IOWA STATEWIDE
UNIVERSAL PRACTITIONER
CREDENTIALING APPLICATION

NAME: _____
Last Name **First Name** **Middle Name** **Title**

- **Type or print responses in ink.**
- **Complete this form in its entirety and attach all requested documentation and explanations.**
- **A CV or "See CV" may not be used in lieu of completing any answers on this application.**
- **If a question does not apply to you, answer with "Non-Applicable" or "N/A".**
- **If additional space is necessary to provide answers, attach additional sheet(s) of paper.**
- **All dates must be formatted as: Month/Date/Year (MM/DD/YEAR) Type/print "present" in Ending Date year for current status of activity, if applicable.**

THIS APPLICATION MUST BE SIGNED AND DATED WHERE INDICATED

POSITION/RANK: _____ **ANTICIPATED START DATE:** _____
(Professor, Assist. Professor; if applicable)

PRIMARY PRACTICE SPECIALTY: _____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

SECONDARY PRACTICE SPECIALTY(IES): _____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

_____ **BOARD CERTIFIED:** ☐ **YES** ☐ **NO**

PERSON/ENTITY TO CONTACT REGARDING THIS APPLICATION:

NAME: _____

ENTITY/GROUP AFFILIATION: _____

ADDRESS: _____

_____

CITY, STATE, ZIP: _____

PHONE NUMBER: (_____)_____ **FAX NUMBER:** (_____)_____

E-MAIL: _____

SECTION A: DEMOGRAPHIC INFORMATION

_____
Legal Last Name First Middle Professional Title/Degree

_____
Preferred Last Name First Middle Professional Title/Degree

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

_____Effective from: _____/_____/_____ to: _____/_____/_____
(Last, First, Middle)

_____Effective from: _____/_____/_____ to: _____/_____/_____
(Last, First, Middle)

SSN: _____ Birth Date: _____/_____/_____

For Directory purposes - Gender: Male ☐ Female ☐

Place of Birth:

_____
City County State Country

Are you a US Citizen? ☐ Yes ☐ No

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

Visa Type: _____ Visa Number: _____

Current Home Address: _____

_____

City: _____ State: _____ Zip Code: _____

(_____)_____ (_____)_____ _____
Phone Number Cell Phone Number E-Mail Address

New Home Address: _____ Effective Date: _____/_____/_____

_____

City: _____ State: _____ Zip Code: _____

(_____)_____ (_____)_____ _____
Phone Number Cell Phone Number E-Mail Address

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

In case of an emergency, contact: _____
Full Name Relationship

_____ (_____)_____
Address (Street, City, State, Zip) Phone Number

SECTION B: OFFICE/PRACTICE SITE INFORMATION

Answer the following questions on pages 3-5, specific to you and the practice site listed below. Indicate if this ***site*** is the primary or additional site by marking the appropriate box. **Pages 3-5 should be duplicated and completed for every site at which you provide services.**

☐ **PRIMARY** ☐ **ADDITIONAL/SATELLITE**

Practice Location Name:_____

Address:_____

_____

City: _____ State: _____ Zip Code: _____

Main Office Phone Number: (_____)_____ Scheduling Phone Number: (_____)_____

Main Office Fax: (_____)_____ Emergency/After-hours Number: (_____)_____

Reports/test results Phone: (_____)_____ Reports/Results Fax: (_____)_____

Your Campus/In-house Address: (If applicable):_____

If different than above, provide your specific: Phone Number: (_____)_____ Fax Number: (_____)_____

Your E-mail Address: _____

Beginning practice date at this location: _____/_____/_____

Practice arrangement (Please check all that apply):

☐ Solo ☐ Specialty Group ☐ Multi-Specialty Group ☐ Employee ☐ Resident ☐ Fellow ☐ Fellow Associate
☐ Partner/Associate ☐ Locum Tenens - Start date: _____/_____/_____ End date: _____/_____/_____

List *your* office hours (hours available to see patients):

	Sun	***Mon***	***Tues***	***Wed***	***Thurs***	***Fri***	***Sat***
Open							
Close							

Describe your coverage arrangements (24x7):

_____

_____

List the name(s) of all provider back-ups:

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Supervising/Collaborative Physician for non-physician applicant:

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

SECTION B: OFFICE/PRACTICE SITE INFORMATION - continued

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

For the following questions check those boxes that apply to you at the *practice location identified on page 3*. (If you have more than one directory listing, photocopy and complete this section for each listing and/or each location):

Directory Listing/Specialty: _____

Check all that apply: ☐ Primary Care Provider (PCP) ☐ Co-Care Manager ☐ Specialist
☐ Both PCP & Specialist ☐ PCP Back-up Only ☐ Specialist serving as a Back-up

Are you (the applicant practitioner) accepting new patients? Yes ☐ No ☐

Special languages spoken/translated by you: _____

Identify your specific practice limitations on patients (age, gender, payer, scope of practice) if any:

_____

_____

Office handicapped accessible? Yes ☐ No ☐
Office accessible via public transportation? Yes ☐ No ☐
Services available for hearing impaired? Yes ☐ No ☐

Estimated waiting time in days for appointments: Non-Urgent/Elective _____ days Urgent _____ days.

Provide billing and registration numbers (if applicable). These may be individual or group/clinic numbers:

Type	***Group Number***	***Individual Number***
Federal Tax Identification Number:		
Medicare Number:		
Medicaid Number:		
Wellmark BCBS Number:		
Delta Dental Number:		
CLIA Certificate Number:		N/A
UPIN Number	N/A	
NPI Number		

Does this practice location bill under a group number listed above? ☐ Yes ☐ No
Does this practice location use a group Tax ID number listed above? ☐ Yes ☐ No
Does this practice location have the capability to submit claims electronically? ☐ Yes ☐ No

Billing Contact and Account/Billing Address if different than the practice location address identified on Page 3:

Full Name: _____

Make Checks Payable to: _____

Address: _____ Phone Number: (_____)_____

_____ Fax Number: (_____)_____

City: _____ State: _____ Zip Code: _____

E-Mail: _____

SECTION B: OFFICE/PRACTICE SITE INFORMATION – continued

Answers to the questions on this page apply to the practice location identified on Page 3. This page should be duplicated and completed for every site at which you provide services.

Office Manager:

Last Name: _____ First Name: _____

Address: _____ Phone Number: (_____)_____

_____ E-mail: _____

City: _____ State: _____ Zip Code: _____

Nurse Coordinator:

Last Name: _____ First Name: _____

Address: _____ Phone Number: (_____)_____

_____ E-mail: _____

City: _____ State: _____ Zip Code: _____

Credentialing/Privileging Contact:

Last Name: _____ First Name: _____

Address: _____ Phone Number: (_____)_____

_____ E-mail: _____

City: _____ State: _____ Zip Code: _____

List all MD, DO, DDS, DPM, DC, and OD practitioners at this location (attach additional sheets if necessary):

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

List all other licensed practitioners at this location (PA, ARNP, CRNA, PhD, LISW, etc.) (attach additional sheets if necessary):

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

Name: _____Title: _____ License #_____

SECTION C: LICENSURE INFORMATION

State licensing examination(s) taken/used: ☐ Flex ☐ USMLE ☐ Reciprocity ☐ Other: _____

ECFMG Information: Certification Number: _____ Certification Date: _____/_____/_____

Provide all license information, **both current and expired** (copy and include additional sheets if necessary):

Professional License #	*Degree*	*Name on License*	*State Issued*	*Country*	*Issue Date*	*Expiration Date*

Do you hold a current DEA registration number? Yes ☐ No ☐ If No, explain: _____

_____

Do you hold a current State Controlled Substance Certificate (SCSC)? Yes ☐ No ☐ If No, explain: _____

_____

DEA and SCSC numbers and expiration dates:

Certificate	*State Issued*	*Certificate Number*	*Issue Date*	*Expiration Date*
Federal DEA				
Federal DEA				
State CSC				
State CSC				

SECTION D: MALPRACTICE LIABILITY COVERAGE

By signing and dating this application you are attesting to the current malpractice coverage identified below.

Current Carrier: _____

Address: _____ Agent Name: _____

_____ Phone Number: (_____)_____

City: _____ State: _____ Zip Code: _____

Policy Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____

Current Carrier: _____

Address: _____ Agent Name: _____

_____ Phone Number: (_____)_____

City: _____ State: _____ Zip Code: _____

Policy Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____

List any privileges or procedures which are excluded or restricted under your current policy: _____

_____

_____

_____

Previous Carrier: _____

Address: _____ Agent Name: _____

_____ Phone Number: (_____)_____

City: _____ State: _____ Zip Code: _____

Policy Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____

Previous Carrier: _____

Address: _____ Agent Name: _____

_____ Phone Number: (_____)_____

City: _____ State: _____ Zip Code: _____

Policy Number: _____

Coverage Amounts: $_____/Occurrence $_____/Aggregate

Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____

SECTION E: HOSPITAL AND FACILITY PRIVILEGES

List all hospitals and facilities at which you have held, have pending or currently hold privileges and describe the type(s) of privileges, (do not include privileges during internship, residency or training) (copy and include additional sheets if necessary):

Hospital/Facility Name: ______________________________

Address:______________________________

____

City: ______________ State: __________ Zip Code: _________ Email: ______________

Phone Number: (________)____________ Fax Number: (________)____________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: ______________________ Date From: ______/_______/________ To: _______/_______/_______

Hospital/Facility Name: ______________________________

Address:______________________________

____

City: ______________ State: __________ Zip Code: _________ Email: ______________

Phone Number: (________)____________ Fax Number: (________)____________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: ______________________ Date From: ______/_______/________ To: _______/_______/_______

Hospital/Facility Name: ______________________________

Address:______________________________

____

City: ______________ State: __________ Zip Code: _________ Email: ______________

Phone Number: (________)____________ Fax Number: (________)____________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: ______________________ Date From: ______/_______/________ To: _______/_______/_______

Hospital/Facility Name: ______________________________

Address:______________________________

____

City: ______________ State: __________ Zip Code: _________ Email: ______________

Phone Number: (________)____________ Fax Number: (________)____________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: ______________________ Date From: ______/_______/________ To: _______/_______/_______

Hospital/Facility Name: ______________________________

Address:______________________________

____

City: ______________ State: __________ Zip Code: _________ Email: ______________

Phone Number: (________)____________ Fax Number: (________)____________

☐ Active ☐ Admitting ☐ Courtesy ☐ Consulting ☐ Provisional ☐ Full Clinical ☐ Temporary ☐ Pending

☐ Other: ______________________ Date From: ______/_______/________ To: _______/_______/_______

SECTION F: CERTIFICATION

Please give the following information for each certification you have completed, or are eligible to complete (see below) (copy and include additional sheets if necessary):

☐ **NOT APPLICABLE**

☐ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________________ Board Sub-specialty: ______________________________

Issuing Entity Address (City and State): ______________________________

Phone Number: (________)____________________ Fax Number: (________)____________________

Certificate Number: ______________________________ Original Certification Date: _______/_______/_______

Expiration Date: _______/_______/_______ Recertification Date(s): _______/_______/_______, _______/_______/_______

☐ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________________ Board Sub-specialty: ______________________________

Issuing Entity Address (City and State): ______________________________

Phone Number: (________)____________________ Fax Number: (________)____________________

Certificate Number: ______________________________ Original Certification Date: _______/_______/_______

Expiration Date: _______/_______/_______ Recertification Date(s): _______/_______/_______, _______/_______/_______

☐ **CERTIFICATION:**

Board Name/Certificate Type/Issued By: ______________________________

Board Specialty: ______________________________ Board Sub-specialty: ______________________________

Issuing Entity Address (City and State): ______________________________

Phone Number: (________)____________________ Fax Number: (________)____________________

Certificate Number: ______________________________ Original Certification Date: _______/_______/_______

Expiration Date: _______/_______/_______ Recertification Date(s): _______/_______/_______, _______/_______/_______

☐ **ELIGIBLE/ADMISSABLE FOR CERTIFICATION** (Attach letter confirming admissibility):

Board Name/Certificate Type: ______________________________

Written Examination: Completed _______/_______/_______ Scheduled _______/_______/_______

Oral Examination: Completed _______/_______/_______ Scheduled _______/_______/_______

Admissibility Dates: From _______/_______/_______ to _______/_______/_______

SECTION G: EDUCATION

Check the appropriate box and complete the following information for each level of education completed (copy and include additional sheets if necessary):

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

Institution Name:____

Address:____

____

City: ______________________ State/Country: ____________________ Zip Code: ____________

Dates Attended: Beginning Date: _______/________/________ Ending Date: _______/________/________

Degree Received: ______________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: (________)______________ Fax Number: (________)______________ Email: ____________________

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

Institution Name:____

Address:____

____

City: ______________________ State/Country: ____________________ Zip Code: ____________

Dates Attended: Beginning Date: _______/________/________ Ending Date: _______/________/________

Degree Received: ______________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: (________)______________ Fax Number: (________)______________ Email: ____________________

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

Institution Name:____

Address:____

____

City: ______________________ State/Country: ____________________ Zip Code: ____________

Dates Attended: Beginning Date: _______/________/________ Ending Date: _______/________/________

Degree Received: ______________ Area of Study/Major: ____________________ Year Graduated: ________

Phone Number: (________)______________ Fax Number: (________)______________ Email: ____________________

Explain any gaps in education: ____

____

____

____

SECTION H: TRAINING

Give the following information for each training program completed (copy and include additional sheets if necessary):

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

Institution Name: ____

Address: ____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____

Type/Specialty: ____________________ Year Completed: ________ If not completed, please explain below.

Program Supervisor/Director Name: ____

Phone Number: (______)__________ Fax Number: (______)__________ Email: ____________________

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

Institution Name: ____

Address: ____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____

Type/Specialty: ____________________ Year Completed: ________ If not completed, please explain below.

Program Supervisor/Director Name: ____

Phone Number: (______)__________ Fax Number: (______)__________ Email: ____________________

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

Institution Name: ____

Address: ____

____

City: ____________________ State/Country: ____________________ Zip Code: __________

Dates Attended: Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____

Type/Specialty: ____________________ Year Completed: ________ If not completed, please explain below.

Program Supervisor/Director Name: ____

Phone Number: (______)__________ Fax Number: (______)__________ Email: ____________________

Explain any incomplete training, any gaps in training, or any gaps between education and training: ____________________

____

____

SECTION I: PROFESSIONAL HISTORY

List <u>all</u> professional career experience and mark appropriate box for ***type*** (include additional sheet(s) if necessary), beginning with current professional activity. **Be sure to explain any chronological gaps below (if applicable).**

<u>Type</u>: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ______________________________

Position: ______________________________

Address: ______________________________

____

City: ____________ State: ____________ Zip Code: ____________

Phone Number: (________)____________ Fax Number: (________)____________

Beginning Date: ________/________/________ Ending Date: ________/________/________

<u>Type</u>: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ______________________________

Position: ______________________________

Address: ______________________________

____

City: ____________ State: ____________ Zip Code: ____________

Phone Number: (________)____________ Fax Number: (________)____________

Beginning Date: ________/________/________ Ending Date: ________/________/________

<u>Type</u>: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: ______________________________

Position: ______________________________

Address: ______________________________

____

City: ____________ State: ____________ Zip Code: ____________

Phone Number: (________)____________ Fax Number: (________)____________

Beginning Date: ________/________/________ Ending Date: ________/________/________

***<u>Explain any gaps in professional history</u>*:** ______________________________

____

____

____

____

SECTION J: PROFESSIONAL REFERENCES

Give **four** professional peer references that have personal knowledge of your recent clinical abilities, ethics, health status and can provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional ability. Do not include family or fellow students. Suggested peer references are: professors, practitioners in the same specialty, or department chairs.

Name: ____ Title: __________________________________

Address: ____

____

City: ______________________________ State: _____________________ Zip Code: ____________

Position: ____ Phone Number: (_______)______________

E-mail: ____ Fax Number: (_______)______________

Name: ____ Title: __________________________________

Address: ____

____

City: ______________________________ State: _____________________ Zip Code: ____________

Position: ____ Phone Number: (_______)______________

E-mail: ____ Fax Number: (_______)______________

Name: ____ Title: __________________________________

Address: ____

____

City: ______________________________ State: _____________________ Zip Code: ____________

Position: ____ Phone Number: (_______)______________

E-mail: ____ Fax Number: (_______)______________

Name: ____ Title: __________________________________

Address: ____

____

City: ______________________________ State: _____________________ Zip Code: ____________

Position: ____ Phone Number: (_______)______________

E-mail: ____ Fax Number: (_______)______________

Please be sure to carefully read and answer each question below, and explain *any* "yes" answers on page 15.
*** Note - A special form is attached for Malpractice Claim History on Addendum C ➔➔**

SECTION K: QUALITY FOCUSED QUESTIONS

1.	Have you ever voluntarily or involuntarily surrendered or relinquished a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification?……..	☐ YES ☐ NO
2.	Have you ever voluntarily or involuntarily had a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification revoked, suspended, limited, denied or refused by an Iowa licensing, state or federal drug administration, certifying board, or by such an entity in any other state(s)?……..	☐ YES ☐ NO
3.	Have there been any previously successful or are there any currently pending challenges, complaint(s), sanction(s), disciplinary actions(s), investigations or denials recommended or taken against your state, district or federal professional license(s), registrations (DEA or State Controlled Substance Certificate), board certification or any other certification(s)?……	☐ YES ☐ NO
4.	Have you ever voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?……	☐ YES ☐ NO
5.	Have you ever voluntarily or involuntarily withdrawn a request for an increase in privileges?……	☐ YES ☐ NO
6.	Have you ever been refused membership on a clinical, medical, dental or professional staff (other than for a general closure of that staff to providers of your specialty)?…….	☐ YES ☐ NO
7.	Have you ever had a hospital, health care facility, or other health care organization invoke probation, issue a reprimand, impose proctoring (other than proctoring when privileges are initially granted), require a second opinion or initiate an investigation of your professional conduct or competency?……	☐ YES ☐ NO
8.	Are you currently performing or do you plan to perform any procedures for which you have ever been refused or lost privileges?……..	☐ YES ☐ NO
9.	Have you ever been the subject of a formal or public citation or warning or ever had a sanction of any kind imposed by any health care institution, health care organization, licensing authority or other governmental entity, or voluntarily or involuntarily resigned under threat of the same?.....	☐ YES ☐ NO
10.	Have your employment, medical staff appointment/membership, or clinical privileges ever been challenged or voluntarily or involuntarily suspended, reduced, revoked, refused (denied), relinquished, terminated, limited or lost at any hospital, healthcare plan or other healthcare facility or organization?…….	☐ YES ☐ NO
11.	Have you ever been convicted of any crime related to your clinical, medical, dental or professional practice?	☐ YES ☐ NO
12.	Regarding Medicare, Medicaid, or any other governmental health-related programs, have you ever been convicted of a crime or been subjected to civil penalties, disciplinary proceedings, investigations, denial of or suspension from participation, or had any type of sanction?…….	☐ YES ☐ NO
13.	Do you have any felony, grand jury indictment, or other criminal charges pending?……	☐ YES ☐ NO
14.	Have you ever been convicted of, found guilty of or pled no contest to a felony, grand jury indictment or crime, other than a minor traffic violation?……	☐ YES ☐ NO
15.	Do you presently have a physical, mental or emotional condition (including alcohol or drug dependence) that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients?……..	☐ YES ☐ NO
16.	Has your malpractice insurance ever been denied, suspended, limited, not renewed or terminated by a carrier?…….	☐ YES ☐ NO

SECTION K: QUALITY FOCUSED QUESTIONS…continued…

17. Have you ever had a malpractice case filed against you? (If yes, explain on Addendum C)…….…… ☐ YES ☐ NO

18. Have you ever had a malpractice judgment entered against you? (If yes, explain on Addendum C)……. ☐ YES ☐ NO

19. Have any malpractice settlements ever been made on your behalf? (If yes, explain on Addendum C)……. ☐ YES ☐ NO

20. Are there any open claims or pending malpractice cases presently filed against you? (If yes, explain on Addendum C)…….. ☐ YES ☐ NO

21. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank?…… ☐ YES ☐ NO

22. Have you ever been denied membership in or voluntarily or involuntarily been terminated by any professional organization?…….. ☐ YES ☐ NO

23. Have you ever had any sanctions or disciplinary action executed against you by a Professional Standards Review Organization (PSRO), utilization or quality control Peer Review Organization (PRO), or any professional organization?…….. ☐ YES ☐ NO

24. Has your participation in a managed care plan or healthcare organization been limited, denied, or terminated, or have you been sanctioned by such an organization?…… ☐ YES ☐ NO

For any "YES" answers to the Quality Focused Questions above, please provide detailed explanation here, with the exception of any Malpractice Claim History (for Malpractice Claim History provide detailed information on Addendum C).

Question #	Detailed Explanation

If there is additional information about you or your practice that you feel will have a bearing on the consideration of this application, please provide details (attach an additional page if needed):

_____

_____

_____

_____

_____

TO AVOID DELAY IN THE PROCESSING OF THIS APPLICATION
PLEASE BE SURE TO SIGN AND DATE FOR CERTIFICATION / ATTESTATION / and RELEASE BELOW AND ANY ADDENDUMS (if applicable).

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application;
- You may correct any erroneous information found in your credentialing files; and
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted.
- Upon request, you will be informed about the status of your credentialing application.

I represent and warrant that all of the information provided and the responses given on this application are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of information could result in the rejection or termination of my participation in any plan, staff or panel, in addition to penalties provided by law. I hereby authorize the hospital, CVO, credentialing entity or managed care plan, or its delegated agents, staff and representatives to collect and review all records and documents, which may include records of previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank and Criminal Background Check investigations, that may be material to an evaluation of my professional qualifications and competence. I also understand that certain fields of data on this application contain time-sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize the entity to which this application is submitted, to collect from me and other sources this information on an as-needed basis, and understand and agree they may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application. I hereby release from liability the entity to which this application is submitted and their delegated agents, staff and representatives for their acts performed without malice in connection with the evaluation of my application and my credentials and qualifications. It is my understanding that the entity to which this application is submitted shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, my designated entity, or as authorized under state or federal law or regulation, and, I further release from any liability any and all individuals and organizations who provide information to the entity reviewing my credentials, and its agents, staff and representatives, in good faith and without malice, concerning my professional qualifications, competence, ethics and character, and I hereby consent to the release of such information. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

If making this application for hospital privileges, I acknowledge that I have been provided the Bylaws, Rules and Regulations of the hospital to which this application applies, and I agree to abide by them and the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for staff membership. I also pledge to provide or arrange for continuous care of my patients.

Practitioner Signature: _____ **Date:** _____/_____/_____

Practitioner Name (please type or print): _____

Practitioner Initials: _____

PRACTITIONER ACKNOWLEDGEMENT STATEMENT

MEDICARE / MEDICAID / CHAMPUS (TRI-CARE)

Medicare/Medicaid and Champus (TriCare) payment to hospitals is based on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending practitioners by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment or civil penalty under applicable Federal laws.

_____

Name (Please Print)

_____

Practitioner's Legal Signature

_____

Practitioner's signature as written on medical records

_____

Practitioner's initials

_____

Date

This statement must be signed, dated and returned with your completed application.

Medicare/Medicaid and Champus (Tri-Care) payment applies to all hospitals.

ALTERNATE COVERAGE- FOR HOSPITAL OR FACILITY APPLICANTS ONLY

Please list **TWO** alternate practitioners who have privileges at the hospital or facility to which you are applying. The alternates must be in the same department / section and have like privileges to cover for you in your absence**. If you are unable to list two alternates, please contact the medical staff office of the appropriate facility if further instructions are needed.**

Hospital/Facility	Alternate #1	Alternate #2
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MALPRACTICE CLAIM HISTORY FORM

Practitioner Name: _____

If you have any professional malpractice activity to report on this application, complete this page for each professional liability incident (copy and include additional sheets if necessary).

Description of allegation or action taken: _____

_____

Date of incident: _____/_____/_____ Date of claim or suit filed: _____/_____/_____

Location of incident: _____

Insurance carrier name: _____

Insurance carrier address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Describe your involvement with the patient's care. Your narrative must include the following at a minimum:

1) Condition and diagnosis at time of incident
2) Dates and description of treatment rendered
3) Condition of patient subsequent to treatment

_____

_____

_____

_____

_____

Your Status: ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify) _____

Claim Status: ☐ Open ☐ Pending ☐ Closed

If closed, indicate the date closed and case outcome: Date Closed: _____/_____/_____

☐ Dismissed with prejudice ☐ Settled with Prejudice ☐ Judgment for Defendant

☐ Dismissed without prejudice ☐ Settled without Prejudice ☐ Judgment for Plaintiff

Amount of settlement or judgment paid on your behalf (if any): $_____

Date of payment: _____/_____/_____

I certify that the information in this document is correct and complete to the best of knowledge:

_____ _____

Practitioner's Signature Date

MERCY MEDICAL CENTER – DM
MERCY E-ICU CONNECT
CRITICAL CARE TELEMEDICINE SERVICES

PHYSICIAN DELEGATION – LEVEL OF CARE

Critical Care Telemedicine is provided for adult critical care patients @ MMC – DM, 24-hours day/7-days week, from a centralized command center. The e-ICU area is staffed by critical care physicians and experienced nurses to provide an additional level of safety, clinical monitoring, and prompt response to changes in patient conditions. The monitoring does not replace the role of the attending or consultant physician. The e-ICU utilizes approved critical care policies and evidence based protocols if not addressed by the primary service.

Policies & Evidence Based Protocols: will be utilized for: DVT prophylaxis, ACS, AMI, UGI bleeding prophylaxis, Prevention of Ventilator associated Pneumonia, therapeutic levels of aminoglycosides, digoxin, procainamide, vancomycin, heparin, coumadin and others, maintenance of electrolytes, and adequate/appropriate sedation/analgesia.

Urgent/Life Threatening Conditions Defined: Urgent conditions include cardiac/respiratory arrest, life threatening arrhythmias, prolonged hypoxemia/hypercarbia, significant hypertension/ hypotension, major neuro changes, unplanned intubation.

I request the e-ICU connect service to assist in the care of my patients as indicated by category selection:

☐ **Category I**

The e-ICU physician contacts the primary service for all medical conditions warranting attention and intervenes, only for urgent/life threatening situations. The e-ICU staff will contact the primary service for further orders, management.

☐ **Category II**

The e-ICU physician implements the care plan of the primary service, utilizes evidence based protocols, intervenes and manages urgent/life threatening situations and contacts the primary service/resident as soon as possible after stabilization of the patient.

Category II is the default category for those that do not make selection.

Physician Name (Please Print)	Signature	Date

cc: e-ICU Center

Mercy Medical Center-Des Moines
Confidentiality Agreement

Mercy Medical Center recognizes the importance of protecting confidential information concerning individuals including patients and residents, their families, medical staff and employees as well as organizational materials involving the operations of **Mercy Medical Center**. It is the obligation of each employee, student, volunteer, medical and professional staff member, independent contractor, contractor, vendor, etc., to maintain the confidentiality of this information in the manner described in this Agreement.

Mercy Medical Center, which includes Mercy Centerville, places a high priority on maintaining the confidentiality of its protected health and non-public hospital information. **Mercy Medical Center** computer systems allow individuals to access restricted or confidential individual and facility information. To access that information, **Mercy Medical Center** will issue user identification and secured private passwords to authorized individuals. It is the authorized individual's ethical and legal responsibility to maintain and comply with all confidentiality requirements.

In the course of your duties for **Mercy Medical Center**, you may be given access to protected health information about patients, clients, residents, employees, medical and professional staff, students or other independent contractors and individuals. In addition, you may also be privy to **Mercy Medical Center** information that is, but is not limited to, information concerning employees, intellectual property, non-public financial contracts, materials of a competitive nature, and policies, business practices, payroll and benefits information, billing and personnel records, and technical information such as ideas and inventions (whether this information belongs to **Mercy Medical Center** or was shared with us in confidence by a third party) and of which may be received from any source and in any form (i.e. paper, magnetic or optical media, oral conversations, film, etc.) The value and sensitivity of any of the above-described information is protected by law and by the policies of **Mercy Medical Center** and is hereafter referred to as "protected health information" and/or "confidential information".

As a condition of continued employment or affiliation with **Mercy Medical Center**, and to obtain access to any of the above described protected health and/or confidential information, you agree to execute this Agreement thereby acknowledging that your access to such information is for the purpose of performing your responsibilities within **Mercy Medical Center**, and for no other purpose and further, you agree to the following:

1. I will look at and use only the protected health and confidential information I need to care for and treat my patients, clients, residents or other individuals, if applicable, or to perform my job. I will not look at protected health information or seek other confidential information that I do not need to perform my job. I understand that **Mercy Medical Center** has the ability to determine whether I have followed this or any other obligation of this Agreement and will periodically monitor my compliance.

2. I understand that protected health information or any other confidential information is not to be shared with anyone who does not require the information to perform his or her job functions. I will be especially careful not to share this information with others in casual conversation.

3. I will handle all confidential information and protected health information in any medium, including but not limited to paper and electronic, with care to prevent unauthorized use or disclosure of protected health information or other confidential information. I understand that I am not permitted to remove any of this material from my work area. I also understand that I may not copy or remove it from any individual floors, departments or units of **Mercy Medical Center**.

4. Because electronic messages may be intercepted by other people, I will not use e-mail to send protected health information or any other confidential information unless authorized by the individual and **Mercy Medical Center**.

5. If I no longer need confidential or protected health information, I will dispose of it in accordance with the policies of **Mercy Medical Center**, if applicable, or in a manner that ensures that others without authorized access will not see it. I recognize that the appropriate disposal method will depend upon the type of information in question.

6. If I am conducting research, any research utilizing confidential information and/or protected health information will be performed in accordance with Federal and State regulations and with **Mercy Medical Center** Institutional Review Committee (IRC) policies.

7. If my responsibilities include sharing protected health information or **Mercy Medical Center's** confidential information with outside parties including, but not limited to ambulance drivers, contractors, consultants, home care providers, insurance companies, or research sponsors, I will use only processes and procedures approved by **Mercy Medical Center**.

8. All passwords, verification codes, or electronic signature codes assigned to me are equivalent to my personal signature:

    - They are intended for my use only.
    - I will not share them with anyone or let anyone use them.
    - I will not attempt to learn or use the passwords, verification codes, or electronic signature codes of others.
    - I am responsible and accountable for all entries made and retrievals accessed using such passwords or codes regardless of an intentional or negligent act or omission by me.
    - I will not use them after my employment or affiliation with **Mercy Medical Center** ends.

9. If I find that someone else has been using my passwords, electronic signatures, or other codes assigned, or if I learn that someone else is using passwords, electronic signatures or codes improperly, I will immediately notify my manager or the **Mercy Medical Center** Privacy Officer at 643-4557.

10. I will not abuse my rights to access and use **Mercy Medical Center's** computers, information systems, Intranet, or the Internet. They are intended to be used specifically in performing my assigned job responsibilities.

11. I will not copy or download software that is not approved by Mercy Medical Center.

12. I will handle all protected health information or confidential information stored on a computer or downloaded to diskettes or CDs with care to prevent unauthorized access to, disclosure of, or loss of this information.

13. I understand that the protected health information or confidential information and software I use for my job are not to be used for personal benefit or to benefit another unauthorized user/entity. I also understand that **Mercy Medical Center** may inspect the computer it owns to ensure that its data and software are used according to its policies and procedures.

14. I understand and agree to abide by the obligations of this Confidentiality Agreement and **Mercy Medical Center's** Policies and Procedures related to Privacy, Information Security/Information Technology and Confidentiality. If I do not follow these requirements, I understand that I may be subject to disciplinary action, up to and including loss of privileges, being dismissed from my position, and/or termination of contract or affiliation with **Mercy Medical Center**.

15. I understand that the obligations of this Confidentiality Agreement will survive the termination of expiration of my employment or affiliation with Mercy Medical Center. In the event of any breach of this Agreement, **Mercy Medical Center** shall be entitled to recover monetary damages or injunction or any and all other remedies available.

By my signature below I am indicating that I have read, understand, and agree to adhere to the conditions of this Confidentiality Agreement for continued employment or affiliation with **Mercy Medical Center**.

Name (print) _____

Signature _____

Date: _____

Corporate Responsibility Notice Regarding Excluded / Non Excluded Providers Participation in Federally Funded Health Care Programs/ to Medical Staff Members/Independent Health Care Practitioners

Medicare providers may not claim reimbursement for any items or services (other than certain emergency services) furnished, ordered, or prescribed by an individual or entity excluded from participation in any federally funded health care program, including Medicare or Medicaid. Medicare providers, are also prohibited from entering into contracts or other arrangements with persons or entities that have been excluded from a federal health care program, including the Medicare or Medicaid programs. Medicare providers that violate these prohibitions may themselves be excluded from federally funded health care programs, and/or subject to civil money penalties.

The healthcare entity(ies) that you are applying for privileges is(are) a Medicare provider(s). Consequently, if the entity requires all members and Allied Health Professionals or Prospective Applicants to sign and return the Certification of Non-Exclusion From a Federally Funded Health Care Program.

CERTIFICATION REGARDING NON-EXCLUSION / EXCLUSION FROM A FEDERALLY FUNDED HEALTH CARE PROGRAM

Please check the boxes that apply:

☐ I hereby certify that I am not currently excluded from any federally funded health care program, including Medicare and Medicaid, and I am not aware of any potential exclusion from those programs.

☐ I am currently being investigated in a matter that could lead to exclusion from participating in federally funded health care programs, including Medicare or Medicaid. I here by agree to immediately provide further information to the applicable healthcare entity upon notification of the outcome of the investigation.

☐ I have previously been excluded from participating in a federally funded health care program, including Medicare and Medicaid and have been reinstated or am in the process of reinstatement.

☐ I hereby certify that I am not currently excluded from any federally funded health care program, including Medicare and Medicaid, but was previously excluded from the following program(s) and have been reinstated or am in the process of reinstatement:

☐ Medicare ☐ Medicaid ☐ Other federally funded health care program(s): _____

Date of exclusion:_____

of reinstatement: _____

☐ I hereby further agree to provide a detailed description of the matter involving my exclusion from the above federal program.

I am currently excluded from:
☐Medicare ☐ Medicaid ☐Other federally funded health care program(s): _____

Date(s) of exclusion: _____
Date of reinstatement: _____

I hereby agree to provide a detailed description of the matter involving my exclusion from the above federal program.

Signature _____ Date _____

Printed Name _____

Return this form with other documents required for processing your request for appointment and/or reappointment to CredentiaSource. S:/cred/cred/cvo/excluded & non-excluded form.doc/7-01

APPLICATION FOR INITIAL AND REAPPOINTMENT
IMMUNIZATION ATTESTATION

It is required by most facilities to have established requirements for verification of immunization status for all physicians and independent licensed practitioners requesting membership and/or clinical privileges at each facility. The following requirements are consistent with federal, state and local regulations:

Please check applicable statements in each section.

PPD Tuberculin Skin Test (Mantoux)

☐ I attest my last PPD test was ___/___/_____ (Date) and was ☐ Negative ☐ Positive.
☐ I attest to the fact that I have a history of positive PPD tests and subsequent evaluation showed a negative chest x-ray. I understand if I have an active case of TB I may not see or treat patients until treated.

Measles/Mumps/Rubella-MMR

☐ I was born prior to January 1, 1957; can attest to having had measles and mumps; can show proof of Rubella immunity by serology test.
☐ I was born after January 1, 1957; can attest to having received the required two doses of MMR vaccine.
☐ I have not received the required vaccine.

Varicella Immunity

☐ I attest I have had the disease.
☐ I attest I have received the vaccination.
☐ I attest lab testing has verified immunity.
☐ I cannot provide verification of immunity.

Hepatitis B

☐ I attest to the fact I have previously received the Hepatitis B immunization series.
☐ I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be and continue to be at risk for acquiring Hepatitis B infection.

Signature: _____

Print Name: _____

Date: _____

NOTE: Please return form with the application for initial appointment and reappointment.

Mercy
MEDICAL CENTER
DES MOINES
A member of Mercy Health Network

1111 – 6th Avenue
Des Moines, Iowa 50314
515-247-3121

STARK FINANCIAL RELATIONSHIP DISCLOSURE

In 2004, the Federal Government issued the second phase of its regulations related to the Stark law, commonly known as the physician self-referral law. One requirement of this law is that Mercy maintain an accurate record of all financial relationships that Mercy has with medical staff physicians and their family members. Additionally, Mercy tracks all financial arrangements that the medical staff (and their immediate family) have with outside organizations such as vendors, suppliers, or competing facilities. These relationships could create conflicts of interest when physicians are involved in Mercy decision making. In order to maintain an accurate record, please complete this disclosure form and return it with your credentialing information.

DEFINITIONS

Financial Relationship: An exchange of anything of value between you (or immediate family member) and Mercy, a vendor, supplier of competing facility. Financial relationships can involve compensation, investment, or ownership.

Mercy: Mercy Medical Center, Mercy West Lakes, Iowa Kidney Stone Center, Mercy River Hills Surgery Center, West Lakes Surgery Center, Heart Partners, Mercy Behavioral Services, Mercy College, Mercy Centerville, Mercy Clinics, Mercy Professional Practice Associates, Bishop Drumm, House of Mercy, or any other Mercy owned or partially owned organization.

Immediate Family Member: Spouse, parent, step-parent, child, step-child, sibling, step-sibling, father in law, mother in law, son in law, daughter in law, grandparent, grandchild, spouse of grandparent, spouse or grandchild.

1. Are you employed by Mercy? ☐ Yes ☐ No

2. Are there any other financial relationships between you (or your family members) and Mercy? (include Mercy – family employment relationships)
   ☐ Yes ☐ No

   Description: _____

3. Do you, a family member, or your physician group have any financial relationships with suppliers, pharmaceutical companies, durable medical equipment suppliers, or other vendors (including ownership or investment interests, loans, and other compensation arrangements)?
   ☐ Yes ☐ No

   Description: _____

4. Are you the member of the board of directors or shareholders or do you have any ownership or other interest in or relationship with entities that provide health care services (e.g., ambulatory surgery centers or physician practices). NOTE – Does not include < 1% stock ownership in publicly traded company.
   ☐ Yes ☐ No

   Description: _____

* Notify Medical Staff Services if there are changes in the information you have provided.

NAME: _____ Signature: _____ Date: _____
(Print)

PRACTICE GROUP NAME: _____

cc: Mercy Administration