



# **Application for Employment**

**Oklahoma**

**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.

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**Signature**

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**Printed Name**

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**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.

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**Physician's Signature**

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**Printed Name**

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

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

\_\_\_\_\_  
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)

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**Signature**



December, 1999

Dear Health Care Professional:

In 1998, the Oklahoma Legislature passed a law dealing with credentials verification. That law directed the Board of Health to promulgate rules and the Oklahoma State Department of Health to develop a uniform credentialing application. The application will be used to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

The Department has developed the attached Uniform Credentialing Application. Although many of the items apply primarily to physicians, this form has been designed for use by all health care professionals.

**Please note these specific instructions:**

- 1. DO NOT submit this form to the Oklahoma State Department of Health.**
- 2. Contact the facility or organization to which you plan to apply before submitting this form to find out what addendum, supplemental form, additional information, or additional items will be required.**
- 3. All items must be completed.**
- 4. If an item is not applicable, please so state.**
- 5. Please print legibly or type.**
- 6. Be sure to sign and date the application.**
- 7. If additional space is needed, please attach additional sheets.**

The application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. The form is available on the Department's website at [www.health.state.ok.us](http://www.health.state.ok.us). For questions about the form you may contact the Department at (405) 271-6868. The form may also be available online at the different facilities and organizations to which you will be making application.

Protective Health Services  
Oklahoma State Department of Health

# Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

*Please note: Although many of the items apply primarily to physicians, this form has been designed to be used by all health care professionals. If an item does not apply to you, write "N/A".*

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"). All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to: \_\_\_\_\_

Date: \_\_\_\_\_

**SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.**

**SECTION 1: PERSONAL INFORMATION**

Name \_\_\_\_\_  
Last First Middle Suffix  
Professional Degree \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

Other Name By Which You Have Been Known \_\_\_\_\_  
Dates This Name Was Used: From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_

Other Name By Which You Have Been Known \_\_\_\_\_  
Dates This Name Was Used: From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_

Social Security Number \_\_\_ - \_\_\_ - \_\_\_ NPID (formerly UPIN) \_\_\_\_\_

Date of Birth: \_\_\_ - \_\_\_ - \_\_\_ Place of Birth \_\_\_\_\_ Citizenship \_\_\_\_\_

\_\_\_\_\_  
Visa Type Visa Number (provide copy) Expiration Date

\_\_\_\_\_  
Your Personal Medicare Number Your Personal Medicaid Number

**SECTION 2: DIRECTORY INFORMATION**

**Mailing Address For All Credentialing Correspondence:** \_\_\_\_\_  
Street Address

\_\_\_\_\_  
Suite Number City State Zip Code  
( ) ( ) ( )

\_\_\_\_\_  
Phone Number Fax Number Emergency or Pager Number  
( )

\_\_\_\_\_  
Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: \_\_\_\_\_

**This Section continues on next page.**



### SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice)	Subspecialty	% Of Time
--	--------------	-----------

Secondary Specialty	Subspecialty	% Of Time
---------------------	--------------	-----------

Do you wish to be listed as:  
 Primary Care Provider     Specialist     Hospitalist     On-Call     Other (specify) \_\_\_\_\_

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

Yes  No Are you accepting new patients?

Yes  No Are you willing, in the future to accept new patients?

Yes  No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

Yes  No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

Yes  No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

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

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

( )	( )	( )
-----	-----	-----

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

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

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

( )	( )	( )
-----	-----	-----

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

List any restrictions on your practice (i.e. patient age and gender): \_\_\_\_\_

## SECTION 4: EDUCATION

### Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: (        ) _____			
	Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			
	Graduation Date ____ - ____ - ____			
(2)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: (        ) _____			
	Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			
	Graduation Date ____ - ____ - ____			
(3)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: (        ) _____			
	Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			
	Graduation Date ____ - ____ - ____			

## SECTION 5: TRAINING

### Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed:  Yes  No

Specialty	Institution	Your Program Director
( )		
Address	City	State Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____		

(2) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director
( )		
Address	City	State Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____		

(3) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director
( )		
Address	City	State Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____		

(4) Type of Program:  
 Internship  Residency  Fellowship  Preceptorship  Other (specify) \_\_\_\_\_

Was program successfully completed?  Yes  No

Specialty	Institution	Your Program Director
( )		
Address	City	State Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____		

## SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) \_\_\_\_\_ ( )  
 Institution and Address City State Zip Code Phone Number

\_\_\_\_\_ From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Position/Rank Inclusive Dates (mo/day/year)

(2) \_\_\_\_\_ ( )  
 Institution and Address City State Zip Code Phone Number

\_\_\_\_\_ From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Position/Rank Inclusive Dates (mo/day/year)

(3) \_\_\_\_\_ ( )  
 Institution and Address City State Zip Code Phone Number

\_\_\_\_\_ From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Position/Rank Inclusive Dates (mo/day/year)

## SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, all hospital/health system affiliations where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) \_\_\_\_\_ \_\_\_ Primary \_\_\_ Secondary  
 Facility Name

\_\_\_\_\_ ( )  
 Complete Mailing Address City State Zip Code Telephone Number

From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Dates of Appointment (mo/day/year) Staff Category

\_\_\_\_\_ Department or Service  
 Reason for Discontinuance

(2) \_\_\_\_\_ \_\_\_ Primary \_\_\_ Secondary  
 Facility Name

\_\_\_\_\_ ( )  
 Complete Mailing Address City State Zip Code Telephone Number

From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Dates of Appointment (mo/day/year) Staff Category

\_\_\_\_\_ Department or Service  
 Reason for Discontinuance

This section continues on next page.

**-Section 7 Continued-**

(3) \_\_\_\_\_ Primary \_\_\_ Secondary  
 Facility Name ( )  
 Complete Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Dates of Appointment (mo/day/year) Staff Category  
 Reason for Discontinuance Department or Service

**SECTION 8: OTHER PROFESSIONAL WORK HISTORY**

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) \_\_\_\_\_  
 Name and Nature of Affiliation ( )  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) \_\_\_\_\_  
 Name and Nature of Affiliation ( )  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) \_\_\_\_\_  
 Name and Nature of Affiliation ( )  
 Mailing Address City State Zip Code Telephone Number  
 From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

**US Military/Public Health Service**

List all medical and surgical locations and dates.

From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Location Branch of Service  
 From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_  
 Location Branch of Service



**-Section 10 Continued-**

**SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS**

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____ - ____ - ____	____ - ____ - ____ - ____ - ____	____ - ____ - ____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____ - ____ - ____	____ - ____ - ____ - ____ - ____	____ - ____ - ____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

**BOARD QUALIFICATIONS**

\_\_\_ Yes \_\_\_ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

\_\_\_ Yes \_\_\_ No Are you planning to take the exam?

\_\_\_ Yes \_\_\_ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Written \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Other \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Subspecialty or Added Qualification	Name of Board
Date Qualified ____ - ____ - ____ - ____ - ____	Date Qualification Expires ____ - ____ - ____ - ____ - ____

Classifications:

\_\_\_ Yes \_\_\_ No Are you certified in CPR? Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Basic Life Support (BLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Advanced Cardiac Life Support (ACLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Health Care Provider (CoreC) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Advanced Trauma Life Support (ATLS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Neonatal Advanced Life Support (NALS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Pediatric Advanced Life Support (PALS) Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_ Yes \_\_\_ No Other \_\_\_\_\_ Expires \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## SECTION 11: OFFICE INFORMATION

### Primary Office

Group Name \_\_\_\_\_ Name As It Appears On Your W-9 (if applicable) \_\_\_\_\_ Business Owned By \_\_\_\_\_

Type of Practice:

Solo  Partnership  Single-Specialty Group  Multi-Specialty Group Other (specify) \_\_\_\_\_

Office Manager \_\_\_\_\_ Nurse Coordinator \_\_\_\_\_

Group Medicare Number \_\_\_\_\_ Group Medicaid Number \_\_\_\_\_ IRS Tax ID Number \_\_\_\_\_

Does this office have lab service?  Yes  No Reference Lab?  Yes  No On Site?  Yes  No

CLIA ID # \_\_\_\_\_ CLIA Waiver # \_\_\_\_\_

Does your office have the following:

- Yes  No Radiology
- Yes  No EKG
- Yes  No Audiology
- Yes  No Treadmill
- Yes  No Sigmoidoscopy
- Yes  No Wheelchair/handicapped access?
- Yes  No Other services for the disabled?

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

If yes, please list: \_\_\_\_\_

Yes  No Other: \_\_\_\_\_

Fluent Languages:

You \_\_\_\_\_

Your Staff \_\_\_\_\_

Other Resources \_\_\_\_\_

Yes  No Does this office meet all state and local fire, safety and sanitation requirements?

Yes  No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Yes  No Do you or your business own, operate, manage or participate in any medical enterprise or business?

If yes, explain on a separate attachment.

## SECTION 11: OFFICE INFORMATION

### Secondary Office

Group Name \_\_\_\_\_ Name As It Appears On Your W-9 (if applicable) \_\_\_\_\_ Business Owned By \_\_\_\_\_  
 Type of Practice:  
 Solo  Partnership  Single-Specialty Group  Multi-Specialty Group  Other (specify) \_\_\_\_\_

Office Manager \_\_\_\_\_ Nurse Coordinator \_\_\_\_\_

Group Medicare Number \_\_\_\_\_ Group Medicaid Number \_\_\_\_\_ IRS Tax ID Number \_\_\_\_\_  
 Does this office have lab service?  Yes  No Reference Lab?  Yes  No On Site?  Yes  No

CLIA ID # \_\_\_\_\_ CLIA Waiver # \_\_\_\_\_

Does your office have the following:

- Yes  No Radiology
- Yes  No EKG
- Yes  No Audiology
- Yes  No Treadmill
- Yes  No Sigmoidoscopy
- Yes  No Wheelchair/handicapped access?
- Yes  No Other services for the disabled?

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

If yes, please list: \_\_\_\_\_

Yes  No Other: \_\_\_\_\_

Fluent Languages:

You \_\_\_\_\_

Your Staff \_\_\_\_\_

Other Resources \_\_\_\_\_

Yes  No Does this office meet all state and local fire, safety and sanitation requirements?

Yes  No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Yes  No Do you or your business own, operate, manage or participate in any medical enterprise or business?

If yes, explain on a separate attachment.

## SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

<u>Attached</u>	<u>Item</u>
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

## SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:**

**Practitioners are reminded that each organization will require submission of additional information.**

## SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

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