Submit

# Application for Medical Staff Membership

.....

CHG Healthcare Services

## 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 ☐ MD ☐ DO ☐ DDS ☐ DPM ☐ DC ☐ 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? ☐ Yes ☐ No | | | | | | | |
| If yes, please indicate the following: ☐ US Citizen ☐ 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 | |
|---|---|---|---|---|---|

**PROVIDER INFORMATION**

☐ Professional corporation ☐ Partnership ☐ IPA ☐ Solo practice ☐ Other (Please specify) _____

| Name of medical group or IPA affiliation | | Will you bill under your social security number | ☐ Yes | ☐ No |
|---|---|---|---|---|
| Federal Employer Identification Number (EIN) | | Will you bill under your employer tax identification number? | ☐ Yes | ☐ No |
| Name on EIN | | Is this EIN for profit? | ☐ Yes | ☐ No |

| Do you want to appear in the directory under your primary or secondary specialty, or both: | ☐ Primary | ☐ Secondary | ☐ Both |
|---|---|---|---|

| Do you accept Medicare assignment? | ☐ Yes | ☐ No | Do you accept Medicaid assignment? | ☐ Yes | ☐ No |
|---|---|---|---|---|---|
| Are you accepting new patients? | ☐ Yes | ☐ 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 | ☐ Yes | ☐ No |

**UNDERGRADUATE EDUCATION**

| School name | | Phone | | | | | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |
| Degree awarded | | Attended from (mm/yyyy) | | Attended to (mm/yyyy) | | Date of completion (mm/yyyy) | |

**MEDICAL SCHOOL / PROFESSIONAL EDUCATION**

| School name | | Phone | | | | | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |
| Degree awarded | | Attended from (mm/yyyy) | | Attended to (mm/yyyy) | | Date of completion (mm/yyyy) | |

**OTHER GRADUATE SCHOOL**

| College or University | | Phone | | | | | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |
| Degree awarded | | Attended from (mm/yyyy) | | Attended to (mm/yyyy) | | Date of completion (mm/yyyy) | |

**INTERNSHIP**

| Institution | | Phone | | | | | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |
| Degree awarded | | Attended from (mm/yyyy) | | Attended to (mm/yyyy) | | Date of completion (mm/yyyy) | |

**RESIDENCY(S)** *IF REASON FOR LEAVING RESIDENCY WAS OTHER THAN SUCCESSFUL COMPLETION, PLEASE EXPLAIN ON A SEPARATE SHEET.*

| 1. Institution | | Phone | | | | | |
|---|---|---|---|---|---|---|---|
| Address | | City | | State | | Zip Code | |

| Type/Specialty | Attended from (mm/yyyy) | Attended to (mm/yyyy) | Program completed ☐ Yes ☐ No | Program chair |
|---|---|---|---|---|
| | | | | |

| 2. Institution | | Phone | |
|---|---|---|---|
| Address | City | State | Zip Code |
| Type/Specialty | Attended from (mm/yyyy) | Attended to (mm/yyyy) | Program completed ☐ Yes ☐ 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 ☐ Yes ☐ No / Program chair |

| 2. Institution | | Phone | |
|---|---|---|---|
| Address | City | State | Zip Code |
| Type/Specialty | Attended from (mm/yyyy) | Attended to (mm/yyyy) | Program completed ☐ Yes ☐ 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*:

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:*

MILITARY SERVICE

| | | | | | |
|---|---|---|---|---|---|
| Branch | | Rank | | | |
| Attended from (mm/yyyy) | | Attended to (mm/yyyy) | | Are you in the military reserves? | ☐ Yes ☐ No |
| Discharge status: | ☐ Honorable | ☐ Dishonorable | ☐ 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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| | | | | | | | |
| | | | | | | | |

| INACTIVE LICENSES | ☐ Yes | ☐ No | (If yes, please complete this section.) |
|---|---|---|---|

List all States with inactive licenses

| DEA REGISTRATION | ☐ Yes | ☐ No | (If yes, please complete this section.) |
|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| 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 | ☐ Yes | ☐ No | *If yes, please complete this section.* |
|---|---|---|---|

| Certificate Number | | Date issued | |
|---|---|---|---|

BOARD CERTIFICATIONS

| Name of specialty board | Specialty | Certification date | Exp. Date (mm/yyyy) | Recertified? | Date (mm/yyyy) |
|---|---|---|---|---|---|
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |
| | | | | ☐ Yes ☐ No ☐ N/A | |

| Have you ever taken a specialty board examination and filed to pass? | ☐ Yes | ☐ No |
|---|---|---|

If yes, please provide details:

| If not board certified, have you applied for the certification examination? | ☐ Yes | ☐ No | If yes, date scheduled: | |
|---|---|---|---|---|
| If you have not applied, do you intend to apply for certification? | ☐ Yes | ☐ No | If yes, when do you intend to apply? | |
| Have you been accepted to take a specialty certification examination? | ☐ Yes | ☐ No | If yes, when are you scheduled to take the examination? | |

OTHER NATIONAL/PROFESSIONAL CERTIFICATIONS

| Name of certification | | Name of certifying body | |
|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Initial certification date | | Certification expiration date | | Recertification required? | ☐ Yes | ☐ No |
| Name of certification | | Name of certifying body | | | | |
| Initial certification date | | Certification expiration date | | Recertification required? | ☐ Yes | ☐ No |

**PROFESSIONAL LIABILITY INSURANCE HISTORY**

| | | |
|---|---|---|
| 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. | ☐ Yes | ☐ No |
| Has your professional liability insurance coverage ever been terminated by the action of any insurance company? If yes, attach supplemental claim forms. | ☐ Yes | ☐ No |
| Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? | ☐ Yes | ☐ No |

If yes, list excluded procedures with full explanation and dates of limitations.

| | | |
|---|---|---|
| Have you ever been denied professional liability insurance coverage? | ☐ Yes | ☐ No |

If yes, please provide full details.

**PROFESSIONAL LIABILITY INSURANCE** *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.***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | |

**PROFESSIONAL REFERENCES** *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.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name | | Address | | Phone # | | Email | |
| Name | | Address | | Phone # | | Email | |
| Name | | Address | | Phone # | | Email | |
| Name | | Address | | Phone # | | Email | |

## DISCIPLINARY ACTIONS *Attach a detailed explanation for any "yes" answers.*

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 | ☐ Yes | ☐ No | (f) | Clinical privileges/other rights on any medical staff | ☐ Yes | ☐ No |
| (b) | Other professional registration/license | ☐ Yes | ☐ No | (g) | Other institutional affiliation or status | ☐ Yes | ☐ No |
| (c) | DEA registration | ☐ Yes | ☐ No | (h) | Professional society membership or fellowship/board | ☐ Yes | ☐ No |
| (d) | Academic appointment | ☐ Yes | ☐ No | (i) | Professional office | ☐ Yes | ☐ No |
| (e) | Membership and/or employment on any hospital medical staff | ☐ Yes | ☐ No | (j) | Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid) | ☐ Yes | ☐ No |
| | | | | (k) | Any other type of professional sanction | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| Have you ever been the subject of any investigation by any private, state, or federal health insurance program? | ☐ Yes ☐ No | Have you ever been the subject of a licensing board inquiry? | ☐ Yes ☐ No |
| Have you ever withdrawn an application for medical licensure from a state licensing board? | ☐ Yes ☐ No | Have you ever been censored by any committee of a state or county medical association with regard to ethics or fees? | ☐ Yes ☐ No |
| Have you ever been denied HMO, PPO, or other prepaid health plan participation? | ☐ Yes ☐ No | Have you ever been employed as a physician or provider where your employment was terminated by the employer? | ☐ Yes ☐ No |
| Have you been formally suspended more than twice for delinquent medical records? | ☐ Yes ☐ No | Have you ever withdrawn an application for medical staff membership at any facility? | ☐ Yes ☐ No |
| Have you ever withdrawn your request for any clinical privileges? | ☐ Yes ☐ No | Are you currently engaged in any illegal drug activity? | ☐ Yes ☐ No |

| | |
|---|---|
| Have you ever been convicted of a misdemeanor or felony or are you currently under indictment for any alleged criminal activities? | ☐ Yes ☐ No |
| Have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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? | ☐ Yes ☐ No |
| Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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 |
|---|---|---|
| | | |

**RELEASE & AUTHORIZATION**

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), it 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.

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.

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.

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.

I attest that the information contained in this application is correct and complete.

A copy of the document shall operate as full proof of authority and release.

This document shall be interpreted according to the laws of the State of Utah.

Name _____ Social Security number _____

Signature _____ Date _____