submitted shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, my designated entity, or as authorized under state or federal law or regulation, and, I further release from any liability any and all individuals and organizations who provide information to the entity reviewing my credentials, and its agents, staff and representatives, in good faith and without malice, concerning my professional qualifications, competence, ethics and character, and I hereby consent to the release of such information. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

If making this application for hospital privileges, I acknowledge that I have received and read the Bylaws, Rules and Regulations of the hospital to which this application applies, and I agree to abide by them and the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for staff membership. I also pledge to provide or arrange for continuous care of my patients.

**Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Practitioner Name (please type or print):** \_\_\_\_\_

**Practitioner Initials:** \_\_\_\_\_

## **PRACTITIONER ACKNOWLEDGEMENT STATEMENT**

### **MEDICARE / MEDICAID / CHAMPUS (TRI-CARE)**

Medicare/Medicaid and Champus (TriCare) payment to hospitals is based on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending practitioners by virtue of his or her signature in 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.

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Name (Please Print)

---

Practitioner's Legal Signature

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Practitioner's signature as written on medical records

---

Practitioner's initials

---

Date

This statement must be signed, dated and returned with your completed application.

Medicare/Medicaid and Champus (Tri-Care) payment applies to all hospitals.

**ALTERNATE COVERAGE- FOR HOSPITAL OR FACILITY APPLICANTS ONLY**

Please list **TWO** alternate practitioners who have privileges at the hospital or facility to which you are applying. The alternates must be in the same department / section and have like privileges to cover for you in your absence. **If you are unable to list two alternates, please contact the medical staff office of the appropriate facility if further instructions are needed.**

\_\_\_\_\_  
Hospital/Facility

\_\_\_\_\_  
Alternate #1

\_\_\_\_\_  
Alternate #2

\_\_\_\_\_  
Hospital/Facility

\_\_\_\_\_  
Alternate #1

\_\_\_\_\_  
Alternate #2

\_\_\_\_\_  
Hospital/Facility

\_\_\_\_\_  
Alternate #1

\_\_\_\_\_  
Alternate #2

\_\_\_\_\_  
Hospital/Facility

\_\_\_\_\_  
Alternate #1

\_\_\_\_\_  
Alternate #2

**MALPRACTICE CLAIM HISTORY FORM**

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

If you have any professional malpractice activity to report on this application, complete this page for each professional liability incident (copy and include additional sheets if necessary).

Description of allegation or action taken: \_\_\_\_\_  
\_\_\_\_\_

Date of incident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of claim or suit filed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Location of incident: \_\_\_\_\_

Insurance carrier name: \_\_\_\_\_

Insurance carrier address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Describe your involvement with the patient's care. Your narrative must include the following at a minimum:

- 1) Condition and diagnosis at time of incident
- 2) Dates and description of treatment rendered
- 3) Condition of patient subsequent to treatment

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

Your Status:      " Primary Defendant   " Co-Defendant   " Other (specify) \_\_\_\_\_

Claim Status:    " Open   " Pending   " Closed

If closed, indicate the date closed and case outcome: Date Closed: \_\_\_\_/\_\_\_\_/\_\_\_\_

" Dismissed with prejudice      " Settled with Prejudice      " Judgment for Defendant

" Dismissed without prejudice   " Settled without Prejudice   " Judgment for Plaintiff

Amount of settlement or judgment paid on your behalf (if any): \$ \_\_\_\_\_

Date of payment: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the information in this document is correct and complete to the best of knowledge:

\_\_\_\_\_  
Practitioner's Signature

\_\_\_\_\_  
Date

**ADDENDUM TWO**  
**CONFIDENTIAL HEALTH STATUS INFORMATION**

**Provider Name:** \_\_\_\_\_

In order to process your application, it is necessary to inquire about your health status. The purpose of this form is to confirm whether you are capable of performing the duties and responsibilities of appointment and exercising the clinical privileges requested safely and competently.

**Complete this questionnaire and return to the Central Verification Office. We will place this form in a *sealed Confidential Health Status envelope for each facility you are applying and send it to those medical staff offices.*** The envelope will not be opened until *after* the Medical Executive Committee has taken initial action on your application and evaluated your professional qualifications.

1. Do you have any physical or mental condition that could affect your ability to exercise the clinical privileges requested and perform the duties of staff appointment or that would require an accommodation in order for you to exercise the privileges requested safely and competently?  
  
\_\_\_\_\_Yes \_\_\_\_\_No
2. Have you ever had any problems with alcohol or drug dependency?  
  
\_\_\_\_\_Yes \_\_\_\_\_No
3. Are you currently taking any medication that may affect either your clinical judgment or motor skills?  
  
\_\_\_\_\_Yes \_\_\_\_\_No
4. Are you currently under any limitations concerning your activities or work load?  
  
\_\_\_\_\_Yes \_\_\_\_\_No

If the answer is "yes" to any question, please explain and submit a report from your treating physician specifically addressing how the condition may affect your ability to exercise the privileges you have requested or the duties of staff appointment. Please also explain any proposed accommodation.

**Certification**

I certify that my staff appointment and clinical privileges are conditional upon my demonstrating that I am capable of exercising my privileges safely and competently and performing the duties and essential functions of staff appointment. I understand that the burden is on me to request any proposed accommodations and to justify its reasonableness. By my signature below, I hereby certify that all the information provided above is true, complete and correct. I agree to inform the hospital and supplement, as necessary, should any statement of the information contained above, although true when made, becomes untrue do to a change in circumstances of discovery of new information. Any falsification to this health status questionnaire is grounds for termination.

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**ADDENDUM THREE  
HIPAA  
ACKNOWLEDGMENT OF  
ORGANIZED HEALTH CARE ARRANGEMENT**

The undersigned agrees that, with respect to activities at the Hospital, the undersigned shall be considered as part of an Organized Health Care Arrangement (OHCA) with the Hospital as that term is defined at 45 C.F.R. §164.501. The undersigned shall comply with all Hospital policies and federal and state laws and regulations relating to the use and disclosure of individually identifiable health information, and shall adopt such procedures and comply with such policies as may be required from time to time.

The Hospital will provide all patients presenting at their facilities with a Notice of Privacy Practices that includes a notification of the OHCA between the Hospital and its medical staff. The undersigned agrees to inform their patients seen outside the hospital setting of their participation in the OHCA, as a supplement to their own Notice of Privacy Practices.

---

**PRINTED NAME**

---

**SIGNATURE**

---

**DATE**

**ADDENDUM FIVE  
SANFORD HEALTH PLAN  
ACCESS AND AVAILABILITY QUESTIONS**

**Sanford Health Plan requests the following information:**

- o Are you in a recognition program for diabetes, stroke, etc? If so, please identify the program:

\_\_\_\_\_

**Access and Availability Questions:**

1. Are you currently accepting new patients into your practice?

\_\_\_\_\_Yes                      \_\_\_\_\_No

2. Are you willing, in the future, to accept new patients?

\_\_\_\_\_Yes                      \_\_\_\_\_No

3. Does the office have wheelchair or handicapped access?

\_\_\_\_\_Yes                      \_\_\_\_\_No

\_\_\_\_\_  
**PRINTED NAME**

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

**ADDENDUM SIX  
WAIVER OF LIABILITY &  
CONSENT FOR RELEASE OF INFORMATION**

**ALL Applicants must SIGN and DATE the Waiver of Liability & Consent for Release of Information.**

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

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

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

- 1. Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.
- 2. Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
- 3. Release from Liability.** I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand and agree that the CVO or Entity may communicate with me via e-mail over the Internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

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

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

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

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

---

**PRINTED NAME**

---

**SIGNATURE**

---

**DATE**

**ADDENDUM SEVEN  
SUPERVISING PHYSICIAN STATEMENT**

I agree to serve as the supervising physician for \_\_\_\_\_. This person will provide services as my employee and/or will be directly supervised by me.

I verify that I have reviewed and approve of the scope of practice that this healthcare professional is requesting.

At all times, I agree to remain responsible for all acts of the above person while at the hospital.

\_\_\_\_\_  
**Signature of Supervising Physician**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

## ADDENDUM NINE REQUIRED DOCUMENTS CHECKLIST

PROVIDER NAME: \_\_\_\_\_

**PLEASE INCLUDE A COPY OF THE FOLLOWING WITH THIS APPLICATION:**

- Copies of all current State License(s)
- Copies of all State Controlled Dangerous Substance Certificates (*if applicable*)
- Copies of all current Federal DEA registrations (*if applicable*)
- Copies of Board Certification Certificates **or qualifying letter**
- Copies of your Current and Past Professional Liability Insurance face sheets (*for past 10 years*)
- Copies of your Medical or Dental school graduation, internship and residency certificates, ECFMG (*if applicable*)
- Authorized list of procedures you have performed in your residency/fellowship. If your residency/fellowship was over two years ago, attach a certified copy of the list of procedures that you have performed since that time.**
- Pertinent training certificates to your area of specialty
- Emergency Care Training Certificates (CPR, BLS, ACLS, HCPC, ATLS, NALS, PALS etc., *as applicable*)
- Green Card or Work Permit (*if applicable*)
- DD-214 for Military Experience (*if applicable*)
- Notarized copy of state or federal issued photo ID (i.e. Drivers license or passport)
- Current Curriculum Vitae
- Results of your most current TB skin test or assessment if previously positive. Your last test must be within the prior 12 months. The Employee Health Services of Sanford USD Medical Center will provide this service, but documentation of the assessment or test must be complete prior to your appointment.
- A recent photograph for identification purposes. The photograph may be either black & white or color, but must be clear and light enough for scanning and reproducibility. It is preferred that a digital photo be emailed to [credentialing@sanfordhealth.org](mailto:credentialing@sanfordhealth.org) in “JPEG” format.
- Evidence of a rubella titer. If you have not had a rubella test, the Employee Health Services of Sanford USD Medical Center will provide this service, but documentation of the vaccination or lab result must be complete prior to your appointment.
- Confidential Health Status Information Form
- Sanford Health Plan Access & Availability Questions

**BEFORE YOU RETURN THIS APPLICATION – DID YOU:**

- Provide complete street addresses wherever indicated, including past employment, affiliations, references, etc.
- Designated dates by mm/dd/yy format
- EXPLAIN ALL TIME GAPS** of 2 months or greater
- Answer all disclosure questions
- Provide explanation of any responses requiring such.
- Central Verification Attestation
- Apply for all applicable state licensure
- Include all of the enclosures and documents listed above

**Missing items will delay the processing of your application and  
if not received will prevent the processing of your application.**

**ADDENDUM TEN  
SANFORD HEALTH  
APPOINTMENT REQUEST**

*You may complete one application if applying to multiple facilities affiliated with Sanford Health. In order to process verifications for all facilities affiliated with Sanford Health, it is important to identify all facilities for which you are applying on this page. Please check those facilities which apply. If Unsure, please contact your clinic manager for assistance.*

**NOTE: All sites requested will be contacted for authorization of credentialing/privileging.**

I, \_\_\_\_\_, am applying for appointment/privileges with each of the following facilities checked in the “Requesting at this Site” box:

Facility Name	City	State	Requesting at this Site
Bethesda Nursing Home	Beresford	SD	
Community Memorial Hospital	Burke	SD	
MN Veterans Home – Luverne	Luverne	MN	
Murray County Memorial Hospital	Slayton	MN	
Niobrara Valley Hospital	Lynch	NE	
Orange City Health System	Orange City	IA	
Pioneer Memorial Hospital & Health System	Viborg	SD	
Prairie Community Health	Buffalo, Eagle Butte, Faith, MacIntosh, Isabel	SD	
Prairie Lakes Healthcare System	Watertown	SD	
Sanford Canby Medical Center	Canby	MN	
Sanford Deuel County Medical Center	Clear Lake	SD	
Sanford Health Plan	Sioux Falls	SD	
Sanford Home Medical Equipment	Sioux Falls	SD	
Sanford Hospital Canton-Inwood	Canton	SD	
Sanford Hospital Luverne	Luverne	MN	
Sanford Hospital Rock Rapids	Rock Rapids	IA	
Sanford Hospital Webster	Webster	SD	
Sanford Jackson Medical Center	Jackson	MN	
Sanford Mid-Dakota Medical Center	Chamberlain	SD	
Sanford Regional Hospital Worthington	Worthington	MN	
Sanford Sheldon Medical Center	Sheldon	IA	
Sanford Tracy Medical Center	Tracy	MN	
Sanford USD Medical Center	Sioux Falls	SD	
Sanford Vermillion Medical Center	Vermillion	SD	
Sanford Westbrook Medical Center	Westbrook	MN	
TLC Advantage	Sioux Falls	SD	
West Holt Memorial Hospital	Atkinson	NE	
Windom Area Hospital	Windom	MN	
Winner Regional Healthcare Center	Winner	SD	