

Application for  
Medical Staff Membership

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## INSTRUCTIONS

- Complete the application in full. Please type or print all responses. Incomplete application packets delay the approval of your application and the credentialing process.
- Where dates are indicated, include month, day, and year.
- Attach a copy of the following items to your completed application:
  - Government issued photo identification (i.e., driver's license, passport, resident alien card)
  - Current curriculum vitae, including complete education/training, employment/work history, certifications, etc. with dates in month and year format
  - All state medical licenses and controlled substance permits
  - DEA certificate
  - Specialty board certification or admissibility to sit for board, if applicable, from an American Board of Medical Specialties or American Osteopathic Association approved board
  - Medical school or professional school diploma
  - Residency certificate, if not board certified
  - ECFMG certificate, if applicable
  - Current visa or alien registration, if applicable
  - Current Malpractice Insurance Certificate
- Attach additional sheets if there is insufficient space on this form to answer any question. Reference the question and page number.

IDENTIFYING INFORMATION									
Last Name			First name			Middle name		Previous Names Used	
Degree <input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> DDS	<input type="checkbox"/> DPM	<input type="checkbox"/> DC	<input type="checkbox"/> Other (please specify)			Social Security Number	
NPI Number					Date of Birth*				
Birth City		Birth State / Province			Birth Country				
SPECIALTY									
Primary Practice Specialty				Secondary Practice Specialty					
Are you able to work legally in the United States?				<input type="checkbox"/> Yes		<input type="checkbox"/> No			
If yes, please indicate the following:		<input type="checkbox"/> US Citizen		<input type="checkbox"/> Visa or work authorization (You may be asked to provide proof of eligibility to work in the US.)					
Other than English, list all languages you speak									
*Used for credentials verification purposes only. CompHealth does not discriminate on the basis of age or other factors.									
PREFERRED ADDRESS									
Address					Apt / Unit Number		Email		
City				State / Province		Zip Code		Country	
Home Phone Number		Work Phone Number			Cell Phone Number				
PRIMARY OFFICE ADDRESS									
Address					Apt / Unit Number		Email		
City				State / Province		Zip Code		Country	
Phone Number		Work Phone Number			Cell Phone Number				
PRIMARY BILLING ADDRESS									
Address					Apt / Unit Number		Email		
City				State / Province		Zip Code		Country	
Phone Number		Work Phone Number			Cell Phone Number				
SECONDARY OFFICE ADDRESS									
Address					Apt / Unit Number		Email		
City				State / Province		Zip Code		Country	
Phone Number		Work Phone Number			Cell Phone Number				
SECONDARY BILLING ADDRESS									
Address					Apt / Unit Number		Email		
City				State / Province		Zip Code		Country	

Phone Number		Work Phone Number		Cell Phone Number	
<b>PROVIDER INFORMATION</b>					
<input type="checkbox"/> Professional corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> IPA	<input type="checkbox"/> Solo practice	<input type="checkbox"/> Other (Please specify) _____	
Name of medical group or IPA affiliation		Will you bill under your social security number		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Federal Employer Identification Number (EIN)		Will you bill under your employer tax identification number?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name on EIN	Is this EIN for profit?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you want to appear in the directory under your primary or secondary specialty, or both:			<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary	<input type="checkbox"/> Both
Do you accept Medicare assignment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you accept Medicaid assignment?	
Do you accept Medicaid assignment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Are you accepting new patients?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	List all languages (other than English) spoken in your office	
Average lead time needed to schedule appointment for non-urgent care			Do your office(s) have handicap access		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>UNDERGRADUATE EDUCATION</b>					
School name				Phone	
Address			City	State	Zip Code
Degree awarded	Attended from (mm/yyyy)		Attended to (mm/yyyy)		Date of completion (mm/yyyy)
<b>MEDICAL SCHOOL / PROFESSIONAL EDUCATION</b>					
School name				Phone	
Address			City	State	Zip Code
Degree awarded	Attended from (mm/yyyy)		Attended to (mm/yyyy)		Date of completion (mm/yyyy)
<b>OTHER GRADUATE SCHOOL</b>					
College or University				Phone	
Address			City	State	Zip Code
Degree awarded	Attended from (mm/yyyy)		Attended to (mm/yyyy)		Date of completion (mm/yyyy)
<b>INTERNSHIP</b>					
Institution				Phone	
Address			City	State	Zip Code
Degree awarded	Attended from (mm/yyyy)		Attended to (mm/yyyy)		Date of completion (mm/yyyy)
<b>RESIDENCY(S) IF REASON FOR LEAVING RESIDENCY WAS OTHER THAN SUCCESSFUL COMPLETION, PLEASE EXPLAIN ON A SEPARATE SHEET.</b>					
1. Institution				Phone	
Address			City	State	Zip Code
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program chair

2. Institution					Phone			
Address				City			State	Zip Code
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Program chair		

FELLOWSHIP(S) OR PRECEPTORSHIPS(S)

1. Institution					Phone			
Address				City			State	Zip Code
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Program chair		

2. Institution					Phone			
Address				City			State	Zip Code
Type/Specialty	Attended from (mm/yyyy)	Attended to (mm/yyyy)	Program completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Program chair		

HOSPITAL AFFILIATIONS *List in reverse chronological order, beginning with the most current, all hospital affiliations/staff memberships since completion of postgraduate training. Include facilities where your application is pending and where medical staff membership has been withdrawn or denied. On an additional sheet, please explain any gaps in your hospital affiliation chronology. Please attach an additional page if more space is needed.*

1. Institution					Phone			
Address				City			State	Zip Code
Attended from (mm/yyyy)		Attended to (mm/yyyy)		Percent (%) of annual admissions				
2. Institution					Phone			
Address				City			State	Zip Code
Attended from (mm/yyyy)		Attended to (mm/yyyy)		Percent (%) of annual admissions				

3. Institution					Phone			
Address				City			State	Zip Code
Attended from (mm/yyyy)		Attended to (mm/yyyy)		Percent (%) of annual admissions				

4. Institution					Phone			
Address				City			State	Zip Code
Attended from (mm/yyyy)		Attended to (mm/yyyy)		Percent (%) of annual admissions				

5. Institution					Phone			
Address				City			State	Zip Code
Attended from (mm/yyyy)		Attended to (mm/yyyy)		Percent (%) of annual admissions				

Additional Hospital Affiliations:

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**WORK HISTORY** List in reverse chronological order, beginning with the most current, all employment affiliations since completion of education/training. Include all dates of affiliation. On a separate sheet, please explain any gaps in your work history.

1. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	
2. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	
3. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	
4. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	
5. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	
6. Name of practice/institution		Phone	
Address	City	State	Zip Code
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Position held	

Additional Work History:

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**MILITARY SERVICE**

Branch	Rank			
Attended from (mm/yyyy)	Attended to (mm/yyyy)	Are you in the military reserves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discharge status:	<input type="checkbox"/> Honorable	<input type="checkbox"/> Dishonorable	<input type="checkbox"/> Other (please specify)	

**PROFESSIONAL LICENSES & CONTROLLED SUBSTANCE PERMITS** PLEASE LIST ANY STATE MEDICAL LICENSES AND STATE CONTROLLED SUBSTANCE PERMITS HELD IN THE PAST FIVE (5) YEARS

ST	License Type	License #	Date Issued	Expiration Date	Controlled Sub Permit #	Date Issued	Expiration Date


INACTIVE LICENSES	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, please complete this section.)
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List all States with inactive licenses

DEA REGISTRATION	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, please complete this section.)
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Registration Number		Date issued (mm/dd/yyyy)		Expiration Date (mm/dd/yyyy)	
Registration Number		Date issued (mm/dd/yyyy)		Expiration Date (mm/dd/yyyy)	
Registration Number		Date issued (mm/dd/yyyy)		Expiration Date (mm/dd/yyyy)	

If you do not currently possess a DEA Registration, please explain here:

ECFMG / FMGEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please complete this section.
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Certificate Number		Date issued	
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**BOARD CERTIFICATIONS**

Name of specialty board	Specialty	Certification date	Exp. Date (mm/yyyy)	Recertified?			Date (mm/yyyy)
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	

Have you ever taken a specialty board examination and filed to pass?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please provide details:

If not board certified, have you applied for the certification examination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, date scheduled:	
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If you have not applied, do you intend to apply for certification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when do you intend to apply?	
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Have you been accepted to take a specialty certification examination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when are you scheduled to take the examination?	
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**OTHER NATIONAL/PROFESSIONAL CERTIFICATIONS**

Name of certification		Name of certifying body	
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*Application for Medical Staff Membership*

Initial certification date		Certification expiration date		Recertification required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of certification			Name of certifying body			
Initial certification date		Certification expiration date		Recertification required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>PROFESSIONAL LIABILITY INSURANCE HISTORY</b>						
Have there been or are there any pending malpractice claims, suits, settlements, arbitration proceedings, or notices of intent to commence action involving your medical practice? If yes, attach supplemental claim forms.					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your professional liability insurance coverage ever been terminated by the action of any insurance company? If yes, attach supplemental claim forms.					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your current liability insurance carrier excluded any specific procedures from your insurance coverage?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, list excluded procedures with full explanation and dates of limitations.						
Have you ever been denied professional liability insurance coverage?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide full details.						
<b>PROFESSIONAL LIABILITY INSURANCE</b> <i>List in reverse chronological order, beginning with the most current, all liability insurance carriers in the past five years. Include copies of malpractice certificates for all current coverage.</i>						
1. Present carrier				Policy number		
Name of policyholder						
Coverage limits		Inception date		Expiration date		Years with company
Address			City		State	Zip code
2. Present carrier				Policy number		
Name of policyholder						
Coverage limits		Inception date		Expiration date		Years with company
Address			City		State	Zip code
3. Present carrier				Policy number		
Name of policyholder						
Coverage limits		Inception date		Expiration date		Years with company
Address			City		State	Zip code
<b>PROFESSIONAL REFERENCES</b> <i>Please list 4 professional references with whom you have had clinical contact within the last 2 years. (At least 2 of these should be within your specialty.) They should be able to assess your professional skills and capabilities.</i>						
Name		Address		Phone #		Email
Name		Address		Phone #		Email
Name		Address		Phone #		Email
Name		Address		Phone #		Email



DISCIPLINARY ACTIONS <i>Attach a detailed explanation for any "yes" answers.</i>							
Have any of the following been, or are currently in the process of being denied, revoked, suspended, refused, limited, placed on probation or placed under other disciplinary action?							
(a)	Medical license in any state	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(f)	Clinical privileges/other rights on any medical staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b)	Other professional registration/license	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(g)	Other institutional affiliation or status	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c)	DEA registration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(h)	Professional society membership or fellowship/board	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d)	Academic appointment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(i)	Professional office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(e)	Membership and/or employment on any hospital medical staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(j)	Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
				(k)	Any other type of professional sanction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been the subject of any investigation by any private, state, or federal health insurance program?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been the subject of a licensing board inquiry?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever withdrawn an application for medical licensure from a state licensing board?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been censured by any committee of a state or county medical association with regard to ethics or fees?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been denied HMO, PPO, or other prepaid health plan participation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever been employed as a physician or provider where your employment was terminated by the employer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been formally suspended more than twice for delinquent medical records?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever withdrawn an application for medical staff membership at any facility?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever withdrawn your request for any clinical privileges?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently engaged in any illegal drug activity?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been convicted of a misdemeanor or felony or are you currently under indictment for any alleged criminal activities?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever voluntarily surrendered medical license, staff privileges, DEA registration, or consented to a limitation of the same pending a review or investigation?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been placed on probation in any training program, or have you failed to satisfactorily complete any training program or part thereof?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered "yes" to any of the above questions, please provide full details:							
HEALTH STATUS							
Have you had, or do you now have, any physical or mental condition, including any chemical/substance dependency, that would compromise your ability to practice medicine or perform appropriate clinical duties?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you unable to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?						Yes	No
If you answered "yes" to either of the above questions, please provide full details, including a description of any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.							
Name of personal physician				Phone			
Address		City		State		Zip Code	

Last Name	First name	Middle name	Previous Surname	Suffix
<p><b>RELEASE &amp; AUTHORIZATION</b></p>	<p>In making medical application for membership to the medical staff, I hereby authorize (Client) and its credentialing verification organization, CHG Companies, Inc. (dba CompHealth Credentialing), its affiliates and successors to obtain any information that may be relevant to an evaluation of my professional qualifications, including information about disciplinary actions or other confidential or privileged information, and other credentials.</p> <p>I authorize the release of all information necessary from all medical schools, colleges, universities, transcript offices, medical institutions or organizations, hospitals, employers, personal references, physicians, attorneys, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner data Bank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, specialty boards, and any other pertinent source.</p> <p>I hereby indemnify and hold harmless Client, and CHG Companies, Inc, their agents, officers and employees, as well as any third parties, including, but not limited to, the Federation of State Medical Boards and other listed above, from any damages or liability, civil or otherwise, from any acts performed in good faith without malice and in connection with the collection and verification of such information.</p> <p>I understand that I have the burden of providing adequate information to Client and CHG Companies, Inc, its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial or summary dismissal as a participating provider. If any material changes occur affecting my professional status, it is my obligation to notify Client, and CHG Companies, Inc. or the appropriate affiliate or successor as soon as possible.</p> <p>I attest that the information contained in this application is correct and complete.</p> <p>A copy of the document shall operate as full proof of authority and release.</p> <p>This document shall be interpreted according to the laws of the State of Utah.</p> <p>Name _____ Social Security number _____</p> <p>Signature _____ Date _____</p>			