STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information

Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

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ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

Curriculum Vitae
CONFIDENTIAL INFORMATION:
All Current Professional Licenses
Current Federal DEA License, If Applicable
Current State Controlled Substance License(s), If Applicable
Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
Current CLIA Certificate, If Applicable
Current W-9s, If Applicable
ECFMG Certificate, If Applicable
Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature	Type or Print Name	Date

- ** PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY,
- ** AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN
- ** ATTESTATION AND RELEASE OF INFORMATION FORM. **

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CHAPTER A: PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION Name: MD Last List other names by which you have been known: First MI If you have been known by other names, please explain why your name changed: Place of Birth: _____City Birth Date: (mm/dd/yy) Sex: Male Female Language Fluency of Applicant: English Other: U.S. Citizen? Yes No Spanish If no, do you have a legal right to reside permanently and work in the U.S.? Yes No **CONFIDENTIAL INFORMATION** Resident Visa No: Social Security Number: **Emergency Contact Person:** First MI Telephone Number: () Mailing Address: City Street State Zip Daytime Phone: () Fax Number: () E-Mail Address: Check here if you have appended additional information for this section:

linois Professional License l	Number:		
License Unlimited?	Yes ☐ No ☐ → If No.	please explain limitation:	
	ssional License(s) in Other State		
	License #:		
	Yes ☐ No ☐ → If No.		
·	License #:		(mm/dd/yy
License Unlimited?	Yes ☐ No ☐ → If No.	please explain limitation:	
State:	License #:	Exp. Date:	(mm/dd/y
License Unlimited?	Yes ☐ No ☐ If No.	please explain limitation:	
Check here if you have	appended additional information	for this section:	
Check here if you have Current Federal DEA Lico DEA License Number Ex	appended additional information	CONFIDENTIAL I. License Unlimited? Ye	NFORMATION es
Check here if you have Current Federal DEA Lice DEA License Number Ex If No, please explain Check here if you have	appended additional information ense Number: approximation Date: limitation: appended additional information Controlled Substance Number(s	CONFIDENTIAL I. License Unlimited? Your for this section:	NFORMATION
Check here if you have Current Federal DEA Lice DEA License Number Ex If No, please explain Check here if you have current and Previous State	appended additional information ense Number: appiration Date: limitation: appended additional information Controlled Substance Number(s	License Unlimited? You for this section:	NFORMATION
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Check here if you have Current Federal DEA Lice DEA License Number Ex If No, please explain Check here if you have Current and Previous State State:	appended additional information ense Number: appropriation Date: appended additional information Controlled Substance Number(s CONFIDENTIAL INFO CS License #: CS License #:	License Unlimited? You for this section: License Unlimited? You have the section:	NFORMATION es

National Provider Identification Number (NP)	D):	
Medicaid ID#:		
X-Ray Certification: State: Certific	ate #:Expiration Date:	(mm/dd/yy)
Check here if you have appended additional in	iformation for this section: \Box	
COMPLET	E FOR EACH SPECIALTY	
Specialty I:		
Are you Board Certified in Specialty I?	Yes No No	
If Yes, name of Certifying Board:		
Date of Certification:	Date of Recertification (if applicable):	
(mm/yy)	(mm/yy)	
•	led to take the specialty boards certification? Yes	
If Certifying Boards taken, give date:	Certification Expiration Date, if An	y:
If not taken, date scheduled to take Spec		(
Specialty/Subspecialty II:		
Are you Board Certified in Specialty II?		
If Yes, name of Certifying Board:		
Date of Certification:	Date of Recertification (if applicable):	
(mm/yy)	(mm/yy)	
·	led to take the specialty boards certification? Yes	_
	Certification Expiration Date, if An	y:
If not taken, date scheduled to take Spec	• • •	('55)
	(mm/yy)	

Specialty/Subspecialty III:	
Are you Board Certified in Specialty III? Yes \(\square\) No \(\square\)	
If Yes, name of Certifying Board:	=
Date of Certification: Date of Recertification (if applicable):	
(mm/yy) (mm/yy) If No, have you taken or are you scheduled to take the specialty boards certification? Yes	No 🗆
If Certifying Boards taken, give date: Certification Expiration Date, if Any:	110
	(mm/yy)
Specialty/Subspecialty IV:	
Are you Board Certified in Specialty IV? Yes No	
If Yes, name of Certifying Board:	_
Date of Certification: Date of Recertification (if applicable): (mm/yy)	
If No, have you taken or are you scheduled to take the specialty boards certification? Yes	No 🗌
If Certifying Boards taken, give date:Certification Expiration Date, if Any:	
(mm/yy) If not taken, date scheduled to take Specialty Boards: (mm/yy) (mm/yy)	(mm/yy)
Check here if you have appended additional information for this section: \Box	
(Please continue n	next page)
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SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CONFIDENTIAL INFORMATION: Carrier:		
Carrier:		
Address:		
Street	City	State Zip
Policy Number:	Original Effective Date:(mm/dd/	
Policy Limits: Per Occurrence: \$		
Retroactive Date:		
(mm/dd/yy)		
What type of coverage do you have?	_	
Has any judgment or payment of claim of	or settlement amount exceeded the la	imits of this coverage?
PREVIOUS PROFESSIONAL LI	ABILITY INSURANCE	
	ABILITY INSURANCE	
PREVIOUS PROFESSIONAL LI CONFIDENTIAL INFORMATION:	ABILITY INSURANCE	
	ABILITY INSURANCE	
CONFIDENTIAL INFORMATION:	_	
CONFIDENTIAL INFORMATION: Carrier: Address: Street	City	State Zip
CONFIDENTIAL INFORMATION: Carrier: Address:	City Original Effective Date:	Expiration Date:
CONFIDENTIAL INFORMATION: Carrier: Address: Street	City Original Effective Date:(mm/dd/	Expiration Date: (mm/dd/yy)
CONFIDENTIAL INFORMATION: Carrier: Address: Street Policy Number: Policy Limits: Per Occurrence: \$ Retroactive Date:	City Original Effective Date:(mm/dd/	Expiration Date: (mm/dd/yy)
CONFIDENTIAL INFORMATION: Carrier: Address: Street Policy Number: Policy Limits: Per Occurrence: \$	City Original Effective Date: (mm/dd/ Aggregate: \$	/yy) Expiration Date: (mm/dd/yy)

PREVIOUS PROFESSIONAL I	JABILITY INSURANCE	
CONFIDENTIAL INFORMATION:		
Carrier:		
Address:		
Street	City	State Zip
Policy Number:	Original Effective Date:	Expiration Date:
Policy Limits: Per Occurrence: \$	(mm/dd/yy) Aggregate: \$	(mm/dd/yy)
Retroactive Date:		
(mm/dd/yy) What type of coverage do you have?	☐ Claims Made ☐ Occurrence	ce
• • • • • • • • • • • • • • • • • • • •	n or settlement amount exceeded the limit	
The state of the s		Yes No
PREVIOUS PROFESSIONAL I CONFIDENTIAL INFORMATION:		
Carrier:		
Address:		
Street	City	State Zip
Street	City	State Zip
	Original Effective Date:	Expiration Date:
	Original Effective Date: (mm/dd/yy)	Expiration Date:
Policy Number: Policy Limits: Per Occurrence: \$ Retroactive Date: (mm/dd/yy)	Original Effective Date: (mm/dd/yy) Aggregate: \$	Expiration Date: (mm/dd/yy)
Policy Number: Policy Limits: Per Occurrence: \$ Retroactive Date:	Original Effective Date: (mm/dd/yy) Aggregate: \$	Expiration Date: (mm/dd/yy)

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL	SCHOOL			
Institution Name:				
Mailing Address:				
Street		City	State Zip	, ,
Telephone Number: ()	Fax Number: ()			
Degree: Year	Graduated:			
Dates attended: From:				
If you are a graduate of a foreign Medical Graduates (ECFMG)?		tified by the Education	al Commission f	or Foreign
Date Issued:	Serial Number for E	CFMG:		
mm/yy				
Were you the subject of an	y disciplinary action during y	our attendance at this in	stitution? T	es No
(Attach an explana	ation of a "Yes" answer.)			
If you attended more than one m duplicates the information requested		blease check here and	attach an explai	nation that
INTERNSHIP				
Institution Name:				
Department Chair or Program Direc	tor:			
Department chair of Fragram 2 nee	Last Name	First Name	MI	Degree
Mailing Address:				
Street		City	State Zip)
Telephone Number: ()	Fax Number: ()			
Dates attended: From:	To:			
		icht mlassa list smasialt		
Type of internship: Rotating	<u> </u>		-	
Did you successfully complete this p	orogram?	If no, please a	ittach an explanat	tion.
Were you the subject of any discipli	nary action during your atten	dance at this institution?	Yes] No
(Attach an explana	ation of a "Yes" answer.)			
If more than one internship, please requested above:	e check here and attach add	tional information that	duplicates the in	nformation

FIRST RESIDENCY			
Institution Name:			
Department Chair or Program Director:			
Last Name	First Name	MI	Degree
Mailing Address:	O''	- Ct t	7:
Street	City	State	Zip
Telephone Number: () Fax Number: ()			
Dates attended: From: To: mm/yy mm/yy			
Type of residency:			
Did you successfully complete this program? Yes No	If no places as	ttach an avn	lanation
	•	^	
Were you the subject of any disciplinary action during your atten	dance at this institution?	∐ Yes	∐ No
(Attach an explanation of a "Yes" answer.)			
SECOND RESIDENCY			
In address on Names			
Institution Name:			
Department Chair or Program Director: Last Name	First Name	MI	Degree
Mailing Address:	1 list Name	IVII	Degree
Street	City	State	Zip
Telephone Number: () Fax Number: ()			
Dates attended: From: To:			
mm/yy mm/yy			
Type of residency:			
Did you successfully complete this program?	→ If no, please at	tach an exp	lanation.
Were you the subject of any disciplinary action during your atten	dance at this institution?	Yes	☐ No
(Attach an explanation of a "Yes" answer.)			
If more than two residencies, please check here and attach addition requested above:		licates the in	nformation

FIRST FELLOWSHIP			
Institution Name:			
Department Chair or Program Director:			
Last Name	First Name	MI	Degree
Mailing Address:			
Street	City	State	Zip
Telephone Number: () Fax Number: ()			
Dates attended: From: To:			
mm/yy mm/yy			
Type of fellowship:			
Did you successfully complete this program? $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	If no, please a	ttach an expl	anation.
Were you the subject of any disciplinary action during your attend	lance at this institution?	Yes	☐ No
(Attach an explanation of a "Yes" answer.)			
` '			
SECOND FELLOWSHIP			
Institution Name:			
Department Chair or Program Director:			
Last Name	First Name	MI	Degree
Mailing Address:			
Street	City	State	Zip
Telephone Number: () Fax Number: ()			
Dates attended: From: To:			
mm/yy mm/yy			
Type of fellowship:			
Did you successfully complete this program? \square Yes \square No	If no, please a	ttach an expl	anation.
Were you the subject of any disciplinary action during your attend	lance at this institution?	Yes	☐ No
(Attach an explanation of a "Yes" answer.)			
If more than two fellowships, please check here and attach addition requested above: \square	nal information that du	plicates the i	nformation

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT) Institution Name: Department Chair or Program Director: First Name Degree Mailing Address: Street City State Zip Telephone Number: () Fax Number: () Rank/Position, if applicable: Dates: mm/yy Were you the subject of any disciplinary action during your attendance at this institution? Yes □ No (Attach an explanation of a "Yes" answer.) TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS) Institution Name: Department Chair or Program Director: First Name Degree Mailing Address: Zip Telephone Number: () Fax Number: () Rank/Position, if applicable: mm/yy Were you the subject of any disciplinary action during your attendance at this institution? (Attach an explanation of a "Yes" answer.) If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: (Please continue next page)

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A 11		
Address:	C'.	C
Street	City	State Zip
Membership Status:		To Present
	From (mr	n/yy)
Department/Division:	Medical Staff Of	ffice FAX #: ()
Department Telephone #: ()		
	t this Hospital?	
Any Limitations in Your Area of Specialty a	t this Hospital?	
Any Limitations in Your Area of Specialty a	t this Hospital?	
Any Limitations in Your Area of Specialty a	t this Hospital?	
Any Limitations in Your Area of Specialty a r Hospital Hospital Name: Address:	t this Hospital?	
Any Limitations in Your Area of Specialty a r Hospital Hospital Name:	t this Hospital?	State Zip
Any Limitations in Your Area of Specialty a r Hospital Hospital Name: Address:		State Zip
Any Limitations in Your Area of Specialty a r Hospital Hospital Name: Street	City	State Zip To:
Any Limitations in Your Area of Specialty a Hospital Hospital Name: Street	City Dates: From (mr	State Zip To:

Street ership Status:	Street	City State Zip Dates:	Street Membership Status: Dates: From (mm/yy) Department/Division: Department Telephone #: () Any Limitations in Your Area of Specialty at this Hospital? SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E (Include additional sheets if more than three hospitals.) Spital Name: Address: Street Membership Status: Dates: To: From (mm/yy) Department/Division: Department/Division: Department Telephone #: () Any Limitations in Your Area of Specialty at this Hospital? Street City From (mm/yy) Medical Staff Office FAX #: () Department Telephone #: () Any Limitations in Your Area of Specialty at this Hospital? Street City From (mm/yy) Medical Staff Office FAX #: () Department Telephone #: () Any Limitations in Your Area of Specialty at this Hospital? Street City From (mm/yy) Medical Staff Office FAX #: () Dates: From (mm/yy) Medical Staff Office FAX #: () Dates: From (mm/yy) To (mm/yy) Medical Staff Office FAX #: ()	ther Hospital	
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	SECTION G. AMBULATORY SUI	RGERY CENTER P	RACTICE
	Please list all ambulatory surgery centers who		
	privileges. Use the Membership Status key at the more than three ambulatory surgery centers.)	e top of page 13. (Inclu	ude additional sheets i
	more than three amountarry surgery centers.)		
Pri	mary Ambulatory Surgery Center		
	ASC Name:		
	Address:		
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SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to Pres	sent	
(mm/yy)		
Previous work place:		
Address:		
Street	City	State Zip
Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to:		
(mm/yy) (m	m/yy)	
Previous work place:		
Address:		
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Telephone: () Fax Number: ()		
Title or Professional Occupation:		
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Previous work place:		
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Telephone: () Fax Number: ()		
Title or Professional Occupation:		
Time in this employment: From: to:		
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Time in this employme vious work place: Address: Street	Fax Number: (ccupation:)	(mm/yy)	City	State	Zip

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

(CONFIDENTIAL INFOR	MATION						
1.	Name:					Title:		
	Last	First	N	MI	Degree			
	Specialty:						_	
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2.	Name:					Title:		
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SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1.	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?	Yes	□ No
2.	Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers?	☐ Yes	□No
3.	. Have you lost any board certification(s), and/or failed to recertify?	Yes	□ No
4.	Have you been examined by a Certifying Board but failed to pass?	Yes	☐ No
5.	Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	Yes	□ No
6.	Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	Yes	□ No
7.	Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?	Yes	□ No
8.	Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?	Yes	☐ No
9	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?	☐ Yes	□ No
10.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?	☐ Yes	□ No
11.	Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	Yes	□ No

12.	Yes	□No	
13.	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	Yes	□ No
PR	OFESSIONAL LIABILITY ACTIONS		
	f you answer yes to any question(s) in this section please complete FORM B. Please m ORM B if needed, and complete one for each yes answer.	ake copies	of
1.	Have any professional liability judgments ever been entered against you?	Yes	☐ No
2.	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?	Yes	□ No
3.	Are there any currently pending professional liability suits, actions and/or claims filed against you?	Yes	□ No
4.	Has any person or entity ever been sued for your clinical actions?	☐ Yes	□ No
LIA	ABILITY INSURANCE		
	If you answer yes to this question please complete FORM C.		
cove	e you ever been denied or voluntarily relinquished your professional liability insurance erage, and/or have had your professional liability insurance coverage canceled, non-wed or limits reduced?	☐ Yes	□ No
CR	IMINAL ACTIONS		
	f you answer yes to any question(s) in this section please complete FORM D. Please ORM D if needed, and complete one for each yes answer.	make copi	es of
1.	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	☐ Yes	□ No
2.	Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	☐ Yes	□ No
	Care Professionals Credentialing & Business Data Gathering Form cant Name:		20

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

if you answer yes to this question please complete POKM E.		
Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	☐ Yes	□ No
CHEMICAL SUBSTANCES OR ALCOHOL ABUSE		
If you answer yes to any question(s) in this section please complete FORM F. Please FORM F if needed, and complete one for each yes answer.	make copi	es of
1. Are you currently engaged in illegal use of any legal or illegal substances?	Yes	☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances?	Yes	☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?	Yes	□ No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?	☐ Yes	□ No
INVESTMENTS		
In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?	Yes	□ No
If Yes, please provide explanation:		
(Please con	itinue nez	xt page)

CHAPTER B: BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary									
Site	Group/Business Name								
	Building Name								
	Office Address – Number ar	nd Street – Suite							
	City		County	State	Zip				
	Main Telephone Number	Office Administrator	– Last	First	MI				
	() Beeper Number	() FAX Number	E-mail						
	() Emergency Number	() Answering Service	<u></u>						
Specialty pra	acticed at this site:	_							
Is your pract	tice restricted within your specia	alty (e.g., by age or type of	of patient)?	Yes No					
If yes, d	describe the restrictions:								
Briefly desc	ribe your practice at this locatio	n, including any special p	practice focus or	equipment:					
Are you curr	rently accepting new patients at	this location? Yes	s 🗌 No						
If yes, de	escribe any restrictions (e.g., ap	pointment type, patient ty	/pe):						
	de the number of active patients de the number of patient visits y								

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							
	to	to	to	to	to	to	to

-							•	
Pleace	indicat	e standard	natient	waiting	times to	r schedule a	n annointment	at this site for:
ı ıcasc	muicai	a stanuai u	Daucii	, waiinz	umesu	, scheune a	ու արույլույլու	at this site for.

			New Patient	Existi	ng Patient
Emergency Care					
Urgent Care					
Symptomatic Care (e.g., sore throat	t)				
Routine Visits (e.g., blood pressure	checl	k)			
Preventive Routine Care (e.g., scho	ol or	annual physical)			
Please provide the following regarding you	r pra	ctice at this site:			
Maximum Number of Appointments per H	 Iour				
Average Waiting Time in Office (from sch		ed appointment time	to actual exam	ination)	
Average Response Time for Returning		cute or Urgent Situat			
Patient Calls:		nergency Situation:			
	Ko	outine Call:			
Please check all procedures you perform at	this s	site:	1		
☐ Age-appropriate immunizations		☐ EKG			ving blood
Tympanometry/audiometry screening	ıg	☐ X-rays			or surgery
Pulmonary function studies		Flexible sigmo			ration repair
Office gynecology (routine pelvic/P		Asthma treatm			gy skin testing
Osteopathic /Chiropractic manipulat	ion	☐ IV hydration/t	reatment	Phys	ical Therapy
List any special skills or qualifications you medicine or treat certain patients or classefluency in a foreign language or proficiency	es of]	patients. List sepa			
Special Skills of Practitioner:					
Special Skills of Staff:					
Languages Spoken by Practitioner:					
Languages Written by Practitioner:					
Languages Spoken by Staff:					
Languages Written by Staff:					
Is this practice site handicapped accessible Building Parkin	,	k all that apply)?	Restroom		
Does this site employ paraprofessionals for	direc	ct patient care?	Yes	No	
If yes, is supervision always provid	ed on	premises during par	raprofessionals	direct pa	atient care?
Yes No				•	
Do the paraprofessional(s) b	oill un	der any of your Tax	ID Numbers?	☐ Ye	s 🗌 No
If yes, list Tax ID Numbers used:		CONF	SIDENTIAL IN	FORMA	TION
			_		

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

Lab Ser	Lab Service at this site?								
		If yes,	check whet	her: Primary	☐ Seconda	ry 🗌 Tertian	ry		
	CLIA Waiver:	Yes	□No	•		•			
		If yes, Cl	 LIA Expirati	ion Date:					
DI	• 1 . 41 . 6.11 .		_			• • • • • • • • • • • • • • • • • • • •	C		
	Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.								
Name:		-							
_	Last			First		MI Degree			
	Specialty:								
						Telephone: ()		
	Street	;		City	State Zip				
	Availability:		☐ Nights						
	CONFIDENTIA	AL INFOR	MATION:	Tax ID #:					
Name:									
_	Last			First		MI Degree			
						Telephone: ()		
	Street			City	State Zip		<u>, </u>		
	Availability:	☐ Days	☐ Nights	Weekends	•				
	CONFIDENTIA	AL INFOR	MATION:	Tax ID #:					
Name:									
_	Last			First		MI Degree			
	Specialty:					_			
	A 1.1					Telephone: ()		
	Street			City	State Zip		,		
	Availability:	Days	☐ Nights	Weekends	☐ Holidays				
	CONFIDENTIA	AL INFOR	MATION:	Tax ID #:					
Please 1	provide the follo	wing inforn	nation abou	ıt physician(s)/pr	ractitioner(s) who	practice in this	s office:		
Name:						Specialty:			
	Last		Firs	t	MI				
Name:						Specialty:			
	Last		Firs	t	MI	_			
Name:						Specialty:			
_	Last		Firs	t	MI				

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1 Name of Business Arrangement On SS4 or W-9 Form:
Type of Arrangement (e.g., solo or group practice, IPA, PHO):
CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
Billing Address, if Different from Primary Site:
Telephone Number, if Different from Primary Site: ()
Business Arrangement #2 Name of Business Arrangement On SS4 or W-9 Form:
Type of Arrangement (e.g., solo or group practice, IPA, PHO):
CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
Billing Address, if Different from Primary Site:
Telephone Number, if Different from Primary Site: ()
Business Arrangement #3 Name of Business Arrangement On SS4 or W-9 Form:
Name of Business Arrangement On SS4 or W-9 Form:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO):
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Telephone Number, if Different from Primary Site: ()
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Telephone Number, if Different from Primary Site: (
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Telephone Number, if Different from Primary Site: () Business Arrangement #4 Name of Business Arrangement On SS4 or W-9 Form:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Telephone Number, if Different from Primary Site: () Business Arrangement #4 Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO):

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site								
#	Group/Business Name							
	Building Name							
	Office Address – Number an	nd Street – Suite						
	City		County	State	Zip			
	() Main Telephone Number	Office Administrator	– Last	First	MI			
	() Beeper Number	() FAX Number	E-mail					
	() Emergency Number	Answering Service						
Specialty pra	acticed at this site:							
Is your pract	ice restricted within your specia	alty (e.g., by age or type	of patient)?	Yes No				
If yes, d	lescribe the restrictions:							
Briefly descr	ribe your practice at this location	n, including any special	practice focus or	r equipment:				
Are you curr	rently accepting new patients at	this location?	es 🗌 No					
If yes, de	escribe any restrictions (e.g., ap	pointment type, patient t	ype):					
Please provi	de the number of active patients	s enrolled with you at thi	s site:					
Please provi	de the number of patient visits	you have at this site per	/ear:					
	ur office schedule at this lo	ocation in the following	ng table. Writ	te your specific	e hours in the			

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							
	to	to	to	to	to	to	to

-							•	
Pleace	indicat	e standard	natient	waiting	times to	r schedule a	n annointment	at this site for:
ı ıcasc	muicai	a stanuai u	Daucii	, waiinz	umesu	, scheune a	ու արույլույլու	at this site for.

			New Patient	Existin	ng Patient
	Emergency Care				
	Urgent Care				
	Symptomatic Care (e.g., sore throat)				
	Routine Visits (e.g., blood pressure chec	ck)			
	Preventive Routine Care (e.g., school or	annual physical)			
Plea	se provide the following regarding your pra	nctice at this site:		I	
N	Maximum Number of Appointments per Hour				
-	Average Waiting Time in Office (from schedule	ed appointment time	to actual exami	ination)	
-		cute or Urgent Situat			
	Patient Calls:	mergency Situation:			
		outine Call:			
Plea	se check all procedures you perform at this	site:			
	Age-appropriate immunizations	☐ EKG			ing blood
	Tympanometry/audiometry screening	☐ X-rays			surgery
	☐ Pulmonary function studies	☐ Flexible sigmo			ation repair
	Office gynecology (routine pelvic/PAP)	Asthma treatm	nent	_ ~	gy skin testing
	Osteopathic /Chiropractic manipulation	☐ IV hydration/t	reatment	Physic	cal Therapy
med	any special skills or qualifications you or licine or treat certain patients or classes of ncy in a foreign language or proficiency in standard Special Skills of Practitioner:	patients. List sepa			
	Special Skills of Staff:				
	Languages Spoken by Practitioner:				
	Languages Written by Practitioner:				
	Languages Spoken by Staff:				
	Languages Written by Staff:				
Is tl	nis practice site handicapped accessible (chec	ck all that apply)?	Restroom		
Doe	s this site employ paraprofessionals for direc	ct patient care?	Yes 1	No	
	If yes, is supervision always provided on Yes No Do the paraprofessional(s) bill ur			direct pat	tient care?
	If yes, list Tax ID Numbers used:		SIDENTIAL IN	FORMAT	TION

Health Care Professionals Credentialing & Business Data Gathering Form Applicant Name:

Lab Sei	Lab Service at this site?								
		If yes, c	heck wheth	er: Primary	☐ Seconda	ry 🔲	Tertiary	/	
	CLIA Waiver:	Yes	□Nο			•	•		
			_	on Date:					
Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.									
Name:									
_	Last			First		MI I	Degree		
	Specialty:								
	Address:					Telepl	none: ()	
	Address: Street			City	State Zip	_ ^			_
	Availability:	Days	Nights	Weekends	Holidays				
	CONFIDENTIA	L INFORM	ATION:	Гах ID #:			_		
N									
Name:	Last			First		MI I	Degree		
	Specialty:					.,,,	ogree		
	Address:					— Teleni	none: ()	
	Street			City	State Zip		1011c. <u>(</u>	/	_
	Availability:	Days	Nights	☐ Weekends	-				
	CONFIDENTIA	L INFORM	ATION:	Гах ID <u>#:</u>					
N T									
Name:	Last			First		MI I	Degree		
						IVII I	ocgree		
	Specialty:Address:					— Teleni	none: ()	
	Street			City	State Zip		ione. ()	_
		Days	Nights		Holidays				
	CONFIDENTIA	L INFORM	ATION:	Гах ID #:			_		
Please p	provide the follow	ing informa	tion about	physician(s)/pr	actitioner(s) who	practic	e in this	office:	
Name:						Specia	ılty:		
	Last		First		MI	-			
Name:						_Specia	ılty:		
	Last		First		MI	-			
Name:						Specia	ılty:		
_	Last		First		MI		-		

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Susiness Arrangement #1 Name of Business Arrangement On SS4 or W-9 Form:
Type of Arrangement (e.g., solo or group practice, IPA, PHO):
CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
Billing Address, if Different from Primary Site:
Telephone Number, if Different from Primary Site: ()
Susiness Arrangement #2 Name of Business Arrangement On SS4 or W-9 Form:
Type of Arrangement (e.g., solo or group practice, IPA, PHO):
CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
Billing Address, if Different from Primary Site:
Telephone Number, if Different from Primary Site: ()
Susiness Arrangement #3 Name of Business Arrangement On SS4 or W-9 Form:
Susiness Arrangement #3 Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO):
Name of Business Arrangement On SS4 or W-9 Form:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO):
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Celephone Number, if Different from Primary Site: (
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Celephone Number, if Different from Primary Site: () Business Arrangement #4 Name of Business Arrangement On SS4 or W-9 Form:
Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO): CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: Billing Address, if Different from Primary Site: Celephone Number, if Different from Primary Site: () Business Arrangement #4 Name of Business Arrangement On SS4 or W-9 Form: Type of Arrangement (e.g., solo or group practice, IPA, PHO):

End Credentialing and Business Data Gathering Form. Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Nam	e:		
	Last	First	MI
ndicate the nur	mber of ONE of the questions in S	ection J to which you answered "yes"	: Question Number:
A. Describe th	e circumstances surrounding this of	occurrence. Please include the date of	the occurrence.
3. Provide an	explanation of any actions taken.	Please include the date the action was	taken.
C. Provide the	current status of the issue.		
O. If known:	Contact:		
o. II known.	Contact:		
	Street	City	State Zip
	Telephone: ()		
Signature:		D	ate:

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:		
Last	First	MI
A. Plaintiff's Name:		
Last	First	MI
If court case, Case Name & Case Number	:	
B. Your Involvement in the Care (Attending, Cons	sulting, Etc.):	
C. Your Status in the Case (Sole Defendant, Co-D Suit, Etc.):	*	Practice Name in
D. Allegations, including Patient Outcome, if Ava	iilable:	
E. Date of Incident (mm/yy):	F. Date Filed (mm/yy):	
G. Date Case Closed (mm/yy):	_	
Resolution Case: Dismissed Settlement out of Cour	Judgment Arbitration rt Pending Mediation	Other
H. Amount Paid on Your Behalf (if any): \$		
I. Professional Liability Insurer Name (if one was	involved):	
J. Insurer Telephone Number: ()	K. Policy Number:	
L. Insurer Address (Street, City, State, Zip Code):		
Signature:	Date:	

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:		
Last	First	MI
A. History of Professional Liability Insura	nnce (Please check One)	
Canceled Voluntarily	Non-Renewed	
Canceled Involuntarily	Application Denied	
B. Carrier Name:		
C. Carrier Telephone Number: ()		
D. Policy Number:		
E. Carrier Address (Street, City, State, Zip C	ode):	
F. Dates of Coverage: From (mm/yy):	To (mm/yy):	
Signature:	Date	•

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name:		
Last	First	MI
A. Date of Incident (mm/yy):		
B. Date of Complaint or Conviction (mm/yy):		
C. Date of Resolution (mm/yy):	_	
D. Type of Resolution (Dismissed, Plea Bargain	, Misdemeanor, Felony):	_
E. Allegation(s):		
F. Details of Incident:		
G. Actions Taken Against You:		
H. Current Status of Situation:		
I. Medical Practice Privileges Affected as a Resu	ult of This Situation:	
Signature:	Da	te:

FORM E - MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name:			
Last		First	MI
A. Describe this medica	l condition:		
	or could this condition affect year. Full range of clinical activities?		medicine in your specialty
C. What is the current st	atus of your condition?		
D. Provide the name and about your health cor	d address of your personal physidition.	sician/health care provider wh	no can provide information
Name		Telephone Number	
			()
Last	First	MI Degree	()
Last	First	MI Degree	()
			_
Signature: Date:		Date:	

FORM F - CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name: Last	First	MI	
Describe the substance you use:			
A. To what extent does, or could, your us specialty area or to perform a full range.	se of this substance affect your current abge of clinical activities?	ility to practice medicine in your	
B. Monitored by State Board Mandate (N	Tame and Address) C. Monitored Volunt	arily (Name and Address)	
D. Other information about the current sta	atus of your use of substances:		
E. Abstinent since (mm/yy):			
F. Provide the name and address of your pyour treatment for alcohol or chemica current/future professional practice.	personal physician/health care provider what substance use and can comment on what	no can provide information about at impact (if any) it has on your	
Name:			
Address:			
Street Telephone: ()	City	State Zip	
Signature:		Date:	