



Application for Employment

New Mexico

Copies of the following must be included in your packet:

- All State Medical Licensure**
- State Controlled Substance License**
- DEA Certificate**
- ACLS, ATLS, PALS, BLS etc**
- Driver's License**
- Color Photo - Clear and Current**
- Proof of CME - Past 3 Years**
- ECFMG - if applicable**
- Copy of Medical School Diploma**
- CV (current)**
- Board Certificate - if applicable**
- Recent TB Test Results**
- NPI Letter or Email**
- Birth Certificate**



Contact Information

Name: _____

Email Address: _____

Home Phone: _____

Office Phone: _____

Mobile Phone: _____

Pager & Pin: _____

Other Number: _____



Please List at least 5 peer references:

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Email: _____

Fax: _____



Immunity and Release

I understand and agree that I am in the process of applying as an Independent Contractor to staff contracts held by Emergency Staffing Solutions and that no agreement will be effective until signed by both Emergency Staffing Solutions and me nor will I have any contractual agreement with Emergency Staffing Solutions until that occurs.

I hereby confirm that the information contained in my application is complete and accurate. Material omissions or false statements may be grounds for Emergency Staffing Solutions disregarding this application or terminating my Independent Contractor status. I authorize Emergency Staffing Solutions to contact the references listed in this application and to conduct a customary investigation of my professional background and personal history, including contacting sources not listed by me. A photocopy of this authorization shall be as valid as the original.

I hereby release and hold harmless from and against any and all liability all representatives of Emergency Staffing Solutions and the Hospital(s) for their acts and communications performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I also hereby release from any liability any individuals and organizations who provide information to Emergency Staffing Solutions and the Hospital(s) in good faith and without malice concerning my professional competence, ethics, character and other qualifications for employment, clinical privileges and staff appointments, and I hereby consent for the release of such information.

Signature

Printed Name

Date



Emergency Department Experience



Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Other Hospital/Practice Experience

(continued - if necessary)



Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Hospital/Practice Name Chief of Staff/Supervisor Name

Street Address City, State, Zip

Department Start Date End Date

Physician's Authorization

I hereby authorize Emergency Staffing Solutions or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at any facility contracted by Emergency Staffing Solutions of the amount payable to such individual under Part B or Title XVIII of the Social Security Act and to receive on my behalf any payments that may be made pursuant to such assignment. It is understood and agreed that the reasonable charge, which will serve as the basis for payments in accordance with the terms of such assignment, shall be the full charge for the service.

This authorization may be withdrawn at any time upon giving at least 30 days prior written notice to the administrator.

Physician's Signature

Printed Name

Date



Health Statement

I hereby declare that _____ is in good physical health, mentally and emotionally stable, further more, has no health impairments affecting the priveleges requested in his/her application to Emergency Staffing Solutions. This physician has not been hospitalized or institutionalized for any significant health problems during the past five years and is not receiving current therapy for any health problems.

****to be completed by a physician other than yourself****

Physician Signature

Printed Name

Date



Emergency Medicine Delineation

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform in an emergency situation

3 - I have not performed, and I am not comfortable in performing in an emergency situation

1 2 3	Management of electrolyte disturbances	1 2 3	Treatment of diabetic ketocidosis
1 2 3	Suturing, including facial lacerations	1 2 3	Treatment of snakebite
1 2 3	Treatment of common poisonings	1 2 3	Routine x-rays for fracture
1 2 3	Management of pediatric emergencies	1 2 3	Anesthesia (IV conscious sedation)
1 2 3	Management of severe head injuries	1 2 3	Bladder Cath/Irrigation
1 2 3	Treatment of hypovolemic shock	1 2 3	Cardiac Massage (closed/open)
1 2 3	Anesthesia (IV/regional block)	1 2 3	Central Lines
1 2 3	Arthrocentesis	1 2 3	Foreign Body Removal
1 2 3	Cardiac Electroconversion	1 2 3	Gastric Lavage
1 2 3	Cricothyotomy	1 2 3	Lumbar Puncture
1 2 3	Endotracheal intubation (nasal/oral)	1 2 3	Nasal Packing/Cautery
1 2 3	Fracture/Dislocation (Reduc./Immobil.)	1 2 3	Wound repair/Dressing
1 2 3	Incision/Drainage	1 2 3	Paracentesis
1 2 3	Interosseous IV	1 2 3	Pericardiocentesis
1 2 3	Nail Trephination/Removal	1 2 3	Surgical Debridement
1 2 3	Pacemaker/IV or transcutaneous	1 2 3	Thoracostomy Tube Drainage
1 2 3	Peritoneal Lavage	1 2 3	Treatment of common orthopedic problems
1 2 3	Spinal Immobilization	1 2 3	
1 2 3	Thoracentesis	1 2 3	
1 2 3	Precipitous Vaginal Delivery	1 2 3	
1 2 3	Diagnosis & treatment of common cardiac arrhythmias		
1 2 3	Familiar with Public Health recommendations regarding venereal disease		
1 2 3	Diagnosis/mangement of respiratory failure, including mechanical ventilation		

Physician's Signature

Printed Name

Date



Hospitalist Delineation

Please circle the appropriate number for each item

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform

3 - I have not performed, and I am not comfortable in performing

- | | | | |
|-------|---|-------|---|
| 1 2 3 | Arterial catheterization for monitoring | 1 2 3 | Paracentesis |
| 1 2 3 | Arterial puncture for ABG | 1 2 3 | Pericardiocentesis - emergent |
| 1 2 3 | Arthrocentesis | 1 2 3 | Placement transvenous pacer |
| 1 2 3 | Bone marrow biopsy | 1 2 3 | Rhythm strip interpretation |
| 1 2 3 | Bone marrow aspirate | 1 2 3 | Simple Peripheral IV catheter |
| 1 2 3 | Bronchoscopy, diagnostic | 1 2 3 | Swan-Ganz catheter |
| 1 2 3 | Cardioversion - emergent | 1 2 3 | Thoracentesis |
| 1 2 3 | Central venous catheter placement and management | 1 2 3 | Thrombolysis infusion |
| 1 2 3 | Chest tube | 1 2 3 | Ventilator management |
| 1 2 3 | Code Team Leader | 1 2 3 | Endotracheal intubation |
| 1 2 3 | Conscious sedation | 1 2 3 | Lumbar puncture |
| 1 2 3 | External jugular catheterization | 1 2 3 | Neonatal Privileges |
| 1 2 3 | External/transcutaneous pacemaker | 1 2 3 | Suprapubic Bladder Catheterization |
| 1 2 3 | Aspiration & Joint injection | 1 2 3 | Interosseous IV |

Physician's Signature

Printed Name

Date



Past and Pending Claims Information

*Please copy this form for each incident reported



Physician Name: _____

Date of Incident: _____ **Date of Claim:** _____

Patients Name: _____ **Age:** _____ **Sex:** _____

Nature of treatment and diagnosis at time of incident:

Allegations made against you:

Did the patient expire? Yes _____ **No** _____

Disability: _____

Was the case settled? Yes _____ **No** _____ **Amount of settlement?** _____

Pending: _____ **Settled:** _____

Mediation/Arbitration: _____ **Suit Dropped:** _____

Trial: _____

Names of other doctors and hospitals, if any, involved in the claim of this suit:

Date completed

Signature of Applicant

Billing Information

In order to expedite the billing process for the facilities you will be working at, please provide the following information:

Physician Name: _____

NPI Number: _____

UPIN Number: _____

Medicare Number: _____

Medicaid Number: _____

Drivers License Number: _____

Drivers License Expiration Date: _____

Drivers License State: _____



Authorization for Enumeration for NPI

I, _____ (please print name and credentials), with
_____ (name of group), hereby authorize Emergency
Staffing Solutions (ESS) to cause to be submitted an application enumeration under
the NPI system (NPPES) on my behalf.

I further authorize ESS to acquire a user name and log-in ID for the NPPES account
created in my name, to enable updates and correction to the information as required
by the rules and regulation governing the National Provider Identifier standard. I will
supply any changes and correction to such information to ESS in a timely fashion, to
allow them to appropriately perform this function on my behalf.

This authorization shall continue until such time as: 1) I request in writing, ESS to turn
over the NPPES user name and log-in ID to me for upkeep on my account, or 2) I am
no longer affiliated with the group, name above, or 3) until the relationship between
the group and ESS terminates, pursuant to the terms of the Billing Services Agreement
between the same.

Executed this _____ day of _____ (month), _____ (year)

Signature





The New Mexico Physician and Practitioner Credentials Application

Name(s) of Health Care Organization(s) to Which Application is Being Made

Date of Application: _____

Name: _____
Last First Middle Other Names Used

Circle all that apply and for which you are currently licensed: MD DO DDS DC DPM OD PA CNM
CNP CRNA RN PT OT ST DOrienMed Acup Clin Psych Psych Assoc LMHC LPAT LADAC
LISW LMSW LPC LPCC LMFT CNS/Psych CNS/Medical Spch Path
Other: _____ Specialty: _____

Gender: F M Citizenship: _____ Place of Birth: _____
Social Security Number: _____ Date of Birth: _____
State Tax ID#: _____ Pending Federal Tax ID#: _____ Pending
Medicare #: _____ Pending Medicaid #: _____ Pending
Unique Physician Identification Number (UPIN): _____ Pending
National Provider Identifier Number (NPI): _____ Applied
Office Manager or Contact Person and telephone number: _____

Practice/Group Name: _____ Effective Date: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

E-Mail Address: _____ Answering Service Number: _____

Can we contact you by e-mail for credentialing correspondence? Yes No

Foreign Languages (spoken fluently by practitioner): _____

Foreign Languages (spoken fluently at practice): _____

Current Mailing Address (if different from above): Same As Above

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Billing Address (if different from mailing address):

Same As Mailing Address

Contact Person: _____ Tax ID #: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name: _____ Tax ID #: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Home Address:

Street Address: _____

City, State and Zip Code: _____

Telephone Number: _____ Pager Number: _____

Spouse's Name (Optional): _____

Practice Associates:

Call Coverage (if different):

_____/_____
_____/_____
_____/_____
_____/_____

What are the office hours for your Practice or Group Practice? (Provide days/hours):

What provisions have been made for after hours? _____

PROFESSIONAL REFERENCES

Please list five professional peers with the same type of license or a higher level of licensure who are familiar with your professional performance in the past five (5) years (not including current or impending partners or associates in practice).

Name and Title: _____ **Specialty:** _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____ **Specialty:** _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____ **Specialty:** _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

Name and Title: _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

Name and Title: _____
Street Address: _____
City, State, Country and Zip Code: _____
Telephone Number: _____ Facsimile: _____

EDUCATION

Undergraduate Education:

College or University: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Attended: From / / To / / Degree Earned: _____
Mo/Yr Mo/Yr

Graduate Education: (List all medical, osteopathic, dental or podiatric schools attended.)

College or University: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Attended: From / / To / / Degree Earned: _____
Mo/Yr Mo/Yr

POST GRADUATE TRAINING N/A

List all hospitals where you received training and attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary.

_____ Specialty: _____
Specify Internship, Residency, or Fellowship
Institution: _____ Dates Attended: From / /
Street Address: _____ To / /
City, State, Country and Zip Code: _____
Mo/Yr Mo/Yr

_____ Specialty: _____
Specify Internship, Residency, or Fellowship
Institution: _____ Dates Attended: From / /
Street Address: _____ To / /
City, State, Country and Zip Code: _____
Mo/Yr Mo/Yr

Specialty: _____

Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From _____ / _____ / _____
Mo/Yr

Street Address: _____ To _____ / _____ / _____
Mo/Yr

City, State, Country and Zip Code: _____

Teaching Appointments N/A

Institution: _____

Street Address: _____

City, State, Country and Zip Code: _____

Dates Attended: From _____ / _____ To _____ / _____ Department/Position: _____

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume. **Please provide a written explanation for any gaps in work history of six (6) months or more.**

Organization: _____ Dates: From _____ / _____ To _____ / _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ / _____ To _____ / _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ / _____ To _____ / _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ / _____ To _____ / _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

Organization: _____ Dates: From _____ / _____ To _____ / _____
Mo/Yr Mo/Yr

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Contact Person: _____

HOSPITAL AND HEALTHCARE AFFILIATIONS

Are you a PCP? Yes No
Do you deliver babies? Yes No
Are you an MD, DO, or DPM? Yes No

If yes to any question above, you must:

- (a) Have admitting privileges at a hospital (list below) **OR**
- (b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Do you have courtesy or consulting privileges at your current primary admitting facility? Yes No

If yes, do these courtesy or consulting privileges allow you to admit patients? Yes No

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name): _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Privileges Assigned: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

Facility Name: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Appointment Dates: From _____ To _____ Type of Appointment/Status: _____

MILITARY SERVICE

Branch: _____ Dates: From _____ To _____
Rank: _____ Type of Discharge: _____

LICENSURE-REGISTRATION-CERTIFICATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____
State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____
State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____
State Professional License/Certification Number: _____ Pending
State: _____ Issue Date: _____ Expiration Date: _____

ECFMG (Educational Commission for Foreign Medical Graduates) Number (if applicable): _____
Date Issued: _____ Please attach a copy of your ECFMG certificate.

Federal Drug Enforcement Administration (DEA) Registration: Pending N/A
DEA Number: _____ Expiration Date: _____

State Controlled Substance Registration (CSR): Pending N/A
CSR Number: _____ Expiration Date: _____ State: _____

Immigration Status: _____ Immigration Certification Number _____

CLIA Number (if applicable): _____ Approval Level: _____ Expiration Date: _____

PROFESSIONAL LIABILITY INSURANCE

Do you have current liability insurance? Yes No
Please list liability insurance carriers for the past fifteen (15) years. Attach a separate page, if necessary.

Current Carrier: _____ Coverage Limits: _____
Street Address: _____ Current Pending
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

Carrier: _____ Coverage Limits: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

Carrier: _____ Coverage Limits: _____
Street Address: _____
City, State, Country and Zip Code: _____
Dates Insured: From: _____ To: _____ Policy Number: _____

SPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? Yes No N/A

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

Certified/Recertified by the Board of: _____

Date Certified: _____ Date Last Recertified: _____ Expiration Date: _____

Certified/Recertified by the Board of: _____

Date Certified: _____ Date Last Recertified: _____ Expiration Date: _____

Accepted for Examination by the Board of: _____

Until (Expiration Date): _____ If not accepted, have you made application? Yes No

If no, provide an explanation: _____

Certified/Recertified by the Subspecialty Board of: _____

Date Certified: _____ Date Last Recertified: _____ Expiration Date: _____

Certified/Recertified by the Subspecialty Board of: _____

Date Certified: _____ Date Last Recertified: _____ Expiration Date: _____

Accepted for Examination by the Subspecialty Board of: _____

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response except for question #12. **If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.**

1. Has your professional liability coverage ever been terminated by action of the insurance company?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever had any sanctions imposed by Medicare and/or Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you ever been arrested, convicted of, or pled no contest to a crime or have you ever been named as a defendant in any criminal proceedings, convicted of a felony, or subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has your license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended or revoked, or are any currently held licenses pending investigation or being challenged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
13. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. <ul style="list-style-type: none"> • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney. 	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Do you use illegal drugs or have you illegally used drugs in the past five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CHECKLIST OF DOCUMENTS TO BE RETURNED BY APPLICANT

- Completed and signed application (and supplemental documents required by the healthcare organization, if applicable). Signature stamps and date stamps are not acceptable.
- Completed and signed release, with all organizations to which you are applying identified in the first line of the release. Please note that if you do not provide the authority to redisclose, you will be required to sign a separate release for any additional healthcare organizations to which you have made application. Signature stamps and date stamps are not acceptable.
- Current curriculum vitae or resume including months and years for all places of employment during the past fifteen years. Explain any gaps of six months or more during the past five years.
- Copy of latest professional state license/certificate or registration. Pending
- Proof of current professional liability coverage that includes the effective date, amount and type of coverage. If your coverage will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Copy of current state Controlled Substance Registration. If your registration will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Copy of current federal DEA registration certificate. If your registration will be expiring within the next sixty days, please provide a copy of the renewal certificate. Pending
- Completed privileges forms, as appropriate. For hospital appointments, please attach privileges requested. For health plan panel membership, all MD's and DO's, and all Nurse Practitioners and Nurse Midwives who are primary care providers (PCP's), must either have admitting privileges or a letter explaining the arrangements that have been made with a physician to admit patients, along with a signed letter from this physician confirming the arrangement.
- Copy of ECFMG Certificate, if foreign medical graduate.
- Any additional attachments required by the application.

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate health care organization. Practitioners may utilize any or all of the following to ensure accurate file information.

- **The right of practitioners to review information submitted to support their credentialing application.**
- **The right of practitioners to correct erroneous information.**
- **The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request.**
- **The right of practitioners to be notified of these rights.**

Attestation and Consent

I affirm that all information and documentation submitted by me in this application is correct, complete, and current to my best knowledge and belief. I acknowledge that any misstatement in or omissions from this application may constitute cause for denial of my application for membership or participation. I understand and agree that, as an applicant for participation, I 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.

I hereby authorize the entity to which this Application, Attestation, and Consent is being submitted to contact and/or consult with any persons, entities, or institutions which I have been affiliated, have used for liability insurance, or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as reference by me. I consent to the release and communication of information and documents with entities or institutions in jurisdictions in which I have been trained, resided, practiced, or applied for professional licensure, for the purpose of evaluating my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice claims history.

I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This provision applies to all persons, entities and institutions who will provide and/or receive, as a part of the credentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency, and mental health information.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency, and/or mental health concerns which interfere with my ability to practice medicine.

A copy of this original statement as signed by me shall have the same force and effect as the signed original statement.

Name (Please Print):

Signature:

Date:
