OREGON PRACTITIONER CREDENTIALING APPLICATION



- APPLICATION
- PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)

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.

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 <u>unsigned</u> and <u>undated</u> 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.
- Attach copies of the documents requested each time the application is submitted.
- If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.
- Submit 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.

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

Initials:	_ Date:	Page 1 of 12	MSC 9048 (4/26/2017)
-----------	---------	--------------	----------------------

OREGON PRACTITIONER CREDENTIALING APPLICATION

II. Practitioner Information		Please _I	provide the	practitione	er's full leg	gal name.
Last Name (include suffix; Jr., Sr., III):	First:		Middle:		De	egree(s):
Is there any other name under which you have be Name(s) and Year(s) Used:	en known or have used since	ce starting pro	l fessional trai	ning?	Yes 🗌	No 🗌
Home street address:			ephone numb	oer:	Mobile/alte	ernate number:
		Email add	dress:		_ · ·	
City:	State:			ZIP:		
Country:	Birth date: Month / D	Day / Year		Birth place	e:	
Citizenship:	Social Security numb	er:		Gender: Male	Female [
Immigrant Visa number (if applicable): Vis	sa expiration date:		Status:	ı	Ту	rpe:
Educational Commission for Foreign Medical Gr	raduates (ECFMG) number	(if applicable):	Month / Y	ear Issued:	
				l		
III. Specialty Information		·				rectory listings.
Principal clinical specialty (For most current sp http://www.wpc-edi.com/codes):	pecialties list, see:	Do you war Yes	nt to be desig	nated as a pi	rimary care j	practitioner (PCP)?
Additional clinical practice specialties:						
Category of professional activity, check all l	boxes that apply:					
Clinical practice:		Other 1	professiona	l activities	<u>::</u>	
Full Time	Part Time	Ad	lministration		Teac	ching
Locum / Temporary	Telemedicine	Re	esearch		Reti	red
Other (explain)		Ot	her (explain)			
IV. Board Certification / Rece This section does not apply to licensure.	ertification				D	oes not apply
List all current and past certifications.	Please attach addition	nal sheets, i	if necessar	1	'	
Name and address of issuin	g board	Spe	cialty	rece	ertified/ rtified th/year	Expiration date (if any) month/year
If not currently board certified, describe testing for certification below. Please atta			and dates	of previou	s testing a	nd/or intended future
nitials: Date:	Page	2 of 12				MSC 9048 (4/26/201

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA. Fluoroscopy. Radiography, etc. Type:	V. Other Certificati	ons	1	Please attach c	opy of certificate(s),	if applicable.	
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: 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: Department name (if hospital based): Type: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: Ext. State: Iffective date at location, month / year: Type: Ext. State: Iffective date at location, month / year: Type: State: Office manager's fax number: Type: Ext. Office manager's fax number: Type: Patient appointment telephone number: Type: State: Office email address: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year: Type: State: Iffective date at location, month / year:	Examples include: ACLS, BI	S, ATLS	, PALS, NRP, AANA, I	Fluoroscopy, R	adiography, 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: For additional certifications, please attach a separate sheet. VI. Practice and Employment Information Name of primary practice/affiliation or clinic: Department name (if hospital based): Primary Clinical Practice street address: Effective date at location, month / year: Ext. Primary office telephone number: Lext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Lext. Department name (if hospital based): Fatt. Office manager's felephone number: Page number: Office email address: Ext. Credentialing Contact and Address (if different from above): Name of secondary practice/affiliation or clinic: Department name (if hospital based): Secondary Clinical Practice street address: Ext. Department name (if hospital based): Fatt. Secondary Clinical Practice street address: Ext. Department name (if hospital based): State: ZIP: Primary office telephone number: Primary office fax number: Page number: Department name (if hospital based): Secondary Clinical Practice street address: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Primary office fax number: Page numb	Type:	Nun	nber:	Month / Year of	certification:	Month / Year of expiration:	
Number: Month / Year of certification: Month / Year of Expiration:	Type:	Nun	mber:	Month / Year of	certification:	Month / Year of Expiration:	
VI. Practice and Employment Information Name of primary practice/affiliation or clinie: Department name (if hospital based): Primary Clinical Practice street address: Effective date at location, month / year: City: County: State: Effective date at location, month / year: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Exchange / answering service number: - Ext. Credentialing contact's telephone number: Federat tax ID number or social security number: Primary office fax number: Credentialing contact's telephone number: Exchange / answering service number: Credentialing contact's telephone number: Credentialing contact's telephone number: Credentialing contact's telephone number: Credentialing contact's telephone number: Federat tax ID number or social security number: Credentialing contact's telephone number: Department name (if hospital based): Attn: Office manager: Office manager Department name (if hospital based): Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's fax number: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Department name (if hospital based): Attn: Office manager's fax number: Ext. Mailing/Billing Address (if different from above): Attn: Office manager's fax number: - Ext. Mailing/Billing Address (if different from above): Credentialing contact's telephone number: - Ext. Name office date at location, month / year: Ext. Sechange / answering service number: - Ext. Office manager's fax number: - Ext. Name office date at location, month / year: - Ext. Name office date at location, month / year: - Ext. Name office date at location, month / year: - Ext. Name office date at location, month / year: - Ext. Name office date at location, month / year: - Ext. Name office telephone number: - Ext. Name office date at location, month / year: - Ext.	Type:	Nun	mber:	Month / Year of	certification:	Month / Year of Expiration:	
VI. Practice and Employment Information Name of primary practice/affiliation or clinic: Department name (if hospital based):	Type:	Nun	mber:	Month / Year of	certification:	Month / Year of Expiration:	
VI. Practice and Employment Information Name of primary practice/affiliation or clinic: Department name (if hospital based):	For additional certifications.	please a	ttach a separate sheet.				
Department name (if hospital based):		1	,				
Department name (if hospital based):	VI. Practice and En	nployn	nent Information	1			
City: County: State: ZIP: Primary office telephone number: Patient appointment telephone number: - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Credentialing Contact and Address (if different from above): Credentialing Contact's telephone number: Credentialing contact's fax number: - Ext. Pager number: Office email address: - Ext. Credentialing Contact and Address (if different from above): Credentialing Contact's telephone number: Credentialing contact's fax number: Credentialing contact's email address: - Ext. Pager number: Department name (if hospital based): 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: Primary office telephone number: - Ext. Aailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. - Ext. Office manager's fax number: - Ext. Office manager's fax number: - Ext. - Credentialing Contact and Address (if different from above): Credentialing Contact an					name (if hospital base	d):	
Primary office telephone number: - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Office manager's fax number: - Ext. Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing Contact and particle street address: - Ext. City: County: State: Department name (if hospital based): Secondary Clinical Practice street address: - Ext. Mailing/Billing Address (if different from above): City: County: State: Department name (if hospital based): Secondary Clinical Practice street address: Effective date at location, month / year: City: County: State: Department name (if hospital based): Secondary Clinical Practice street address: Effective date at location, month / year: Attn: Office manager: Primary office fax number: - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager: Office manager: Office manager: Office manager: Office manager: Credentialing Contact and Address (if different from above): Credentialing Contact (and address): Credentialing Contact (and address): Credentialing Contact (and add	Primary Clinical Practice street	address:			Effective date at loc	eation, month / year:	
Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Exchange / answering service number: Pager number: Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Credentialing contact's telephone number: Ext. Department name (if hospital based): City: County: State: ZiP: City: County: State: ZiP: Primary office telephone number: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Name affiliated with tax ID number:	City:	County:		State:		ZIP:	
Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. - Ext. Office manager's fax number: - Ext. Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Credentialing contact's telephone number: - Ext. Credentialing contact's telephone number: - Ext. Federal tax ID number or social security number, if used for business purposes: 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: Primary office telephone number: - Ext. Attn: Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Office manager's fax number: - Ext. Office manager's fax number: - Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. - Office email address: - Ext. - Office email address: Credentialing contact's telephone number: - Ext. - Office email address: Credentialing contact's telephone number: - Ext. - Office email address: Credentialing contact's telephone number: - Ext. - Name of iliated with tax ID number: Credentialing contact's telephone number: - Ext. Name affiliated with tax ID number: Name affiliated with tax ID number:		r:	Primary office fax number	er:		•	
Office manager: Office manager's telephone number: Ext. Department name (if hospital based): Secondary Clinical Practice street address: City: County: State: Department name (if hospital based): Secondary Clinical Practice street address: Ext. Primary office fax number: Ext. Primary office telephone number: Ext. Primary office telephone number: Department name: Office manager's telephone number: Credentialing contact's fax 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: Primary office telephone number: Primary office fax number: Pager number: Pager number: Office manager's telephone number: Sext. Office manager's telephone number: Credentialing Contact and Address (if different from above): Credentialing contact stelephone number: - Ext. Credentialing contact stelephone number: - Ext. Credentialing contact stelephone number: - Ext. Name affiliated with tax ID number: Credentialing contact's email address: - Ext. Name affiliated with tax ID number:		rent from a	above):		E	xt.	
Exchange / answering service number: - Ext Credentialing Contact and Address (if different from above): Credentialing Contact's telephone number: - Ext Ext St. Credentialing contact's telephone number: - Ext. Federal tax ID number or social security number, if used for business purposes: 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: Primary office telephone number: - Ext. Adailing/Billing Address (if different from above): Attn: Office manager: Office manager's felephone number: - Ext Office manager's felephone number: - Ext Office manager's fax number: - Ext Office manager's for manager's fax number: - Ext Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext Name of secondary Clinical Practice with tax ID number: - Ext Name of secondary Clinical Practice with tax ID number: - Ext Name of secondary Clinical Practice with tax ID number: - Ext Name of secondary Clinical Practice with tax ID number: - Ext Name affiliated with tax ID number: - Ext Name affiliated with tax ID number: - Ext Name affiliated with tax ID number:					Attn:		
Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Federal tax ID number or social security number, if used for business purposes: Name of secondary practice/affiliation or clinic: Department name (if hospital based): Secondary Clinical Practice street address: City: County: State: Primary office telephone number: - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Pager number: - Ext. Office email address: Credentialing contact's telephone number: - Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Credentialing contact's telephone number: - Name affiliated with tax ID number:	Office manager:			_			
Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext Ext Ext Pederal tax ID number or social security number, if used for business purposes: 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: Primary office telephone number: - Ext. Primary office fax number: - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager: - Ext. Office manager: - Ext. Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Credentialing contact's telephone number: - Name affiliated with tax ID number:		mber:	Pager number:		Office email address:		
Federal tax ID number or social security number, if used for business purposes: 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: Primary office telephone number: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Office manager's fax number: Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Name affiliated with tax ID number: Name affiliated with tax ID number:		ess (if diffe	erent from above):		1		
Federal tax ID number or social security number, if used for business purposes: 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: Primary office telephone number: Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Office manager's fax number: Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Name affiliated with tax ID number: Name affiliated with tax ID number:							
Name of secondary practice/affiliation or clinic: Department name (if hospital based):	_	e number:	Credentialing contact	's fax number:	Credentialing conta	ct's email address:	
Secondary Clinical Practice street address: Effective date at location, month / year:		security nu	umber, if used for business	purposes:	Name affiliated wit	h tax ID number:	
Secondary Clinical Practice street address: Effective date at location, month / year:	Name of secondary practice/affiliation or clinic: Department name (if hospital based):			d):			
City: County: State: ZIP: Primary office telephone number: Primary office fax number: Patient appointment telephone number: - Ext Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext Office manager's fax number: - Ext Credentialing Contact and Address (if different from above): Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Credentialing contact's fax number: - Ext Credentialing contact's telephone number: Credentialing contact's email address: - Ext Name affiliated with tax ID number: Name affiliated with tax ID number:							
Primary office telephone number: - Ext. - Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: - Ext. Office manager's fax number: - Ext. Office manager's fax number: - Ext. - Office email address: - Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: - Ext. Credentialing contact's telephone number: - Name affiliated with tax ID number:	Secondary Clinical Practice stre	et address	:		Effective date at loc	cation, month / year:	
Ext. Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Exchange / answering service number: Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Name affiliated with tax ID number:	City:	County:		State:	•	ZIP:	
Mailing/Billing Address (if different from above): Attn: Office manager: Office manager's telephone number: Ext. Exchange / answering service number: Ext. Office manager's fax number: Ext. Office manager's fax number: Office manager's fax number: Office manager's fax number: Office manager's fax number: Ext. Office manager's fax number: Ext. Credentialing Contact address: Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Credentialing contact's email address: Ext. Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:		r:	Primary office fax number	er:		-	
Office manager: Office manager's telephone number: Ext. Exchange / answering service number: Ext. Office manager's fax number: Office email address: Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Ext. Credentialing contact's fax number: Ext. Name affiliated with tax ID number:		rent from	above):				
Exchange / answering service number: Ext Office email address: Ext. Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Ext. Credentialing contact's telephone number: Ext. Credentialing contact's fax number: Ext. Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:	Attn:						
Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Credentialing contact's telephone number: 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:					x number:		
Credentialing Contact and Address (if different from above): Credentialing contact's telephone number: Credentialing contact's fax number: Credentialing contact's email address: Ext. Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:				Office email address:			
Ext Ext Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:		ess (if diffe	erent from above):				
Ext Ext Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:			1		_		
					Credentialing conta	ct's email address:	
Please list other office locations with above information on a separate sheet.	Federal tax ID number or social security number, if used for business purposes: Name affiliated with tax ID number:					h tax ID number:	
	Please list other office location	ons with o	above information on a	separate sheet	•		

MSC 9048 (4/26/2017)

Initials: _____ Date: _____

VII. Practice Call Coverage		-			y of those practitioners who ou are unavailable.	
Name:			Specialty:			
1.						
2.						
3.						
4.						
5.						
VIII. Undergraduate Educati	on		Pleas	e attach additior	nal sheets, if necessary.	
Complete school name and street address:		Degree 1	eceived:		Month / year of start:	
					Month / year of graduation:	
City:		State:		Course of study of	l or major:	
IX. Graduate Education			additional sl	neets,	Does not apply	
Complete school name and street address:	if n	Degree 1			Month / year of start:	
					Month / year of anadystica	
					Month / year of graduation:	
City:		State: Course of study		Course of study of	or major:	
X. Medical / Professional Edu	ıcation		Pi	lease attach addi	tional sheets, if necessary.	
Complete medical / professional school name ar	d 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 d	id not com	inlete the prog	ram, nlease exnla	in on a separate sheet.)	
Complete medical / professional school name ar			-prese the prog	- · · · · · · · · · · · · · · · · · · ·	on on a separate succes,	
City:		State			ZIP:	
Degree received:		Phone nu	mber: -		Fax number, if available	
From month / year:	To month / year:			Month / year of c	completion:	
Did you complete the program? Yes	No ☐ (if you d	id not con	plete the prog	ram, please expla	in on a separate sheet.)	

Initials: _____ Date: ____

XI. Post-Graduate Year 1 / Inter	nship <i>Please a</i>	ttach 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 \(\scale= \) No	☐ (if you did	not complete the progra	ım, please explair	on a separate sheet.)
XII. Residencies	Please attach ad	ditional sheets, if neces	ssary.	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:	L	Month / year of	completion:
Did you complete the program? Yes ☐ No	(if you did	not complete the progra	ım, please explair	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 progra	ım, please explain	on a separate sheet.)
XIII. Fellowships, Preceptorships		linical Training	Programs	Does not apply
Please attach additional sheets, if necessity of the complete institution name and street address:	ssary.			
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 progra	ım, please explaiı	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		not complete the progra	_	•
Did you complete the program? Tes No	(II you did	not complete the progra	ını, picase expiair	on a separate sneet.)

Initials: _____ Date: ____

Please attach additional sheets, if neces	•		
Oregon license or registration number:	Type:	Month / Day / Year	of Expiration:
Drug Enforcement Administration (DEA) reg	gistration number (if applicable):	Month / Day / Year	of Expiration:
Controlled substance registration (CSR) num	ber (if applicable):	Month / Day / Year	of Issue:
Entity type 1 (individual) NPI number:	Medicare number:	DMAP number:	
Physician Assistant Supervising Physician Fu	all Name and Oregon License Number:	1	
XV. Other State Health Car Please include all ever held.	re Licenses, Registrations & C	ertificates	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:	I	I	
State / Country:	Number:	Type:	
Year obtained:	Month / Day / Year of expiration:	Year relinquished	:
Reason:	I	I	
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:	l		
Please attach additional sheets, if neces	sary.		

Initials: _____ Date: _____

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: Month / day / year of appointment Status (e.g. active, courtesy, provisional, allied health, etc.): Professional liability carrier: Facility name: Fax number, if available Complete address: Phone number: Month / day / year of appointment Status (e.g. active, courtesy, provisional, allied health, etc.): Professional liability carrier: Facility name: Fax number, if available Complete address: Phone number: Status (e.g. active, courtesy, provisional, Month / day / year of appointment allied health, etc.): Professional liability carrier: Facility name: Phone number: Fax number, if available Complete address: Month / day / year of appointment Status (e.g. active, courtesy, provisional, allied health, etc.): Professional liability carrier: 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: Fax number, if available Phone number: Complete address: Month / day / year of submission Status (e.g. active, courtesy, provisional, allied health, etc.): Facility name: Fax number, if available Phone number: Complete address: Month / day / year of submission Status (e.g. active, courtesy, provisional, allied health, etc.): C. Previous Affiliations Does not apply Please attach additional sheets, if necessary. Facility name: Phone number: Fax number, if available Complete address: From month / day / year: To month / day / year: Professional liability carrier: Reason for leaving: Facility name: Phone number: Fax number, if available Complete address: From month / day / year: To month / day / year: Professional liability carrier: Reason for leaving: Facility name: Phone number: Fax number, if available Complete address: From month / day / year: To month / day / year: Professional liability carrier: Reason for leaving:

XVI. Hospital and Other Health Care Facility Affiliations

Initials: Date:

XVII. Professional Pr Curriculum vitae is not sufficie	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. Please attach additional sheets, if necessary.					
Name of current practice / employer	r:	Contact's name:			
Telephone number: Ext	Fax number:	Complete address:			
From month / year:	To month / year:				
Contact's email address, if available	e:	Professional liability carrier:			
Name of previous practice / employ	er:	Contact's name:			
Telephone number: Ext	Fax number:	Complete address:			
From month / year:	To month / year:				
Contact's email address, if available	e: 	Professional liability carrier:			
Name of previous practice / employ	rer:	Contact's name:			
Telephone number: Ext	Fax number:	Complete address:			
From month / year:	To month / year:				
Contact's email address, if available	2:	Professional liability carrier:			
Name of previous practice / employ	er:	Contact's name:			
Telephone number: Ext	Fax number:	Complete address:			
From month / year:	To month / year:				
Contact's email address, if available	2:	Professional liability carrier:			
Name of previous practice / employ	er:	Contact's name:			
Telephone number: Ext From month / year:	Fax number: To month / year:	Complete address:			
·					
Contact's email address, if available:		Professional liability carrier:			
Name of previous practice / employ	er:	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:			

В.	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.					
		Activities and/or names:		From month / year:	To month / year:	
	I. Peer Referen					
			h recent observations are d			
	ou have privileges.	include relatives. II possib	le, include at least one mem	ber from the Medica	ii Stair of each facility at	
	reference:		Complete address, in	nclude department if app	licable:	
Specialty	v:					
Profession	onal relationship:					
Telephoi	phone number: Fax number: Email address, if available:			nilable:		
Name of	reference:	•	Complete address, in	nclude department if app	licable:	
Specialty	y:					
D. C	1 1 2 12					
Profession	onal relationship:					
Telephoi	ne number: - ext	Fax number:	Email address, if ava	Email address, if available:		
Name of	reference:		Complete address, in	nclude department if app	licable:	
Specialty	y:					
Profession	onal relationship:					
T 1 1		- I	E 1 11 '6	71.11		
Telephoi	ne number: - ext	Fax number:	Email address, if ava	ailable:		
XIX.	Continuing Mo	edical Education				
			dit(s) during the past two (2)	years.	Does not apply	
Please Name:	attach a separate shee	t, if needed.	Month / year attende	ad.	Hours:	
name:			Month / year attende	eu.	nours.	
Name:			Month / year attende	ed:	Hours:	
Name:			Month / year attende	ed:	Hours:	
Name:			Month / year attende	ed:	Hours:	
Name:			Month / year attende	ed:	Hours:	
Name:			Month / year attende	ed:	Hours:	
			I		1	

MSC 9048 (4/26/2017)

Initials: _____ Date: _____

XX. Professional Liability	Insurance			
Current insurance carrier / provider of prof	essional liability coverage:	Policy number:		coverage (check one): made Occurrence
Name of local contact:		Mailing address:		
Contact's telephone number: Fax number, if available: Ext		_		
Per claim limit of liability:	Aggregate amount:	Contact's email address,	if available:	
Month / day / year effective:	Month / day / year retroactiv	ve date, if applicable:	Month / day / year	of expiration:
Please list all previous profession Please attach additional sheets, if		in the past five (5) yea	ars.	Does not apply
Insurance carrier / provider of professional	liability coverage:	Policy number:		f coverage (check one): -made Occurrence
Name of local contact:		Mailing address:	•	
Contact's telephone number: Ext	Fax number, if available:			
Per claim limit of liability:	Aggregate amount:	Contact's email address,	if available:	
Month / day / year effective:	Month / day / year retroactiv	ve 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, if available:	-		
Per claim limit of liability:	Aggregate amount:	Contact's email address,	if available:	
Month / day / year effective:	Month / day / year retroactiv	ve date, if applicable:	Month / day / year	of expiration:
Insurance carrier / provider of professional	liability coverage:	Policy number:		f coverage (check one): -made Occurrence
Name of local contact:		Mailing address:	<u> </u>	
Contact's telephone number: Ext	Fax number, if available:			
Per claim limit of liability:	Aggregate amount:	Contact's email address,	if available:	
Month / day / year effective:	Month / day / year retroactiv	ve date, if applicable:	Month / day / year	of expiration:
Insurance carrier / provider of professional liability coverage:		Policy number:		f coverage (check one): -made Occurrence
Name of local contact:		Mailing address:		
Contact's telephone number: Ext	Fax number, if available:	_		
Per claim limit of liability:	Aggregate amount:	Contact's email address,	if available:	
Month / day / year effective:	Month / day / year retroactiv	ve 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. Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) YES NO 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? B. YES 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? C. YES 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 relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review? D. YES NO 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? E. YES 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? F. Has your membership or fellowship in any local, county, state, regional, national, or international professional YES organization ever been revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review? Have you ever voluntarily or involuntarily left or been discharged from the education program leading to your current G. YES licensure or any subsequent training programs? H. Have you ever had board certification revoked? YES I. YES Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity? J. YES Have you ever been charged with a criminal violation (felony or misdemeanor)? K. YES Do you presently use any illegal drugs? L. Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency YES 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. M. Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner YES agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance? N. YES 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. O. YES 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? *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

accordance with contract provisions.

Signature:

Date:

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

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.

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:

- 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 p	permission for the release of the credentials information contained in this practitioner applicat to the following health care related organization(s):	on
		_

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 pro	ovider that handled the claim:
Your status in the legal action (primary defendant, co-defendant	at, 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 an	d 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.