

Community Health Group Allied Health Professional Application

Nurse Practitioner
 Certified Nurse Midwife
 LCSW
 Clinical Psychologist
 MFCC
 Other _____

I. INSTRUCTIONS

This form should be typed 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. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State License(s) / Certificate(s)
- Face Sheet of Professional Liability Policy or Certification

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name(s):		Title:
Home Mailing Address	City:	
	State:	Zip:
Home Telephone Number: ())	E-Mail Address:	
Home Fax Number: ())	Pager Number: ())	
Birth Date:	Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).
Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Area of Practice:	Race/Ethnicity (voluntary):	
Areas of Interest:		
Contract type: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare <i>Check all that apply.</i>		

III. BILLING INFORMATION

Billing Company:		
Street Address:	City:	
	State:	Zip:
Contact:	Telephone Number: ())	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Medical Group(s) IPA(s) Affiliation:		

IV. PRACTICE INFORMATION

Practice Name (if applicable):		
Primary Office Street Address:	City:	
	State:	Zip:
Telephone Number: ())	Fax Number: ())	

IV. PRACTICE INFORMATION (CONT.....)

Office Manager/Administrator:	Telephone Number: ()
	Fax Number: ()

Name Affiliated with Tax ID Number:	Federal Tax ID Number:
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Site #2 Street Address:	City:	
	State:	Zip:

Office Manager/Administrator:	Telephone Number: ()
	Fax Number: ()

Name Affiliated with Tax ID Number:	Federal Tax ID Number:
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Site #3 Street Address:	City:	
	State:	Zip:

Office Manager Administrator	Telephone Number: ()
	Fax Number: ()

Name Affiliated with Tax ID Number:	Federal Tax ID Number:
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Other Interests in Practice, Research, etc.:

Has your office received any of the following accreditations, certifications or licensures?

California Department of Health Services Licensure

Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

Medicare Certification

The Medical Quality Commission (TMQC)

Other _____

OFFICE HOURS - Please indicate the hours your office is open:

Site	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays
1								
2								
3								

PATIENTS ACTIVE

Site	Medi-Cal	Commercial	Medicare	Total
1				
2				
3				

Please check all that apply:

Solo Practice Single Specialty Group Practice Multi Specialty

IV. PRACTICE INFORMATION (CONT.....)

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

If your practice limited to certain ages: Yes No
 If yes, specify limitations: _____

Do you participate in EDI (electronic data interchange)? Yes No
 Is so, which Network _____

Do you use a practice management system/software: Yes No
 If so, which one? _____

COVERAGE OF PRACTICE (List your answering service and covering providers by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ()	Fax Number: ()
Mailing Address:	City:	
	State:	Zip:
Covering Provider's Name	Telephone Number: ()	
Covering Provider's Name	Telephone Number: ()	
Covering Provider's Name	Telephone Number: ()	
Covering Provider's Name	Telephone Number: ()	

FOREIGN LANGUAGE SPOKEN

Fluently by Provider: _____ Fluently by Staff: _____

PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies which you are a member or applicant.

Organization Name	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

V. EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

UNDERGRADUATE EDUCATION

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	Zip:

V. EDUCATION (cont.....)

GRADUATE/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Graduate/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	Zip:
Graduate/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	Zip:

VI. LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State License/Certificate Number:	Issue Date:	Expiration Date:
Medicare UPIN:	National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:

VII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State:	Zip:
Per Claim Amount: \$	Aggregate Amount: \$	Expiration Date:

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:	Zip:	
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:	Zip:	
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:	Zip:	
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:	City:		
	State:	Zip:	

VIII. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ()	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number: ()	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number: ()	
Mailing Address:		City:	
		State:	Zip:

IX. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of graduate/professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. **Please explain any gaps in professional work history on a separate page.**

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	Zip:
From: (mm/yy)		To: (mm/yy)	
Name of Practice/Employer:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	Zip:
From: (mm/yy)		To: (mm/yy)	
Name of Practice/Employer:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	Zip:
From: (mm/yy)		To: (mm/yy)	

X. ATTESTATION QUESTIONS

Please answer the following questions Yes or No. If your answer to questions A through K is Yes or if your answer to L is No, please provide full details on separate sheet.

1. Has your license to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter or reprimand or is such action pending?
 Yes No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?
 Yes No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), professional association, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?
 Yes No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), professional association, or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?
 Yes No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any preceptorship or other clinical education program?
 Yes No
6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?
 Yes No
7. Have you been denied certification/recertification by a certification board, or has your eligibility, certification or recertification status changed?
 Yes No
8. Have you ever been convicted of any crime (other than a minor traffic violation)?
 Yes No
9. Do you presently use any drugs illegally?
 Yes No
10. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?
 Yes No
11. 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, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?
 Yes No
12. Are you able to perform all the services required by your agreement with 'CHG' with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?
 Yes No

I hereby affirm that the information submitted in this Section X. Attestation Questions and any addenda thereto are true, current, correct, and complete to the best of my knowledge and belief and are furnished in good faith. I understand that I will be notified of and given the opportunity to investigate, correct, or have others correct omissions or misrepresentations that may be discovered during the credentialing verification process.

Print Name Here _____

Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

You, the applicant, have a right to review information obtained by Community Health Group to support your credentialing application. You will be notified of any information that varies substantially from the information you personally provided. You will be given the opportunity to correct or have corrected any erroneous information obtained during the verification process.

XI. INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (Accrediting information®) by and between Community Health Group (CHG) and other Healthcare Organizations (e.g., medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, professional associations, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, Healthcare Organizations®), for the purpose of evaluating this application and any recertification application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including CHG, engaged in quality assessment, peer review and credentialing on behalf of CHG, and all persons and entities providing credentialing information to such representatives of CHG from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in CHG, to the extent that those acts and/or communications are protected by state or federal law.

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 doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify CHG immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice in California or (ii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify CHG in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the State of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that I will be notified of and given the opportunity to investigate, correct, or have others correct omissions or misrepresentations that may be discovered during the credentialing verification process. A photocopy of this document shall be as effective as original however; original signatures and current dates are required on pages 6 and 7.

Print Name Here _____

Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

Community Health Group Allied Health Professional Application

Addendum A Professional Liability Action Explanation

This Addendum is submitted to Community Health Group (CHG).

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum A prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	Zip:

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:

My office Other provider's office

Other, (please specify) _____

Your relationship to Patient: _____

Allegation: _____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? Yes No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization:

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name _____ Phone Number () _____

Name _____ Phone Number () _____

Community Health Group

Allied Health Professional Application

Addendum B

Supervising Physician Explanation

This Addendum is submitted to Community Health Group (CHG).

Please complete this form if by California law you are required to have a supervising physician.

SUPERVISING PHYSICIAN'S IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	Zip:
Speciality:	California Medical License #:	
Credentialed by CHG? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervising physician must be credentialed by CHG before the allied health professional can treat CHG members.	

Print Name Here _____

Signature _____ Date _____
(Stamped Signature Is Not Acceptable)