

# 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 A: DEMOGRAPHIC INFORMATION**

\_\_\_\_\_  
Legal Last Name First Middle Professional Title/Degree

\_\_\_\_\_  
Preferred Last Name First Middle Professional Title/Degree

Other name(s) which you have been identified under:

\_\_\_\_\_  
Effective from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last, First, Middle)

\_\_\_\_\_  
Effective from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last, First, Middle)

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For Directory purposes - Gender: Male  Female

Place of Birth:

\_\_\_\_\_  
City County State Country

Are you a US Citizen?  Yes  No

If no, do you have:  Green Card or  Work Permit (If yes, attach a notarized copy)  Neither (Explain Visa below)

Visa Type: \_\_\_\_\_ Visa Number: \_\_\_\_\_

Current Home Address: \_\_\_\_\_  
\_\_\_\_\_

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

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone Number Cell Phone Number E-Mail Address

New Home Address: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_

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

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Phone Number Cell Phone Number E-Mail Address

Spouse/Significant Other's Full Name (if applicable): \_\_\_\_\_

In case of an emergency, contact: \_\_\_\_\_  
Full Name Relationship

\_\_\_\_\_  
Address (Street, City, State, Zip) (\_\_\_\_) \_\_\_\_\_  
Phone Number

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

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

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

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

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

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

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

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

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

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

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

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

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

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

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

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

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

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

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

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

Active  Admitting  Courtesy  Consulting  Provisional  Full Clinical  Temporary  Pending

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

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

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

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

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: \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

\_\_\_\_\_

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

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

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

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

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

\_\_\_\_\_

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

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

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

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

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

\_\_\_\_\_

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

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

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

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

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

\_\_\_\_\_

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

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

E-mail: \_\_\_\_\_ 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, which may include records of previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank and Criminal Background Check investigations, 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 been provided 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

---

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