

Minnesota Uniform Credentialing Application

Initial

Physician/Dentist/Allied Health Professional

Applicant Name: _____
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 _____
(If applicable)

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A.

Checklist (please complete)

Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- Drug Enforcement Administration Registration with correct address (if applicable)
- Malpractice Litigation and Professional Complaints Form (if applicable)
- Malpractice liability insurance documentation (as defined on page 8)
- Curriculum Vitae (all application items must be completed)
- If not a U.S. citizen, copy of official document(s) indicating authorization to work in the United States
- Allied Health Professionals: License/registration and/or certification (if applicable)

In addition, please verify that you have:

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

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Personal Data

Name: _____
Last First Middle Suffix Title

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

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

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

Social Security Number: ____ - ____ - ____ UPIN: _____ NPI: _____

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

Current Home Address: _____
Street City/State/Country Zip Code

Local Home Address
(if different from above): _____
Street City/State/Country Zip Code

Preferred Mailing Address: Office Home Practitioner's Preferred E-mail address: _____

Pager Number: (____) ____ - _____ Home Phone Number: (____) ____ - _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? Yes No

If yes, specify languages: _____

Primary or Pending Practice Location

Primary Practice Location/Clinic Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

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

Currently practicing at this location? Yes No Start Date: __/__/____

Do you intend to practice as:
Primary Care Specialist Urgent Care Locum Tenens Moonlighting Resident Hospitalist

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

Primary Specialty: _____ Subspecialty: _____

Specialty/Subspecialty in which care will be provided: _____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

Billing Information

Billing Name: _____ Contact Person: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

Additional Practice Location(s)

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): _____

Credentialing Contact: _____ Phone Number: (____) - _____

Currently practicing at this location? Yes No Start Date: __ / __ / __

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

Specialty/Subspecialty in which care will be provided: _____

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): _____

Credentialing Contact: _____ Phone Number: (____) - _____

Currently practicing at this location? Yes No Start Date: __ / __ / __

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

Specialty/Subspecialty in which care will be provided: _____

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): _____

Credentialing Contact: _____ Phone Number: (____) - _____

Currently practicing at this location? Yes No Start Date: __ / __ / __

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

Specialty/Subspecialty in which care will be provided: _____

4. **Other Practice Name:** _____ Phone Number: (____) - _____

Address: _____
Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: (____) - _____

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

Credentialing Contact: _____ Phone Number: (____) - _____

Currently practicing at this location? Yes No Start Date: __ / __ / __

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

Specialty/Subspecialty in which care will be provided: _____

Medical/Graduate/Professional Education

(Month, day and year required)

From ___/___/___ Institution Name: _____

To ___/___/___ Degree Received: MD DO DDS DC DPM PhD Other: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: () - Fax Number: () -

From ___/___/___ Institution Name: _____

To ___/___/___ Degree Received: MD DO DDS DC DPM PhD Other: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: () - Fax Number: () -

ECFMG - Applicable to International Medical Graduates

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

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

(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: () -

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

(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: () -

Primary Hospital Affiliation (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.): _____
Admitting Privileges: Department Name: _____
[] Yes [] No Department Chairperson: _____
[] Application Pending Address _____
Street City/State/Country Zip Code
Phone Number: () - Fax Number: () -

Other Hospital Affiliations - Present and past affiliations beginning with most recent. (Additional space is provided on the Hospital Affiliation Addendum, page 17. You may make extra copies of page 17 or attach a separate sheet for additional affiliations.)

(Month and year required)

From __/__/____ Facility Name: _____
To __/__/____ Type/category of privilege/affiliation (active, courtesy, etc.): _____
Admitting Privileges: Department Name: _____
[] Yes [] No Department Chairperson: _____
[] Application Pending Address _____
Street City/State/Country Zip Code
Phone Number: () - Fax Number: () -

If hospital changed name, list current name and address

From __/__/____ Facility Name: _____
To __/__/____ Type/category of privilege/affiliation (active, courtesy, etc.): _____
Admitting Privileges: Department Name: _____
[] Yes [] No Department Chairperson: _____
[] Application Pending Address _____
Street City/State/Country Zip Code
Phone Number: () - Fax Number: () -

If hospital changed name, list current name and address

From __/__/____ Facility Name: _____
To __/__/____ Type/category of privilege/affiliation (active, courtesy, etc.): _____
Admitting Privileges: Department Name: _____
[] Yes [] No Department Chairperson: _____
[] Application Pending Address _____
Street City/State/Country Zip Code
Phone Number: () - Fax Number: () -

If hospital changed name, list current name and address

[] Check here if you have additional hospital affiliations on attached Hospital Affiliation Addendum, page 17

Specialty/Subspecialty Certification

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date	Cert. Pending
_____	_____	__/__/__	__/__/__	__/__/__	<input type="checkbox"/>
_____	_____	__/__/__	__/__/__	__/__/__	<input type="checkbox"/>
_____	_____	__/__/__	__/__/__	__/__/__	<input type="checkbox"/>
_____	_____	__/__/__	__/__/__	__/__/__	<input type="checkbox"/>

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any. _____

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

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

Drug Enforcement Administration Registration

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application (except for locum tenens coverage)

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: __/__/__(Attach copy of application)

Other _____

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

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

Liability Insurance - Insurance Carrier for Primary and Pending Practice Location

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

Coverage dates:

Start __/__/__ Insurance Carrier Name: _____

Expire __/__/__ Address _____

Certificate Pending Name in which policy issued: _____
Street City/State/Country Zip Code

Policy number: _____

Amount of coverage (per occurrence/aggregate): _____

Disclosure Questions for Initial Credentialing

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

1. Yes No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. Yes No Has your **professional license or registration** ever been investigated or is it currently being investigated and, if so, what were the results?

3. Yes No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. Yes No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. Yes No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. Yes No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. Yes No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization**?

9. Yes No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. Yes No Are there any **charges pending or are you currently charged** with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

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

12. Yes No Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgements? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.** You may be asked for additional information by individual organizations.

13. Yes No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. Yes No Have you ever practiced within your profession without **professional liability insurance**?

15. Yes No Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

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

17. Yes No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

Signature _____

Date: / /

Name _____
 (please print or type)

Application Attestation Update

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

Application Attestation Update

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign one of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature _____ Date / /

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature _____ Date / /

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature _____ Date / /

Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership, 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.

Signature _____ Date / /

Name (please print or type) _____

Application Addendum To Initial and Reappointment Applications

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.

Signature: _____ Date: ___ / ___ / ___

Name: _____
(please print or type)

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet the licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

Signature: _____ Date: ___ / ___ / ___

Name: _____
(please print or type)

Signature/DEA Verification

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

Signature: _____ Date: ___ / ___ / ___

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

Office Address: _____ Specialty: _____

Phone Number: () -

Hospital Affiliation Addendum

(Please make as many extra copies as necessary)

(Month, day and year required)

From: / / Facility Name: _____ If hospital changed name, list current name and address

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

Admitting Privileges: Department Name: _____
 Yes No

Department Chairperson: _____

Application Pending Address: _____
Street City/State/Country Zip Code

Phone Number: () - _____ Fax Number: () - _____

From: / / Facility Name: _____ If hospital changed name, list current name and address

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

Admitting Privileges: Department Name: _____
 Yes No

Department Chairperson: _____

Application Pending Address: _____
Street City/State/Country Zip Code

Phone Number: () - _____ Fax Number: () - _____

From: / / Facility Name: _____ If hospital changed name, list current name and address

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

Admitting Privileges: Department Name: _____
 Yes No

Department Chairperson: _____

Application Pending Address: _____
Street City/State/Country Zip Code

Phone Number: () - _____ Fax Number: () - _____

From: / / Facility Name: _____ If hospital changed name, list current name and address

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

Admitting Privileges: Department Name: _____
 Yes No

Department Chairperson: _____

Application Pending Address: _____
Street City/State/Country Zip Code

Phone Number: () - _____ Fax Number: () - _____

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 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	