Minnesota Uniform Credentialing Application
Reappointment

Applicant Name *(as shown on your state license):*

Last	First	Middle	Suffix	Title

CREDENTIALING CONTACT INFORMATION

Name _____ **Phone Number** _____

Address _____ **Fax Number** _____

_____ **E-mail** _____

_____

Instructions

The reappointment application and attachments should be filled out completely and accurately and must be legible or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **ALL SIGNATURES AND DATES MUST BE CLEARLY LEGIBLE.**

Please verify that you have:

- ☐ Provided complete street address, phone, fax and e-mail addresses wherever indicated, including education/training, past employment, affiliations and references
- ☐ Designate dates by month, day and year time frames
- ☐ Answered all Disclosure Questions (Page 10)
- ☐ Signed and dated the Attestation Signature and Date statement (Page 10)
- ☐ If applicable, completed the Disclosure Explanation Form (Page 11) and enclosed supporting documentation
- ☐ Signed and dated the Authorization and Release (Page 13)

All Information Must Be Printed in Black Ink or Electronically Generated

Practitioner Name: _____
Last First Middle Suffix Title

Practitioner NPI: _____

Practitioner Race and Ethnicity

Supplemental Information Form

Race and/or ethnicity (for health plan use only):
The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Select all that apply:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (please specify):_____
- ☐ Prefer Not to Say

*Providing race and/or ethnicity information on the credentialing application is entirely optional and refusal to provide this information will **not** subject you to adverse treatment. This information will **not** be considered in making any decisions regarding your credentialing.*

If provided on the credentialing application, the health plan may utilize race and/or ethnicity information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories: ☐

Personal Data

Applicant Name *(as shown on your state license):*

_____
Last First Middle Suffix Title

All Former Aliases: _____ Spouse Name (optional): _____

Gender: ☐ M - Male ☐ F - Female ☐ X - Unspecified or Another Gender Identity ☐ U - Undisclosed

Date of Birth: _____ Social Security Number: _____ NPI: _____ CAQH ID: _____

Current Home Address: _____
Street

_____
City/State/Country Zip Code

Preferred Mailing Address: ☐ Office ☐ Home Practitioner's Preferred E-mail address: _____

Cell Phone Number: _____ Home Phone Number: _____

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? ☐ Yes ☐ No

If yes, specify languages: _____

Military - Are you currently on active military duty? ☐ Yes ☐ No

Primary Practice Location

Primary Practice Location/Clinic Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐ No

Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

Additional Practice Location(s) – *since last appointment* Applicant Name:

Other Practice Name: _____

Address: _____
Street City/State/Country Zip Code

Office Phone Number: _____ Fax: _____ E-mail: _____

Federal Tax ID: _____ Type II NPI: _____ Start Date (at this location): _____

Credentialing Contact: _____ Phone Number: _____

Practicing as (select all applicable): ☐ Primary Care ☐ Specialist ☐ Urgent Care ☐ Locum Tenens ☐ Hospitalist/Hospital-Based

☐ Moonlighting Resident ☐ Other: _____ *Services provided via (select all applicable):* ☐ Telehealth ☐ In-Person

Accepting New Patients: ☐ Yes ☐ No Directory Suppress: ☐ Yes ☐ No

Regularly sees patients here at least once per week: ☐ Yes ☐ No

Primary Specialty in which care will be provided: _____

Subspecialty(ies) in which care will be provided: _____

Fellowship/Post-Graduate/Professional Training – *since last appointment*

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Type of Program/Specialty: _____

Completed Training: ☐ Yes ☐ No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Professional and Academic/Faculty Affiliations - *since last appointment*

(Month, day, year required)

From: _____ Institution Name: _____

To: _____ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

If additional space is required, attach a separate sheet.

Chronological Employment/Practice History Applicant Name:

Additional space is provided on the Chronological Employment/Practice History Addendum, page 14.

Chronological listing of employment/practice history ***since your last appointment*.**
List ***all*** experience, including military service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. **LEAVE NO GAPS IN CHRONOLOGY**.

(Month, day, year required)

From: _____ Organization Name: _____

To: _____ Title/Position: _____

Reason for Leaving: _____

Employment Contact: _____ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Organization Name: _____

To: _____ Title/Position: _____

Reason for Leaving: _____

Employment Contact _____ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

From: _____ Organization Name: _____

To: _____ Title/Position: _____

Reason for Leaving: _____

Employment Contact: _____ Clinic Still Open? ☐ Yes ☐ No | If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ **Check here if you have additional employment history on attached Chronological Employment/Practice History Addendum (page 14)**

Time Gaps: Explain gaps/interruptions of greater than three (3) months to practice of medicine/professional practice **-** *since last appointment.*

(Month, day, year required)

From: _____ Explain: _____

To: _____ _____

From: _____ Explain: _____

To: _____ _____

☐ **Check here if you have additional time gap information on attached Chronological Employment/Practice History Addendum (page 14).**

Primary Hospital Affiliation **Applicant Name:**

Pertinent to Primary or Pending Practice Location listed on page 2.

If no hospital admitting privileges, describe method/coverage for continuity of care. Provide covering physician's name, if applicable.

(Month, day, year required)

From: _____ Facility Name: _____

To: _____ Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

Other Hospital and Ambulatory Surgery Center Affiliations - *Since last appointment*

Additional space is provided on the Hospital/ASC Affiliation Addendum, page 15.
(Month, day, year required)

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____ Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

From: _____ Facility Name: _____

To: _____ Former Facility Name (if applicable): _____ Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): _____

☐ Application Pending Department Chairperson: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box above)**

☐ **Check here if you have additional affiliations on attached Hospital/ASC Affiliation Addendum (page 15).**

Reappointment Application – 09/2001; Revised 04/2002; 04/2004, 01/2006, 07/2006, 01/2007, 08/2011, 10/2016, 4/2022, 11/2024

Additional space is provided on the Specialty and Licensure Addendum, page 16.

If not certified, *please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any.*

Primary Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Secondary Specialty

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Sub-specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

☐ **Check here if you have additional specialty on attached Specialty and Licensure Addendum (page 16)**

Licensure - List all past, current and pending professional licenses.

Additional space is provided on the Specialty and Licensure Addendum, page 16.

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending

☐ **Check here if you have additional licensure on attached Specialty and Licensure Addendum (page 16).**

Drug Enforcement Administration Registration

Applicant Name:

NOTE: Address on DEA certificate must be in state where you will be practicing as applicable to this application.

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain: _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain: _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain: _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

DEA Number: _____ State: _____ Expiration Date: _____

Approved for all schedules? ☐ Yes ☐ No, please explain _____

If you do not maintain a DEA certificate, please explain:

☐ Not applicable to practice ☐ DEA certificate pending; date application submitted to DEA: _____

☐ Other _____

State Controlled Substance Certification/Registration (If applicable - not applicable to MN, WI, ND).

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Issued By: _____ Number: _____ Expiration Date: _____

Life Support Certification

Do you have any current life support certifications (BLS, ACLS, ATLS, PALS, NRP, etc.): ☐ Yes ☐ No

If Yes: Type of Certification — Expiration Date(s)

_____ _____

_____ _____

_____ _____

_____ _____

Continuing Education Attestation

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CE credits to meet any applicable licensure requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by an individual facility based on their individual requirements.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature: _____ Date: _____

Name: _____
(please print or type)

Liability Insurance

Applicant Name:

Insurance Carrier for Primary Practice Location and all insurance history since last appointment.

Enclose a copy of professional liability insurance coverage (e.g., certificate of insurance, face sheet, or verification of self-insurance) for **primary practice location** to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered.

Coverage dates:
(Month, day, year required)

Start: _____ Current Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

☐ Certificate Pending Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Please list all insurance policies you have held since your last appointment. Specify dates of coverage for each policy.
Additional documentation of insurance coverage may be required. *If additional space is required, attach a separate sheet.*
For coverage provided by the Federal Tort Claims Act, attach a copy of the federal tort letter and provide applicable dates of coverage.

Coverage dates:
(Month, day, year required)

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Start: _____ Insurance Carrier Name: _____

Expire: _____ Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-mail address: _____

Name in which policy issued: _____

Policy number (if applicable): _____

Amount of coverage (per occurrence): _____

Amount of coverage (per aggregate): _____

Professional/Peer References

Applicant Name:

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A *peer* is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; DPM for DPM; PhD for PhD, etc.) **Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses, phone, fax, and e-mail. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Name: _____ Title: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

E-Mail Address: _____

Disclosure Questions for Recredentialing **Applicant Name:** _____

Please complete and sign this form, attesting to its accuracy. If ***any*** of the following questions are answered in the affirmative, provide an explanation by completing the **Disclosure Explanation Form** on the following page.

1. ☐ Yes ☐ No In the past three years, has your **professional license or registration** been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?

2. ☐ Yes ☐ No In the past three years, has your **professional license or registration** been investigated or is it currently being investigated? *If so, provide details to include the reason for the investigation and the results on the following page.*

3. ☐ Yes ☐ No In the past three years, has your **DEA registration** been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. ☐ Yes ☐ No In the past three years, has your **membership, participation, clinical privileges, or employment** been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

5. ☐ Yes ☐ No In the past three years, have you voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

6. ☐ Yes ☐ No In the past three years, have you involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?

7. ☐ Yes ☐ No In the past three years, has your **membership or fellowship** in any professional organization or your specialty **board certification** been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

8. ☐ Yes ☐ No In the past three years, have you been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

9. ☐ Yes ☐ No In the past three years, has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

10. ☐ Yes ☐ No Are there any charges pending or are you currently charged with or have you, in the past three years, pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?

11. ☐ Yes ☐ No In the past three years, have you been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in **sexual harassment, sexual misconduct**, stalking, or any other similar behavior or crime, or are you aware of any current allegations or charges pending of the same? *Allegations include, but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.*

12. ☐ Yes ☐ No In the past three years, have you ever had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?

13. ☐ Yes ☐ No In the past three years, has your **professional liability carrier** refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?

14. ☐ Yes ☐ No In the past three years, have you practiced within your profession without **professional liability insurance?**

15. ☐ Yes ☐ No Do you currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? *You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.*

16. ☐ Yes ☐ No Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Signature _____ Date _____

Name _____

CONFIDENTIAL INFORMATION

If you answered yes to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). *Make additional copies of this form if needed.*

Applicable Disclosure Question(s): _____ **Date of Occurrence:** _____

Location of Occurrence: *Facility (if applicable)* _____ **State:** _____

Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative.
*Do **not** include name of patient or any other information that may identify the patient.*

Describe outcome, as applicable. Note: If responding to disclosure question #12, skip this section and complete next section.

If you answered yes to Disclosure Question #12, complete the following section.

Describe Outcome of Claim or Lawsuit

Date Filed: _____

CONCLUDED WITH NO PAYMENTS: *(month/year)*

☐ Dropped/Closed Date:_____

☐ Verdict for you Date:_____

☐ Dismissed with prejudice* Date:_____

☐ Dismissed without prejudice** Date:_____

CONCLUDED WITH PAYMENTS: *(month/year)*

☐ Verdict for Plaintiff Date:_____ Amount $_____

☐ Settled Date:_____ Amount $_____

PENDING

☐ Filed, pending Date:_____

**Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim*

**Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim*

Represented by Legal Counsel for this lawsuit: ☐ Yes ☐ No - **If yes, provide name and address of counsel.**

Counsel Name _____ Phone _____

Address _____

Insurance company or employer that provided coverage for this claim.

Name _____ Policy# _____

Address _____ Phone _____

I hereby certify that all the information on this form is complete, true and accurate.

Applicant Signature_____ Date _____

Print Name_____ Phone_____

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by organizational policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

To check the status of your application, contact the applicable organization or go to the applicable organization's website.

The signature blocks below are to be signed ONLY if a previously completed application is being reviewed and updated.

The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Reappointment Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign only **one** of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note:
It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Update Attestation Signature and Date

I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature____ Date________________________

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Authorization and Release

Please read the below information carefully before signing.

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at _____ hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will 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 Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, 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 and authorize such third parties to release such information to the Entity and its Agents.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be 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 actions 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 are contemplated and/or in preparation.

3. **Release from Liability**. I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand that communication regarding my application may occur via email.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

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.

Signature _____ **Date** _____

Name _____

All signatures and dates must be clearly legible or signed with a unique electronic identifier.

Please make additional copies of this Addendum as necessary.

(Month, day, year required)

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________________

Clinic Still Open? ☐ Yes ☐ No

If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________________

Clinic Still Open? ☐ Yes ☐ No

If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

From: ______________ Organization Name: ______________________________

To: ______________ Title/Position: ______________________________

Reason for Leaving: ______________________________

Employment Contact ______________________

Clinic Still Open? ☐ Yes ☐ No

If no, attach sheet listing address and phone number of someone who can verify your time there.

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________ Fax Number: ______________

E-mail address: ______________________________

Time Gaps: Explain gaps/interruptions of greater than three (3) months before, during, or after medical/professional practice

(Month, day, year required)

From: ______________ Explain: ______________________________

To: ______________ ______________________________

From: ______________ Explain: ______________________________

To: ______________ ______________________________

From: ______________ Explain: ______________________________

To: ______________ ______________________________

Please make additional copies of this Addendum as necessary.

(Month, day, year required)

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 5)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 5)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 5)**

From: ______________ Current Facility Name: ______________________________

To: ______________ Former Facility Name (if applicable): ______________________________

Facility Still Open? ☐ Yes ☐ No

Type/category of privilege/affiliation (active, courtesy, etc.): ______________________________

☐ Application Pending Department Chairperson: ______________________________

Address: ______________________________
Street City/State/Country Zip Code

Phone Number: ______________________________ Fax Number: ______________________________

E-mail address: ______________________________

Admitting Privileges: ☐ Yes ☐ No **(If no, please complete box on page 5)**

Specialty and Licensure Addendum **Applicant Name:**

Please make additional copies of this Addendum as necessary.

Specialty/Subspecialty Certification

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

Additional Specialty

Board Name: _____

Board Specialty: _____

Certificate Number: _____ Original Certificate Date: _____

Expiration Date: _____ Certificate Pending ☐

State Licensure

License Type	State	License Number	Date Issued	Expiration Date	License Status
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
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					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending
					☐ Active ☐ Inactive ☐ Pending