Addendum to the Oregon Practitioner Credentialing Application

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

II.BILLING INFORMATION		
Name of Billing Company:		
Street Address:	City:	
	State:	Zip Code:
Contact:	Telephone Number: ( )	
Federal Tax ID Number	Fax Number: ( )	

III. PRACTICE INFORMATION

Are you are a Physician Assistant Supervisor? ☐ Yes ☐ No (if yes, please provide a copy of your supervisor license)

Is your practice limited to certain ages? ☐ Yes ☐ No
If yes, please specify ages:_____

IV.OFFICE HOURS

Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

V. FOREIGN LANGUAGES

Please list the different languages spoken fluently by the applicant or an office staff member.

Fluently By Physician	Fluently By Staff

VI: OTHER

For all PCP's, Ob/Gyn's, and Certified Nurse Mid-Wive's

Have you ever had an ARC audit score below 80%? ☐ Yes ☐ No

If yes, was a re-audit performed? ☐ Yes ☐ No