OREGON PRACTITIONER CREDENTIALING APPLICATION



- APPLICATION
- PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)
- GLOSSARY OF TERMS AND ACRONYMS

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

INSTRUCTIONS

This form should be typed (using a different font than the form) or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.
- Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.
- Please sign and date page 11, Attestation Questions and page 12, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable).
- Each page of the application requires the applicant's initials and the date on which the application was last reviewed.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of the documents requested each time the application is submitted.
- If a section does not apply to you, please check the provided box at the top of the section.
- Mail application to the requesting organization(s).

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

| I am applying to (please list: Hospital S | Staff, HMO, IPA | k): | | |
|--|--------------------------------|-------------------------|--------------------|----------------|
| for: (i.e., staf | f membership, netv | work participation | ı, if applicable). | |
| *Note: Please return completed which you are applying not to t | d application he State of O | to the health regon. | care related o | rganization to |
| Oregon Practitioner Credentialing Application 5/1/12 | Page 1 of 12 | INITIALS: | DATE: | |

OREGON PRACTITIONER CREDENTIALING APPLICATION

| Is there arey other name under which you have been known or have used since starting professional training? Yes No [V] No [V] | Last Name (include suffix; Jr., Sr., III): | First: | | Middle: O | | Degree(s): |
|--|--|--------------------------|-----------------------|--------------|---|--|
| Home Telephone Number Mobile/Alternate Num | Is there any other name under which you hav | e been known or have use | | | ing? Yes [| |
| Email Address: | ranic(s) and I car(s) Used: | | | | | |
| State | | | | | | - World Mornate (Valid) |
| Birth Date: Month / Day / Year Birth Date: Month / Day / Year Los Angeles, CA | | | L. | email Addr | ess: | |
| Birth Date: Month / Day / Year | Portland | State: OR | | | ZIP: 97221 | AND THE STATE OF T |
| Second Security Number: Gender: Male Female | Country: USA | Birth Date: Mor | nth / Day / Year | | Birth Place: | > A |
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| Do you want to be designated as a primary care practitioner (PCP)? Yes No | | MATION | This inform | ation may | he included in | directory listings |
| Administration Teaching Clinical Practice: Other Professional Activities: Full Time | incipal clinical specialty (For most current tp://www.wpc-edi.com/codes): | specialties list, see: | Do you want to b | e designate | ed as a primary car | re practitioner (PCP)? |
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| Clinical Practice: Other Professional Activities: Administration | ategory of professional activity, check al | boxes that apply: | | | · · · · · · · · · · · · · · · · · · · | |
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Page 2 of 12

INITIALS: ____DATE: ___

| Examples include | ER CERTIFICE: ACLS, BLS, ATLS, | | A Fluoroscop | v Padiogram | ertificate(s), if | иррисивіе. |
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| VI. PRA | CTICE INFOR | RMATION | | | and the second second second second | |
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| | | | | | 05/199 | |
| City: Portland | Count | y: | | State: | <u> </u> | ZIP: |
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| E00 . 000 | | Pager Number: | | | Office Em | nail Addracci |
| 503) 299-4485 | Ext and Address (if differen | () | | | Office En | aail Address: |
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| VII. PRACTICE | CALL COVERAGE | provide care for | the name and spec r vour patients wh | en you are unavailable. |
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| 2. Stapher Omney | | , | | |
| 3. 4 10 10 | | | | |
| 4. | C |) | | |
| 5. Street | | | | |
| VIII. UNDERGRA | DUATE EDUCATION | ON P | Please attach addit | ional sheets, if necessary. |
| Complete School Name: | | Degree Received: BA | | Month / Year of Graduation: |
| City: | | State: PA | Course of Stud | |
| X. GRADUATE | | lease attach additiona | al sheets, if | Does Not Apply 🗸 |
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INITIALS: _____DATE: ____

| | sheets, if necessary. | | | Does Not Apply |
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| Complete Institution Name and Street Ad Cambridge Hospital | | | | |
| City: Cambridge | | State: MA | | ZIP: |
| Type of Internship / Specialty: Internal Medicine - Primary Care | | Phone Number: | | Fax Number, if available |
| From Month / Year: | To Month / Year: | | Month / Year of | Completion: |
| Did you complete the program? Yes | ✓ No 🗆 | (If you did not com | plete the program, plea | se explain on a separate sheet.) |
| XII. RESIDENCIES | Please attach ac | lditional sheets, if ne | ecessary. | Does Not Apply |
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| ID NUMBERS | CENSURE, REGISTRATION Please attach additional sheets, if nec | | 25 4 |
|--|--|--------------------|------------------|
| Oregon License or Registration Number: | Type: Physician | Month / Day / Year | of Expiration: |
| Drug Enforcement Administration (DEA) R | egistration Number (if applicable): | Month / Day / Year | of Expiration: |
| Controlled Substance Registration (CSR) Nu | mber (if applicable): | Month / Day / Year | of Issue: |
| Individual NPI Number: | Medicare Number: | DMAP Number: | |
| XV. OTHER STATE HE & CERTIFICATES | ALTH CARE LICENSES, RE Please include all ever held. | EGISTRATIONS | Does Not Apply 🗸 |
| State / Country: | Number: | Type: | |
| Year Obtained: | Month / Day / Year of Expiration: | Year Relinquished: | |
| State / Country: Year Obtained: | Number: Month / Day / Year of Expiration: | Type: | |
| Year Obtained: Reason: | Month / Day / Year of Expiration: | Year Relinquished: | |
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Oregon Practitioner Credentialing Application 5/1/12

Please attach additional sheets, if necessary.

Page 6 of 12 INITIALS: _____DATE: ____

HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History. **CURRENT AFFILIATIONS** Does Not Apply Facility Name: Phone Number: (503 2) 16-2189 Fax Number, if available Complete Address: Providence St. Vincent Hospital (503) 215-8499 9205 SW Barnes Rd. Status (e.g. active, courtesy, provisional, Month / Day / Year of Appointment Portland, OR 97225 allied health, etc.): Active 04/21/1997 Facility Name: Phone Number: Fax Number, if available Complete Address: Legacy Portland Hospitals (503) 4134145 (503) 413-4132 2801 N. Gantenbein Status: Month / Day / Year of Appointment Portland, OR 97227 Courtesy 09/17/1997 Facility Name: Phone Number: Fax Number, if available Complete Address: Status: Month / Day / Year of Appointment Facility Name: Phone Number: Fax Number, if available Complete Address: Status: Month / Day / Year of Appointment If you do not have hospital admitting privileges, check here: Please explain on a separate sheet your plan for continuity of care for your patients who require admitting. APPLICATIONS IN PROCESS Does Not Apply [Facility Name: Phone Number: Fax Number, if available Complete Address: Status (e.g. active, courtesy, provisional, Month / Day / Year of Submission: allied health, etc.): Facility Name: Phone Number: Fax Number, if available Complete Address: Status: Month / Day / Year of Submission: C. PREVIOUS AFFILIATIONS Please attach additional sheets, if necessary. Does Not Apply / Facility Name: Phone Number: Fax Number, if available Complete Address: From Month / Day / Year: To Month / Day / Year: Reason for Leaving: Facility Name: Phone Number: Fax Number, if available Complete Address: From Month / Day / Year: To Month / Day / Year: Reason for Leaving: Facility Name: Phone Number: Fax Number, if available Complete Address: From Month / Day / Year: To Month / Day / Year: Reason for Leaving:

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| A Please account | for all periods of time from | n the data of entry into multiple | Does Not Apply |
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| including militar sheets, if necessa | y service. Please explain in sec | practice history activities since com tion B any gaps greater than two (2) | |
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| Name of Previous Practice / Empl | oyer: | Physicians Insurance A Mutu Contact's Name: | lal Company |
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| В. | dates where applicab | le. Please attach additio | months. Include activities and onal sheets, if necessary. | vi names and | Does Not Apply |
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| VIII. | . PEER REFEI | RENCES | | A CONTRACTOR OF THE CONTRACTOR | |
| lease lis | st three (3) references. | from neers who throw | gh recent observations are dir | AT | |
| | | clude relatives. If possit | gn recent observations are dir ble, include at least one membe | ectly familiar with r from the Madica | your clinical skills a |
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| Ple | ase list activities for wh | ich vou have received CM | IE credit(s) during the past two | (2) vears | Does Not Apply |
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| Per claim limit of liability: | Aggregate amount: | |) 1 | |
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| Please list all previous profes attach additional sheets, if ne | sional liability carriers wi | thin the past five (5 |) years. Please | Door Not Apply [7] |
| Insurance Carrier / Provider of Profes | sional Liability Coverage: | Policy Number: | | Does Not Apply 🕢 |
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| Name of Local Contact: | | Mailing Address: | Claims | -Made Occurrence |
| Contact's Telephone Number: | Fax Number: | | | |
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| 2 | XI. ATTESTATION QUESTIONS — This section to be completed by the Primore Modification to the wording or format of these Attestation Questions will invalidate the | actition e | er. tion |
|--------------------------------------|---|--|------------------------------------|
| P: ar | lease answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet. | please prov | ide details |
| A . | Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review? | YES [| NO 🕟 |
| В. | Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review? | YES 🗆 | NO 🔽 |
| C. | Have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review? | YES 🗌 | NO 🔽 |
| D. | Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review? | YES [| NO 🔽 |
| Е. | Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization's final action? | YES 🗆 | NO 🔽 |
| F. | Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review? | YES 🗌 | NO 🗾 |
| G | Have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs? | YES 🗌 | NO 🔽 |
| Н | Have you ever had board certification revoked? | YES 🗌 | ио 🔽 |
| I | Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity? | YES 🗌 | NO 🔽 |
| J. | Have you ever been charged with a criminal violation (felony or misdemeanor)? | YES 🗌 | ио 🔼 |
| K. | Do you presently use any illegal drugs? | YES 🗆 | № 🔽 |
| L | Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? | YES [| ио 🔽 |
| ,, | If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet. | | |
| М | Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance? | YES 🗌 | № 🗹 |
| N. | Have any professional liability claims or lawsuits ever been closed and/or filed against you? | YES [] | NO 🗹 |
| | If yes, please complete Attachment A, Professional Liability Action Detail, for each past or current claim and/or lawsuit. | ***** | |
| О. | Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance? | YES | NO 🗹 |
| | hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organi rred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, he on or other health delivery entity or system | zation (HMO alth care facu |)), dty |
| clinica and re below applic | fy the information in this entire application is complete, current, correct, and not misleading. I understand and acknowled attements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or tall privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation lease and any or all attachments has the same force and effect as the original. I have reviewed this information on the most and it continues to be true and complete. While this application is being processed, I agree to update the information original attornion of the most application is desired. | termination of on, the authori of recent date in inally provide | ization indicated ed in this |
| | e to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by eith lance with contract provisions. | er party, or in | 1 |
| Signa | Date: | ······································ | |
| | Oregon Practitioner Credentialing Application 5/1/12 Page 11 of 12 INITIALS: DATE: | | |

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

- 1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system] indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
- 2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
- 3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
- 4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
- 5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
- 6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as 1 am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
- 7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
- 8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
- 9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

| Signature: | | Date: |
|---------------|---|---------------------------------------|
| B per mission | n for the release of the credentials information contain to the following health care related organiza | ined in this practitioner application |
| AUG | acted health Plans to which I apply in th | |

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

| Oregon Practitioner Credentialing Application 5/1/12 | Page 12 of 12 | INITIALS: | DATE | |
|--|---------------|-----------|------|--|
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ATTACHMENT A

| PROFESSIONAL LIABILITY ACTION DETAIL - <u>CON</u> | FIDENTIAL |
|---|--|
| Please list any past or current professional liability claim or lawsuit, whi Photocopy this page as needed and submit a separate page for EACl claim/lawsuit. It is not acceptable to simply submit court documents in l Please complete each field. Please attach additional sheet(s), if necessary | ch has been filed against you. H professional liability |
| Practitioner's Name (print or type): | |
| Month / Day / Year of the incident: and clinical details: | |
| N/A | |
| | |
| | |
| Your role and specific rosponsibility is districted | |
| Your role and specific responsibilities in the incident: | |
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| | |
| Subsequent events, including patient's clinical outcome: | |
| 8 paramout outcome. | |
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| | |
| Month / Day / Year the suit or claim was filed: | |
| Name and address of insurance carrier/professional liability provider that h | andled the claim. |
| 1 Provider that is | landicu me clam. |
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| Your status in the legal action (primary defendant, co-defendant, other): | |
| Current status of suit or other action: | |
| Month / Day / Year of settlement, judgment, or dismissal: | |
| If case was settled out-of-court, or with a judgment, settlement amount attri | buted to you: |
| I verify the information contained in this form is correct and complete | |
| Signature: | Date: |
| Modification to the wording or format of the Oregon Practitioner Crodentialing April | |

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.