

# IOWA STATEWIDE UNIVERSAL PRACTITIONER RECREDENTIALING APPLICATION

- Type or print responses in ink. A CV or "See CV" may not be use in lieu of completing any answers on this application.
- Review or complete this form in its entirety and attach all requested documentation and explanations.
- 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). Typing/printing "present" for Ending Dates is acceptable.
- This application must be signed and dated where indicated.
- Some of the following questions apply only to the time period since the last credentialing/recredentialing date. This practitioner's last credentialing/recredentialing date was: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please contact the following person regarding this application: Name: \_\_\_\_\_  
 Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

## SECTION A: DEMOGRAPHIC INFORMATION:

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

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

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

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

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

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

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

## SECTION B: OFFICE/PRACTICE SITE INFORMATION: PRIMARY ADDITIONAL/SATELLITE

Please provide information for every site at which you provide services (attach additional sheet(s) if necessary):

Primary Care Provider (PCP)  Co-Care Manager  Specialist  PCP & Specialist  PCP Back-up Only  Specialist Back-up

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

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

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_ Total # of hours in this office per week: \_\_\_\_\_

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:                   |                     |                          |
| UPIN Number                        | N/A                 |                          |
| NPI Number                         |                     |                          |

For Directory Listing purposes - Gender:  Male  Female Are you accepting new patients?  Yes  No

Special Languages spoken/translated by you at this site: \_\_\_\_\_

List the name(s) of all provider back-ups (attach additional sheet(s) if necessary):

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

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

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

Supervising/Collaborative Physician for non-physician applicant (attach additional sheet(s) if necessary):

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

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

Account/Billing Address if different than the practice location address above:

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

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_ Limitations in Practice: \_\_\_\_\_



**SECTION F: HOSPITAL AND FACILITY PRIVILEGES:** List all hospitals and facilities at which you have pending or currently hold privileges and describe the type(s) of privileges (copy and include additional sheets if necessary):

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**Hospital/Facility Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Category (Active, Courtesy, etc.): \_\_\_\_\_

**SECTION G: CERTIFICATION:** Provide the following information for each certification you have completed, or are eligible to complete since your last credentialing cycle:

NOT APPLICABLE

CERTIFICATION/RECERTIFICATION:

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

Board Specialty: \_\_\_\_\_

Subspecialty (if any): \_\_\_\_\_

Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Board Specialty: \_\_\_\_\_

Subspecialty (if any): \_\_\_\_\_

Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Board Specialty: \_\_\_\_\_

Subspecialty (if any): \_\_\_\_\_

Original Certification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Recertification Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

ELIGIBLE/ADMISSIBLE FOR CERTIFICATION:

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

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

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

**SECTION H: EDUCATION/TRAINING:** Provide the following information for any additional education/training received since your last credentialing cycle:

Type: \_\_\_\_\_ (MA, PhD, Residency, Fellowship, etc.)

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

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

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

Degree/Specialty: \_\_\_\_\_ Program Director's Name: \_\_\_\_\_

**SECTION I: PEER REVIEW REFERENCES FOR HOSPITAL REAPPOINTMENT APPLICATION ONLY:** Give three 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 individual 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.

NOT APPLICABLE

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Position/Relationship: \_\_\_\_\_

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

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

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Position/Relationship: \_\_\_\_\_

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

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

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Position/Relationship: \_\_\_\_\_

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

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

Please be sure to carefully read and answer each question below, and explain any “yes” answers on page 6.

Note - A special form is attached for Malpractice Claim History on the attached Addendum A →→

**SECTION J: QUALITY FOCUSED QUESTIONS (SINCE YOUR LAST CREDENTIALING OR PRIVILEGING WITH THIS ENTITY):**

**\*\*The questions below are for the time period since your last credentialing/recredentialing cycle.**

1. Have you 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 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 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 voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?.....  YES  NO
5. Have you voluntarily or involuntarily withdrawn a request for an increase in privileges?.....  YES  NO
6. Have you 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 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 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 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 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 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 been denied, suspended, limited, not renewed or terminated by a carrier?.....  YES  NO
17. Have you had a malpractice case filed against you? (If yes, explain on Addendum A) .....  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 of the status of your recredentialing 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:** \_\_\_\_\_

**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 provided on this document is correct and complete to the best of my knowledge:

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

\_\_\_\_\_  
Date