The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for recredentialing only. Other forms are required for credentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as “Confidential Information” shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.
ATTACHMENTS

Attach forms A-F as needed to support “yes” responses in Section G: Professional History and copies of the following:

☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:
☐ All Current Professional Licenses
☐ Current Federal DEA License, If Applicable
☐ Current State Controlled Substance License(s), If Applicable
☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
☐ Current CLIA Certificate, If Applicable
☐ Current W-9s, If Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant’s Signature  Type or Print Name  Date

** PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM.**
SECTION A. GENERAL INFORMATION

Name: 

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

List other names by which you have been known: 

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

If you have been known by other names, please explain why your name changed:

Name:

Birth Date: (mm/dd/yy)

Sex: 
- [ ] Male
- [ ] Female

U.S. Citizen? 
- [ ] Yes
- [ ] No

If no, do you have a legal right to reside permanently and work in the U.S.? 
- [ ] Yes
- [ ] No

Resident Visa No: 

Social Security Number: 

Emergency Contact Person: 

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

Telephone Number: 

Mailing Address: 

| Street | City | State | Zip |

Daytime Phone: ( ) Fax Number: ( )

E-Mail Address: 

Check here if you have appended additional information for this section: [ ]

(Please continue next page)
SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: __________________________
License Unlimited?  Yes ☐  No ☐  If No, please explain limitation: __________________________

Current Professional License(s) in Other States
State: ______________________ License #: ______________________ Exp. Date: ___________ (mm/dd/yy)
License Unlimited?  Yes ☐  No ☐  If No, please explain limitation: __________________________

State: ______________________ License #: ______________________ Exp. Date: ___________ (mm/dd/yy)
License Unlimited?  Yes ☐  No ☐  If No, please explain limitation: __________________________

State: ______________________ License #: ______________________ Exp. Date: ___________ (mm/dd/yy)
License Unlimited?  Yes ☐  No ☐  If No, please explain limitation: __________________________

Check here if you have appended additional information for this section: ☐

Current Federal DEA License Number: ______________________ CONFIDENTIAL INFORMATION
DEA License Number Expiration Date: ______________________ License Unlimited?  Yes ☐  No ☐
If No, please explain limitation: __________________________

Check here if you have appended additional information for this section: ☐

Current State Controlled Substance Number(s):

State: ______________________ CS License #: ______________________ Expiration Date: ___________ (mm/dd/yy)
State: ______________________ CS License #: ______________________ Expiration Date: ___________ (mm/dd/yy)
State: ______________________ CS License #: ______________________ Expiration Date: ___________ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

________________________________________
Medicare Unique Provider ID# (UPIN): 
National Provider Identification Number (NPI): 
Medicaid ID#: 
X-Ray Certification: State: Certificate #: Expiration Date: (mm/dd/yy)

Check here if you have appended additional information for this section: 

<table>
<thead>
<tr>
<th>COMPLETE FOR EACH SPECIALTY</th>
</tr>
</thead>
</table>

### Specialty I:
Are you Board Certified in Specialty I? Yes [ ] No [x]
If Yes, name of Certifying Board: __________________________
Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes [ ] No [x]
If Certifying Boards taken, give date: Certification Expiration Date, if Any: (mm/yy) (mm/yy)
If not taken, date scheduled to take Specialty Boards: (mm/yy)

### Specialty/Subspecialty II:
Are you Board Certified in Specialty II? Yes [ ] No [x]
If Yes, name of Certifying Board: __________________________
Date of Certification: (mm/yy) Date of Recertification (if applicable): (mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes [ ] No [x]
If Certifying Boards taken, give date: Certification Expiration Date, if Any: (mm/yy) (mm/yy)
If not taken, date scheduled to take Specialty Boards: (mm/yy)

(Please continue next page)
Specialty/Subspecialty III:

Are you Board Certified in Specialty III?  Yes ☐  No ☐

If Yes, name of Certifying Board: ____________________________

Date of Certification: (mm/yy)  Date of Recertification (if applicable): (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification?  Yes ☐  No ☐

If Certifying Boards taken, give date: (mm/yy)  Certification Expiration Date, if Any: (mm/yy)

If not taken, date scheduled to take Specialty Boards: (mm/yy)

Specialty/Subspecialty IV:

Are you Board Certified in Specialty IV?  Yes ☐  No ☐

If Yes, name of Certifying Board: ____________________________

Date of Certification: (mm/yy)  Date of Recertification (if applicable): (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification?  Yes ☐  No ☐

If Certifying Boards taken, give date: (mm/yy)  Certification Expiration Date, if Any: (mm/yy)

If not taken, date scheduled to take Specialty Boards: (mm/yy)

Check here if you have appended additional information for this section: ☐

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: __________________________________________

Address:__________________________________________

Street  City  State  Zip

Policy Number:_________  Original Effective Date: (mm/dd/yy)  Expiration Date: (mm/dd/yy)

Policy Limits:  Per Occurrence: $_________  Aggregate: $_________

Retroactive Date: _________  (mm/dd/yy)

What type of coverage do you have?  ☐ Claims Made  ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?  ☐ Yes  ☐ No
MEMBERSHIP STATUS – USE FOR SECTIONS C AND D

Please use the following key to indicate membership status in Sections C (Hospital Membership – Current and Pending) and D (Ambulatory Surgery Center Practice) below.

<table>
<thead>
<tr>
<th>A. Active</th>
<th>E. Suspended / Terminated/ Resigned</th>
<th>I. Provisional</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Courtesy</td>
<td>F. Active Provisional Staff</td>
<td>J. Affiliate</td>
</tr>
<tr>
<td>C. Consulting</td>
<td>G. Senior Staff</td>
<td>K. Pending</td>
</tr>
<tr>
<td>D. Adjunct</td>
<td>H. Associate</td>
<td>L. Other (Specify)</td>
</tr>
</tbody>
</table>

SECTION C. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: ____________________________________________

Address:

Street ____________________________________________
City ____________________________________________
State ____________________________________________
Zip ____________________________________________

Membership Status: ____________________________ Dates: ____________ To Present

From (mm/yy) ____________________________

Department/Division: ____________________________

Medical Staff Office FAX #: ( ) ____________

Department Telephone #: ( ) ____________

Any Limitations in Your Area of Specialty at this Hospital? ____________________________

B. Other Hospital

Hospital Name: ____________________________________________

Address:

Street ____________________________________________
City ____________________________________________
State ____________________________________________
Zip ____________________________________________

Membership Status: ____________________________ Dates: ____________ To: ____________

From (mm/yy) ____________________________ To (mm/yy) ____________________________

Department/Division: ____________________________

Medical Staff Office FAX #: ( ) ____________

Department Telephone #: ( ) ____________

Any Limitations in Your Area of Specialty at this Hospital? ____________________________
C. Other Hospital

Hospital Name:______________________________________________________________

Address:____________________________________________________________________

Street
City
State
Zip

Membership Status:_________________________ Dates:_________________________

From (mm/yy)  To:__________________________

Department/Division:_________________________ Medical Staff Office FAX #: (   )

Department Telephone #: (   )

Any Limitations in Your Area of Specialty at this Hospital? ____________________________

Check here if you have appended additional information for this section: ☐

(Please continue next page)
Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 7. (Include additional sheets if more than three ambulatory surgery centers.)

<table>
<thead>
<tr>
<th>A. Primary Ambulatory Surgery Center</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC Name: __________________________</td>
<td></td>
</tr>
<tr>
<td>Address: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Street __________________ City __________________ State Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone: (<strong><strong>) Fax Number: (</strong></strong>)</td>
<td></td>
</tr>
<tr>
<td>Membership Status: __________________ Dates: __________________ From (mm/yy) To (mm/yy)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Other Ambulatory Surgery Center</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC Name: __________________________</td>
<td></td>
</tr>
<tr>
<td>Address: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Street __________________ City __________________ State Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone: (<strong><strong>) Fax Number: (</strong></strong>)</td>
<td></td>
</tr>
<tr>
<td>Membership Status: __________________ Dates: __________________ From (mm/yy) To (mm/yy)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Other Ambulatory Surgery Center</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC Name: __________________________</td>
<td></td>
</tr>
<tr>
<td>Address: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Street __________________ City __________________ State Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone: (<strong><strong>) Fax Number: (</strong></strong>)</td>
<td></td>
</tr>
<tr>
<td>Membership Status: __________________ Dates: __________________ From (mm/yy) To (mm/yy)</td>
<td></td>
</tr>
</tbody>
</table>

Check here if you have appended additional information for this section: ☐

(Please continue next page)
SECTION E. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service) in the last four (4) years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place:

Address: 
Street ___________________________________ City __________ State __________ Zip __________
Telephone: (____) __________ Fax Number: (____) __________
Title or Professional Occupation: ____________________________________________________________
Time in this employment: From: ______ to Present ______

Previous work place:

Address: 
Street ___________________________________ City __________ State __________ Zip __________
Telephone: (____) __________ Fax Number: (____) __________
Title or Professional Occupation: ____________________________________________________________
Time in this employment: From: ______ to ______

Previous work place:

Address: 
Street ___________________________________ City __________ State __________ Zip __________
Telephone: (____) __________ Fax Number: (____) __________
Title or Professional Occupation: ____________________________________________________________
Time in this employment: From: ______ to ______

Previous work place:

Address: 
Street ___________________________________ City __________ State __________ Zip __________
Telephone: (____) __________ Fax Number: (____) __________
Title or Professional Occupation: ____________________________________________________________
Time in this employment: From: ______ to ______

Previous work place:

Address: 
Street ___________________________________ City __________ State __________ Zip __________
Telephone: (____) __________ Fax Number: (____) __________
Title or Professional Occupation: ____________________________________________________________
Time in this employment: From: ______ to ______

Health Care Professionals Recredentialing & Business Data Gathering Form
Applicant Name:
### SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING UPDATE

Please provide an update of your medical education and clinical training over the past four years. Do not duplicate internship, residency, and fellowship information previously reported. *(Attach additional sheets if necessary.)*

#### FIRST UPDATE

- Fellowship
- Residency
- Other

Institution Name: ____________________________________________

Department Chair or Program Director:  

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

Mailing Address:  

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Telephone Number: ( )  

Fax Number: ( )  

Dates attended:  

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

Type of internship:  

- Rotating  
- Straight  

If straight, please list specialty: ____________________________________________

Did you successfully complete this program?  

- Yes  
- No  

If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  

- Yes  
- No  

(Attach an explanation of a “Yes” answer.)

#### SECOND UPDATE

- Fellowship
- Residency
- Other

Institution Name: ____________________________________________

Department Chair or Program Director:  

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
</table>

Mailing Address:  

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Telephone Number: ( )  

Fax Number: ( )  

Dates attended:  

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

Type of internship:  

- Rotating  
- Straight  

If straight, please list specialty: ____________________________________________

Did you successfully complete this program?  

- Yes  
- No  

If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution?  

- Yes  
- No  

(Attach an explanation of a “Yes” answer.)

Check here if you have appended additional information for this section:  

---

Health Care Professionals Recredentialing & Business Data Gathering Form  

Applicant Name:
SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a “yes” or “no.” If you answer “yes” to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each “yes” answer.

Please provide information on your professional history over the past four (4) years.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? □ Yes □ No

2. Have you been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? □ Yes □ No

3. Have you lost any board certification(s), and/or failed to recertify? □ Yes □ No

4. Have you been examined by a Certifying Board but failed to pass? □ Yes □ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? □ Yes □ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? □ Yes □ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? □ Yes □ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? □ Yes □ No

9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? □ Yes □ No

10. Have you been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? □ Yes □ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? □ Yes □ No
12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?

☐ Yes  ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?

☐ Yes  ☐ No

**PROFESSIONAL LIABILITY ACTIONS**

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you?

☐ Yes  ☐ No

2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?

☐ Yes  ☐ No

3. Are there any currently pending professional liability suits, actions and/or claims filed against you?

☐ Yes  ☐ No

4. Has any person or entity been sued for your clinical actions?

☐ Yes  ☐ No

**LIABILITY INSURANCE**

If you answer yes to this question please complete FORM C.

Have you been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?

☐ Yes  ☐ No

**CRIMINAL ACTIONS**

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?

☐ Yes  ☐ No

2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?

☐ Yes  ☐ No
MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?  
☐ Yes  ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances?  
☐ Yes  ☐ No

2. Do you currently overuse and/or abuse alcohol or any other controlled substances?  
☐ Yes  ☐ No

3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?  
☐ Yes  ☐ No  ☐ Not Applicable

4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?  
☐ Yes  ☐ No

INVESTMENTS

In the last five (4) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?  
☐ Yes  ☐ No

If Yes, please provide explanation: __________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

(Please continue next page)
Please provide the following information for the primary site at which you practice.

**Primary Site**

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City
County
State
Zip

(   )
Main Telephone Number

Office Administrator – Last
First
MI

(   )
Beeper Number

FAX Number

E-mail

(   )
Emergency Number

Answering Service

Are you currently accepting new patients at this location?    Yes  No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:  

Please provide the number of patient visits you have at this site per year:  

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

    Special Skills of Practitioner:  
    Special Skills of Staff:  
    Languages Spoken by Practitioner:  
    Languages Written by Practitioner:  
    Languages Spoken by Staff:  
    Languages Written by Staff:  

(Please continue next page)
Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty:</td>
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<td></td>
</tr>
<tr>
<td>Address:</td>
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</tr>
<tr>
<td>Telephone:</td>
<td>( )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Availability: Days Nights Weekends Holidays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONFIDENTIAL INFORMATION: Tax ID #:</td>
<td></td>
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</tbody>
</table>

(Please continue next page)
Please provide the following information for each additional site at which you practice.

<table>
<thead>
<tr>
<th>Site #</th>
<th>Group/Business Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Building Name</td>
</tr>
<tr>
<td></td>
<td>Office Address – Number and Street – Suite</td>
</tr>
<tr>
<td></td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>(    ) Main Telephone Number</td>
</tr>
<tr>
<td></td>
<td>(    ) Beeper Number</td>
</tr>
<tr>
<td></td>
<td>(    ) Emergency Number</td>
</tr>
</tbody>
</table>

Are you currently accepting new patients at this location?  ☐ Yes  ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site: __________

Please provide the number of patient visits you have at this site per year: __________

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

<table>
<thead>
<tr>
<th>Special Skills of Practitioner:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Skills of Staff:</td>
</tr>
<tr>
<td>Languages Spoken by Practitioner:</td>
</tr>
<tr>
<td>Languages Written by Practitioner:</td>
</tr>
<tr>
<td>Languages Spoken by Staff:</td>
</tr>
<tr>
<td>Languages Written by Staff:</td>
</tr>
</tbody>
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(Please continue next page)
Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

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End Recredentialing and Business Data Gathering Form. Attach Forms A-F As Required.
FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name:  
Last: ___________________________  First: ___________________________  MI: ___________________________

Indicate the number of ONE of the questions in Section J to which you answered “yes”: Question Number: ___

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B. Provide an explanation of any actions taken. Please include the date the action was taken.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C. Provide the current status of the issue.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

D. If known:  Contact: _______________________________________________________
Department/Committee: ____________________________________________________
Address:  
Street: ___________________________________________  City: ______  State: ______  Zip: _____
Telephone: (_____ ) ________________

Signature: ___________________________________________  Date: ___________________
FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _______________________________ _______________________________ _______________________________

A. Plaintiff’s Name: _______________________________ _______________________________ _______________________________

If court case, Case Name & Case Number: __________________________________________

B. Your Involvement in the Care (Attending, Consulting, Etc.): _______________________________

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): _______________________________

D. Allegations, including Patient Outcome, if Available: __________________________________________

E. Date of Incident (mm/yy): ________________  F. Date Filed (mm/yy): ________________

G. Date Case Closed (mm/yy): ________________

Resolution Case: ☐ Dismissed ☐ Settlement out of Court ☐ Judgment ☐ Arbitration ☐ Other ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): _______________________________

I. Professional Liability Insurer Name (if one was involved): _______________________________

J. Insurer Telephone Number: ( ___ ) ________________  K. Policy Number: _______________________________

L. Insurer Address (Street, City, State, Zip Code): __________________________________________

Signature: __________________________________________  Date: ________________________________
FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: ____________________________________________________________

A. History of Professional Liability Insurance (Please check One)
   ☐ Canceled Voluntarily ☐ Non-Renewed
   ☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name: ___________________________________________________________

C. Carrier Telephone Number: (____) __________________

D. Policy Number: _________________________________________________________

E. Carrier Address (Street, City, State, Zip Code):
   _______________________________________________________________________
   _______________________________________________________________________

F. Dates of Coverage: From (mm/yy): ___________ To (mm/yy): ___________

G. Circumstances Involved: _________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Signature: __________________________________________________ Date: ___________

Health Care Professionals Credentialing & Business Data Gathering Form
Applicant Name: FORM C
Application Name: ________________________________

A. Date of Incident (mm/yy): __________

B. Date of Complaint or Conviction (mm/yy): __________

C. Date of Resolution (mm/yy): __________

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): ____________________________

E. Allegation(s): __________________________________________________________

F. Details of Incident: __________________________________________________________

G. Actions Taken Against You: ______________________________________________________

H. Current Status of Situation: ______________________________________________________

I. Medical Practice Privileges Affected as a Result of This Situation: ____________________________

Signature: ___________________________ Date: ____________________
DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: ________________________________

A. Describe this medical condition: __________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

C. What is the current status of your condition?
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name: ____________________________ Telephone Number: (____) ____________

Last First MI Degree ____________________________

Last First MI Degree ____________________________

Signature: ________________________________ Date: ____________________________
FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name:  

Last __________________________________________ First __________________________________________ MI __________________________________________

Describe the substance you use:

________________________________________________________________________________________________________________________________________________________

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

________________________________________________________________________________________________________________________________________________________

B. Monitored by State Board Mandate (Name and Address) 

________________________________________________________________________________________________________________________________________________________

C. Monitored Voluntarily (Name and Address) 

________________________________________________________________________________________________________________________________________________________

D. Other information about the current status of your use of substances:

________________________________________________________________________________________________________________________________________________________

E. Abstinent since (mm/yy): _______________

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: __________________________________________________________

Address: _________________________________________________________

Street __________________________________________ City __________ State ___ Zip

Telephone: ( ) ______________

Signature: __________________________________________ Date: ______________