OREGON PRACTITIONER CREDENTIALING APPLICATION

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

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

REVIEWED, AMENDED & APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
5/1/12

OREGON PRACTITIONER CREDENTIALING APPLICATION

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

I. INSTRUCTIONS

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

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

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

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

A curriculum vitae is optional and not an acceptable substitute.

I am applying to (please list: Hospital Staff, HMO, IPA): _____

for: _____ (i.e., staff membership, network participation, if applicable).

***Note: Please return completed application to the health care related organization to which you are applying not to the State of Oregon.**

OREGON PRACTITIONER CREDENTIALING APPLICATION

II. PRACTITIONER INFORMATION

Please provide the practitioner's full legal name.

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes ☐ No ☐
Name(s) and Year(s) Used:

Home Street Address:	Home Telephone Number ( ) -	Mobile/Alternate Number ( ) -
	Email Address:	

City:	State:	ZIP:
Country:	Birth Date: Month / Day / Year	Birth Place:
Citizenship:	Social Security Number:	Gender: Male ☐ Female ☐

Immigrant Visa Number (if applicable):	Visa Expiration Date	Status:	Type:

Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):	Month / Year Issued:

III. SPECIALTY INFORMATION

This information may be included in directory listings.

Principal clinical specialty **(For most current specialties list, see: http://www.wpc-edi.com/codes):**	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐

Additional clinical practice specialties:

Category of professional activity, check all boxes that apply:

Clinical Practice:		Other Professional Activities:	
☒ Full Time	☐ Part Time	☐ Administration	☐ Teaching
☐ Locum / Temporary	☐ Telemedicine	☐ Research	☐ Retired
☐ Other (explain)		☐ Other (explain)	

IV. BOARD CERTIFICATION / RECERTIFICATION

This section does not apply to licensure.

Does Not Apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name and Address of Issuing Board	Specialty	Date Certified/Recertified Month / Year	Expiration Date (if any) Month / Year

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.

V. OTHER CERTIFICATIONS

Please attach copy of certificate(s), if applicable.

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:

For additional certifications, please attach a separate sheet.

VI. PRACTICE INFORMATION

Name of Primary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Primary Clinical Practice Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	ZIP:
Primary Office Telephone Number: ( ) - Ext	Primary Office Fax Number: ( ) -	Patient Appointment Telephone Number: ( ) - Ext	
Mailing/Billing Address (if different from above): Attn:			
Office Manager:	Office Manager's Telephone Number: ( ) - Ext	Office Manager's Fax Number:	
Exchange / Answering Service Number: ( ) - Ext	Pager Number: ( ) -	Office Email Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( ) - Ext	Credentialing Contact's Fax Number: ( ) -	Credentialing Contact's Email Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	

Name of Secondary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Secondary Clinical Practice Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	ZIP:
Secondary Office Telephone Number: ( ) - Ext	Secondary Office Fax Number: ( ) -	Patient Appointment Telephone Number: ( ) - Ext	
Mailing/Billing Address (if different from above): Attn:			
Office Manager:	Office Manager's Telephone Number: ( ) - Ext	Office Manager's Fax Number: ( ) -	
Exchange / Answering Service Number: ( ) - Ext	Pager Number: ( ) -	Office Email Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( ) - Ext	Credentialing Contact's Fax Number: ( ) -	Credentialing Contact's Email Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	

Please list other office locations with above information on a separate sheet.

After hours primary care coverage

This form must be completed to be considered for PCP designation with Moda Health.

1. **Date:** _____

2. **Do you currently provide primary care coverage for your patients 24 hours a day, seven days a week, 365 days a year?**

   ☐ Yes
   ☐ No

If you answered "Yes" to the above question, please complete this form for PCP credentialing.

In order to qualify for PCP designation, a provider must have after-hours primary care coverage and share primary care call with a Moda Health participating provider. The covering provider must also qualify for and be designated as a PCP with Moda Health.

Appropriate examples of after hours coverage include:
- After hours answering service
- Cell phone/pager number on voicemail greeting where patients can reach you after hours

Please outline a description of your after-hours primary care coverage plan:

_____

_____

_____

_____

_____

_____

Name of provider/applicant: _____

Provider/applicant signature: _____ **Date:** _____

VII. PRACTICE CALL COVERAGE

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

	NAME:	SPECIALTY:
1.		
2.		
3.		
4.		
5.		

VIII. UNDERGRADUATE EDUCATION

Please attach additional sheets, if necessary.

Complete School Name:	Degree Received:	Month / Year of Graduation:
City:	State:	Course of Study or Major:

IX. GRADUATE EDUCATION

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete School Name:	Degree Received:	Month / Year of Graduation:
City:	State:	Course of Study or Major:

X. MEDICAL / PROFESSIONAL EDUCATION

Please attach additional sheets, if necessary.

Complete Medical / Professional School Name and Street Address:

City:	State	ZIP:
Degree Received:	Phone Number: ( ) -	Fax Number, if available ( ) -

From Month / Year:	To Month / Year:	Month / Year of Completion:

Did you complete the program? Yes ☐ No ☐ **(If you did not complete the program, please explain on a separate sheet.)**

Complete Medical / Professional School Name and Street Address:

City:	State:	ZIP:
Degree Received:	Phone Number: ( ) - :	Fax Number, if available ( ) -

From Month / Year:	To Month / Year:	Month / Year of Completion:

Did you complete the program? Yes ☐ No ☐ **(If you did not complete the program, please explain on a separate sheet.)**

XI. POST-GRADUATE YEAR 1 / INTERNSHIP

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
City:	State:	ZIP:
Type of Internship / Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XII. RESIDENCIES

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
City:	State:	ZIP:
Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	
Complete Institution Name and Street Address:		
City:	State:	ZIP:
Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XIII. FELLOWSHIPS, PRECEPTORSHIPS, OR OTHER CLINICAL TRAINING PROGRAMS

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
City:	State:	ZIP:
Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	
Complete Institution Name and Street Address:		
City:	State:	ZIP:
Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XIV. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES & ID NUMBERS

Please attach additional sheets, if necessary.

Oregon License or Registration Number:	Type:	Month / Day / Year of Expiration:
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Month / Day / Year of Expiration:
Controlled Substance Registration (CSR) Number (if applicable):		Month / Day / Year of Issue:
Individual NPI Number:	Medicare Number:	DMAP Number:

XV. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Please include all ever held.

Does Not Apply ☐

State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		

Please attach additional sheets, if necessary.

XVI. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.**

A. CURRENT AFFILIATIONS

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Appointment		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		

If you do not have hospital admitting privileges, check here: ☐
Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. APPLICATIONS IN PROCESS

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Submission:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Submission:		

C. PREVIOUS AFFILIATIONS

Please attach additional sheets, if necessary.

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			

XVII. PROFESSIONAL PRACTICE / WORK HISTORY

Curriculum vitae is not sufficient.

Does Not Apply ☐

A. **Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. <u>Please attach additional sheets, if necessary.</u>**

Name of Current Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:

B.	**Please explain any gaps greater than two (2) months. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.**	Does Not Apply ☐

Activities and/or Names:	From Month / Year:	To Month / Year:

XVIII. PEER REFERENCES

Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Email Address, if available:
Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - (Ext	Fax Number: ( ) -	Email Address, if available:
Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Email Address, if available:

XIX. CONTINUING MEDICAL EDUCATION

Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.

Does Not Apply ☐

Name:	**Month / Year Attended:**	**Hours:**
Name:	**Month / Year Attended:**	**Hours:**
Name:	**Month / Year Attended:**	**Hours:**
Name:	**Month / Year Attended:**	**Hours:**
Name:	**Month / Year Attended:**	**Hours:**
Name:	**Month / Year Attended:**	**Hours:**

XX. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -	
Per claim limit of liability:	Aggregate amount:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:

Please list all previous professional liability carriers within the past five (5) years. Please attach additional sheets, if necessary. Does Not Apply ☐

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -	
Per claim limit of liability:	Aggregate amount:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -	
Per claim limit of liability:	Aggregate amount:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -	
Per claim limit of liability:	Aggregate amount:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -	
Per claim limit of liability:	Aggregate amount:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:

XXI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐	NO ☐
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	YES ☐	NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization***** **ever been** withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
G	Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐	NO ☐
H	Have you **ever** had board certification revoked?	YES ☐	NO ☐
I	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
J.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES ☐	NO ☐
K.	Do you presently use any illegal drugs?	YES ☐	NO ☐
L	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐	NO ☐
M	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES ☐	NO ☐
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES ☐	NO ☐

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

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

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

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

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – *CONFIDENTIAL*	
Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.	
Practitioner's Name (print or type):	
Month / Day / Year of the incident: and clinical details:	
Your role and specific responsibilities in the incident:	
Subsequent events, including patient's clinical outcome:	
Month / Day / Year the suit or claim was filed:	
Name and address of insurance carrier/professional liability provider that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Month / Day / Year of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:	
I verify the information contained in this form is correct and complete to the best of my knowledge.	
Signature:	Date:

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

IMPORTANT

Moda Health Practice Survey

Please complete this short survey about your practice. The information you provide will help us to better represent your practice to Moda Health members.

Mary B. Engrav, MD
Medical Director

I. IDENTIFYING INFORMATION		
Last Name:	First:	Middle:
Medical Group/IPA Affiliation(s):		
Do you want to be designated as a Primary Care Practitioner? ☐ Yes ☐ No		

II. PRACTICE INFORMATION
Are you a Physician Assistant Supervisor? ☐ Yes ☐ No
Is your practice limited to certain ages? ☐ Yes ☐ No If yes, please specify ages:_____

III. FOREIGN LANGUAGES SPOKEN IN OFFICE
☐ Spanish ☐ Russian ☐ Other (list) _____ _____ _____

IV. ACCEPTING NEW PATIENTS FOR	YES	NO	COMMENTS
Moda Health Commercial (Direct contract)			
Moda Health Oregon Health Plan (Medicaid)			
Moda Health Medicare Advantage (Medicare)			

V. HEALTH INFORMATION TECHNOLOGY My practice site(s):	YES	NO	COMMENTS
E-prescribes – electronic transmits			
Emails patients at no charge			
Uses web/email consultations – billed			
Implemented and currently uses EMR/EHR			
Uses a certified EMR/EHR			If yes, name certifying body:
Has a website			If yes, URL:

VI. SECLUSION & RESTRAINT (CFR, 438.100)
Does your office have a policy and procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations? ☐ Yes ☐ No If you do not have a policy, please describe the actions you would take in the event there were a disruptive individual/s in your office to ensure that you do not seclude or restrain, ie; Call 911. Our Office Process:_____

VII. OFFICE HOURS – EXTENDED/LIMITED						
Does your practice have hours other than 9am – 5pm Monday-Friday, including extended and limited hours? If yes, please indicate hours below. ☐ Yes ☐ No						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Comments:						