INITIAL PROVIDER APPLICATION

Name: ____

Last First Middle

Primary Specialty: ____

Secondary Specialty: ____

Previous / Maiden Name: ____

CATEGORY:

Full Time

Part Time

TYPE OF PROVIDER:

MD PA
DO NP
Other:

LOCATION(S):

PRIMARY LOCAITON: ____

SECONDARY LOCATION: ____

OTHER: ____

SSN: ____________________ Date of Birth: ____________________ M F

Home Phone: ____________________ Mobile Phone: ____________________

Home Address: ____________________ City/State: ____________________ Zip: __________

Birth City: ____________ Birth State / Country: ____________ Country of Citizenship: ____________

Email Address: ____

ACP OFFICE USE ONLY:

Application Mailed: ____________________ Application Returned: ____________________

Reviewed by: ____________________ Application Complete: ____________________

Emergency Contact Person: ____________________Phone #: ____________________

Languages spoken **(other than English)**: ____

LICENSURE AND CERTIFICAITONS:

License #: ________________________Year of License: _________ Expiration Date: _________ State of License: _______________

License #: ________________________Year of License: _________ Expiration Date: _________ State of License: _______________

CAQH #: __________________________ CAQH User Name: ____________________ CAQH Password: ___________________

DEA #: ____________________________________ NPI #: ____

Medicaid Provider Numbers:

Individual #: ____

Medicare Individual Provider Number(s):

Medicare Individual Provider #: ____

Are you Board Certified? Yes No Primary Specialty: ____

If **not Board Certified**, please explain____

When are you planning to take the Board exam? ____

Name of Board: ____

FORWARD ALL COPIES OF VALID LICENSURES, DEA, BOARD AND SPECIAL CERTIFICATES, ETC. TO THE CREDENTIALING DEPT.

DO NOT WRITE "SEE CV"

EDUCATION / TRAINING

UNDERGRADUATE COLLEGE / UNIVERSITY

Undergraduate School: ____

Address: ____

City: ____ State: ___________________ Zip: __________________________

Degree Earned: _______________________________ From MM/YYYY: _________________ To MM/YYYY: ___________________

Country: ____ **Completed Program? Yes No**

MEDICAL SCHOOL: ____________________ ECFMG #: __________

Address: ____________________

City: __________ State: __________ Zip: __________

Degree Earned: __________ From MM/YYYY: __________ To MM/YYYY: __________

Country: __________ **Completed Program? Yes No**

Other undergraduate degrees which you have earned (please include institution, degree and date earned)

INTERNSHIP OR FIRST YEAR OF POSTGRADUATE TRAINING:

Type: __________ From MM/YYYY: __________ To MM/YYYY: __________

Specialty: ____________________

Hospital: ____________________

Address: ____________________

City: __________ State: __________ Zip: __________

Country: __________ **Completed Program? Yes No**

2nd INTERNSHIP:

Type: __________ From MM/YYYY: __________ To MM/YYYY: __________

Specialty: ____________________

Hospital: ____________________

Address: ____________________

City: __________ State: __________ Zip: __________

Country: __________ **Completed Program? Yes No**

RESIDENCY 1:

Type: ______________________ From MM/YYYY: ____________ To MM/YYYY: ____________

Specialty: ____

Hospital: ____

Address: ____

City: ______________________ State: ______________ Zip: ____________

Country: ______________________ **Completed Program? Yes No**

RESIDENCY 2:

Type: ______________________ From MM/YYYY: ____________ To MM/YYYY: ____________

Specialty: ____

Hospital: ____

Address: ____

City: ______________________ State: ______________ Zip: ____________

Country: ______________________ **Completed Program? Yes No**

FELLOWSHIP:

Type: ______________________ From MM/YYYY: ____________ To MM/YYYY: ____________

Specialty: ____

Hospital: ____

Address: ____

City: ______________________ State: ______________ Zip: ____________

Country: ______________________ **Completed Program? Yes No**

If you have any answered "NO" for completion of a training program, please explain:

PROFESSIONAL REFERENCES:

Please provide FOUR (4) references. Two (2) must be from a **chief physician's and /or director of department** practicing in a field similar to the applicant. These individuals must have knowledge of your competency and be familiar with our professional experience, competence and ethical conduct. Professional references must have direct knowledge of your clinical work within the past (2) years. The Credentialing Office will request a written reference / evaluation from these individuals. **Peers cannot be family members.**

Name: ______________________________ Title: ______________________________

Organization / Company Name: ______________________________

Phone: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________

EMAIL ADDRESS: ______________________________

Name: ______________________________ Title: ______________________________

Organization / Company Name: ______________________________

Phone: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________

EMAIL ADDRESS: ______________________________

Name: ______________________________ Title: ______________________________

Organization / Company Name: ______________________________

Phone: ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________

EMAIL ADDRESS: ______________________________

Name: ______________________________ Title: ______________________________

Organization / Company Name: ______________________________

Phone: ______________________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

EMAIL ADDRESS: ____

HOSPITAL / AFFILIATIONS (DO NOT PLACE WORK HISTORY IN THIS SECTION

Do you currently have hospital privileges? Yes No

If not, do you use a hospitalist to admit for you? Yes No

1. HOSPITAL / FACILITY: ____

Department: ______________ Specialty: ______________ Staff Status / Type of Privileges: ______________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Phone: ______________________ Fax: ______________________

Start Date: ______________ End Date: ______________ Department Chair: ______________

Currently working at this facility? Yes No

2. HOSPITAL / FACILITY: ____

Department: ______________ Specialty: ______________ Staff Status / Type of Privileges: ______________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Phone: ______________________ Fax: ______________________

Start Date: ______________ End Date: ______________ Department Chair: ______________

Currently working at this facility? Yes No

3. HOSPITAL / FACILITY: ______________________________

Department: ____________ Specialty: ____________ Staff Status / Type of Privileges: ____________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________

Phone: ____________ Fax: ____________

Start Date: ____________ End Date: ____________ Department Chair: ____________

Currently working at this facility? Yes No

4. HOSPITAL / FACILITY: ______________________________

Department: ____________ Specialty: ____________ Staff Status / Type of Privileges: ____________

Address: ______________________________

City: ____________ State: ____________ Zip: ____________

Phone: ____________ Fax: ____________

Start Date: ____________ End Date: ____________ Department Chair: ____________

Currently working at this facility? Yes No

DO NOT WRITE "SEE CV"

Work History: Please provide your work history (chronological order) the employer's name, address, length of employment, and type of work. FEEL FREE TO MAKE ADDITIONAL COPIES OF THIS PAGE IF NECESSARY.

Practice / Employer Name: ______________________________

Address: ______________________________

City: ____________ State: ____________Zip: ____________

Phone: ____________ Fax: ____________

Start Date: ____________ End Date: ____________ Supervisor Name: ____________

Reason for Departure (if applicable)

Practice / Employer Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________Zip: ____________

Phone: ____________________ Fax: ____________________

Start Date: ________ End Date: ________ Supervisor Name: ____________________

Reason for Departure (if applicable)

Practice / Employer Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________Zip: ____________

Phone: ____________________ Fax: ____________________

Start Date: ________ End Date: ________ Supervisor Name: ____________________

Reason for Departure (if applicable)

Are you currently servicing in the MILITARY / RESERVE? Yes No

CURRENT PROFESSIONAL LIABILITY INSURANCE

Do you currently have professional liability insurance? Yes No

Do you have any additional liability insurance? Yes No

If yes please attach a copy of the insurance certificate to this application.

Malpractice Carrier Name: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

Policy #: ____________________Policy Type: CLAIMS MADE or OCCURRENCE

Dates of coverage (if not listed on certificate): From: ____________To: ____________

Dollar amount of coverage: $____________________ $____________________

With the exception of any carrier withdrawing from the market, has your malpractice insurance been limited, revoked or not renewed by any company, medical society or organization?

Yes No

If yes, give full details (or attach a separate sheet):

Address: ______________________________

Phone: ______________________ **Fax:** ______________________

Policy #: ______________________ **Policy Type:** CLAIMS MADE or OCCURRENCE

Dates of coverage (if not listed on certificate): From: ______________ To: ______________

Dollar amount of coverage: $______________________ $______________________

Malpractice Carrier Name: ______________________________

Address: ______________________________

Phone: ______________________ **Fax:** ______________________

Policy #: ______________________ **Policy Type:** CLAIMS MADE or OCCURRENCE

Dates of coverage (if not listed on certificate): From: ______________ To: ______________

Dollar amount of coverage: $______________________ $______________________

MANDATORY DISCLOUSRE QUESTIONS:

If you answer **yes** to any of the following questions, **you must provide a comprehensive statement that fully explains the circumstances.** The statement must include applicable dates, the identity of parties and the nature of the proceedings, its status and outcome.

***REQUIRED RESPONSE. THE LACK OF RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.**

LECENSURE

1. Has your license, registration or certificate to practice ever been voluntarily or involuntarily, relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? * — Yes No

2. Has there been any challenge to your license, registration or certification? * — Yes No

HOSPITAL PRIVILEGES AND OTHER AFFLIATIONS

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions? * — Yes No

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not applied for privileges? * — Yes No

5. Have you ever been terminated for cause or not renewed for cause from participation or been subject to any disciplinary action by any managed care organization (HMO, PPO, IPA's, PHO)? * — Yes No

EDUCATION, TRAIING, BOARD CERTIFICATION AND OTHER AFFILIATIONS

6. Were you ever placed on probation, disciplinary, formally reprimanded suspended or asked to resign during internship, residency, fellowship, preceptorship or other clinical education program? Also, answer if you are currently in a training program, have you been placed on probation, disciplined formally reprimanded suspended or asked to resign? * — Yes No

7. Have you ever while under investigation or to avoid an investigation voluntarily withdrawn your status as a student or employee in any program? — Yes No

8. Have any of your board certifications or eligibility ever been revoked? — Yes No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? — Yes No

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. Has your DEA / state narcotic registration ever been denied suspended, reduced or placed on probation or not renewed, or have you ever voluntarily relinquished your DEA / state narcotics registration? — Yes No

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program or in regard to other federal or state governmental healthcare plans or programs? Yes No

OTHER SANCTIONS OR INVESTIGATIONS

12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, function, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? Yes No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or healthcare Integrity and Protection Data Bank? Yes No

14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)? Yes No

15. Have you ever been convicted of, pled guilty to, or pled nolo contendere to, sanctioned reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? Yes No

16. Are you currently being investigated or have been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for investigation by a hospital or healthcare facility or any military agency? Yes No

OTHER SANCTIONS OR INVESTIGATIONS

17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? Yes No

18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? Yes No

MALPRACTICE CLAIMS HISTORY

19. Have you ever had any professional actions (pending arbitrated, mediated, litigated settled or dismissed)? If yes, provide information for each case. Yes No

CRIMINAL / CIVIL HISTORY

20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony and / or crime? * Yes No

21. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) of been found liable or responsible for any civil offense that is reasonably related to your qualification, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or sexual offense or sexual misconduct? * Yes No

22. Have you ever been court-martialed for any actions related to your duties as a medical professional? * Yes No

ABILITY TO PERFORM JOB

23. Are you currently engaged in the illegal use of drugs? Yes No
(“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough o indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled substance Act, 21 U.S.C. 812.22. It “does not include the use of a drug taken under supervision by a licensed heath care professional, or other uses authorized by Controlled Substances Act or other provision of Federal Law.” The term does not include, however, the unlawful use of prescription-controlled substances.)

24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? * And do you have any physician or mental limitations which might affect your ability to treat patients? Yes No

25. Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients? * Yes No

26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? * Yes No

Signature: ________________________________ **Date:** ______________________

RESPONSE TO QUESTIONS CHECKED "YES" Please provide your response(s) in this space. **Malpractice case response**

MALPRACTICE CLAIMS EXPLANATION

Date of Occurrence: ___________________________ **Date Claim was Filed:** ___________________________

Status of Claim (if case is pending, select open) **If closed, enter date:** ___________________________

Open **Close**

$______________________________ Method of Resolution Dismissed Settled

Amount of Award or Settlement Arbitration Mediation

Judgement for Defendant(s)

Judgement for the Plaintiff(s)

Professional Liability Carrier Involved:

Name: ____ Policy #: ____

Address: ____

Phone: ____

Description of allegations

Were you the Primary Defendant or Co-Defendant? **Primary Defendant** **Co-Defendant**

Explanation:

Did the alleged Injury result in death? Yes No

To the best of your knowledge, is the case included in the National Practitioner Data Bank? Yes No

Signature: ____ **Date:** ________________________________

RESPONSE TO QUESTIONS CHECKED "YES" Please provide your response(s) in this space. **Malpractice case response**

MALPRACTICE CLAIMS EXPLANATION

Date of Occurrence: ___________________________ **Date Claim was Filed:** ____________________________

Status of Claim (if case is pending, select open) **If closed, enter date:** ____________________________
Open **Close**

$______________________________ Method of Resolution Dismissed Settled
Amount of Award or Settlement Arbitration Mediation
Judgement for Defendant(s)
Judgement for the Plaintiff(s)

Professional Liability Carrier Involved:

Name: ____ Policy #: ____

Address: ____

Phone: ____

Description of allegations

Were you the Primary Defendant or Co-Defendant? **Primary Defendant** **Co-Defendant**

Explanation:

Did the alleged Injury result in death? Yes No
To the best of your knowledge, is the case included in the National Practitioner Data Bank? Yes No

Signature: ____ **Date:** ___________________________________

Provide Gap explanation (if applicable)

Provide an explanation if you have a gap for more than 3 months.

Signature: ____ Date: _______________________________

ATTESTATION AND DISCLOSURE

I agree to notify AZ Community Physicians in writing within five (5) days of receiving any written or oral notice of any adverse action, including without limitation, any filed and served malpractice suit or arbitration action; any adverse action by the State or out of State Medical Board taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public reprove, and any formal restriction, probation, suspension or revocation of licensure, any adverse action taken by any healthcare organization, which has resulted in a report to any state or out of State Medical Board, or a report with the National Practitioner Data Bank; any revocation of DEA, license; a conviction under the Medical or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

Signature: ____ Date: _____________________________

Standard Authorization, Attestation and Release

(Not for use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization Indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is Individually referred to as the "Entity"), and any of the Entity's affiliated entitles, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining Information and my consent to the release of Information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals Including, without limitation, the Entity, Its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents'), to Investigate Information, which Includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or Its Agent(s) to Inspect and copy all records and documents relating to such an Investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. t authorize any third party, Including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, Insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or Its Agent(s), information, including otherwise privileged or confidential Information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation In, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and Individuals who provide Information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release 'Disciplinary Information,' as defined below, to the Entity and/or Its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to Its participating Entitles at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information' means information concerning (I) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or Impose a corrective action plan; (II) any other disciplinary action Involving me, including, but not limited to, discipline In the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, Its Agent(s), and any other third party for their acts performed in good faith and with- out malice unless such acts are due to the gross negligence or willful misconduct of the Entity, Its Agent(s), or other third party In connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, Its Agent(s), and/or other third party Include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of Its affiliates or agents retains the right to allow access to the application Information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release Is Irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent If law or regulation limits the application of this Irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity In accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that Information obtained in accordance with the provisions of this Authorization, Attestation and Release Is not and will not be a violation of my privacy.

I certify that all information provided by me in my application Is current, true, correct, accurate and complete to the best of my knowledge and belief, and Is furnished in good faith. I will notify the Entity and/or Its Agent(s) within 10 days of any material changes to the Information (Including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that cancellation to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem It to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely Information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or Immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or Its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature: ________________________________ Print Name: ___________________________________

Date: ____