December, 1999

Dear Health Care Professional:

In 1998, the Oklahoma Legislature passed a law dealing with credentials verification. That law directed the Board of Health to promulgate rules and the Oklahoma State Department of Health to develop a uniform credentialing application. The application will be used to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

The Department has developed the attached Uniform Credentialing Application. Although many of the items apply primarily to physicians, this form has been designed for use by all health care professionals.

Please note these specific instructions:

1. **DO NOT submit this form to the Oklahoma State Department of Health.**
2. **Contact the facility or organization to which you plan to apply before submitting this form to find out what addendum, supplemental form, additional information, or additional items will be required.**
3. **All items must be completed.**
4. **If an item is not applicable, please so state.**
5. **Please print legibly or type.**
6. **Be sure to sign and date the application.**
7. **If additional space is needed, please attach additional sheets.**

The application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. The form is available on the Department's website at **www.health.state.ok.us**. For questions about the form you may contact the Department at (405) 271-6868. The form may also be available online at the different facilities and organizations to which you will be making application.

Protective Health Services
Oklahoma State Department of Health

Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"). Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to: _____

_____

Date: _____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.

SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix

Professional Degree _____ Gender: ___ Male ___ Female

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___-___ ___-___ ___ ___ ___ to ___ ___-___ ___-___ ___ ___ ___

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___-___ ___-___ ___ ___ ___ to ___ ___-___ ___-___ ___ ___ ___

Social Security Number ___ ___ ___-___ ___-___ ___ ___ ___ NPID (formerly UPIN)_____

Date of Birth: ___ ___-___ ___-___ ___ ___ ___ _____
Place of Birth Citizenship

_____
Visa Type Visa Number (provide copy) Expiration Date

_____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: _____

This Section continues on next page.

-Section 2 Continued-

Office Street Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Mailing Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Billing Address (If Different From Claims Payment Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Claims Payment Address (If Different From Office Billing Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Make Checks Payable To: _____

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice) | Subspecialty | % Of Time

Secondary Specialty | Subspecialty | % Of Time

Do you wish to be listed as:
___ Primary Care Provider ___ Specialist ___ Hospitalist ___ On-Call ___ Other (specify)_____
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

___ Yes ___ No Are you accepting new patients?

___ Yes ___ No Are you willing, in the future to accept new patients?

___ Yes ___ No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

___ Yes ___ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

___ Yes ___ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) | ( ) | ( )
Phone Number | Fax Number | Answering Service Number

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) | ( ) | ( )
Phone Number | Fax Number | Answering Service Number

List any restrictions on your practice (i.e. patient age and gender): _____

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(2) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(3) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed: ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(2) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(3) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(4) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(2) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(3) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) _____ ___ Primary ___ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

(2) _____ ___ Primary ___ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) _____ ___ Primary ___ Secondary
Facility Name

_____ ( )
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

_____
Location Branch of Service

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

_____
Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

Oklahoma _____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ ___ ___-___ ___-___ ___ ___ ___
USMLE/ECFMG Number Certification Date

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

_____ DEA _____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ DEA _____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

Oklahoma BNDD _____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

_____ CDS _____ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
State Type Number Original Date of Issue Expiration Date

BOARD CERTIFICATION

Are you Board Certified? ___ Yes ___ No _____
Name of Board

___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___ ___ ___ ___-___ ___-___ ___ ___ ___
Date Initially Certified Date Most Recently Recertified Date Certification Expires

___ Yes ___ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification — Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

Subspecialty or Added Qualification — Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

BOARD QUALIFICATIONS

___ Yes ___ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

___ Yes ___ No Are you planning to take the exam?

___ Yes ___ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral __ __ - __ __ - __ __ __ __

Written __ __ - __ __ - __ __ __ __

Other __ __ - __ __ - __ __ __ __

Subspecialty or Added Qualification — Name of Board

Date Qualified __ __ - __ __ - __ __ __ __ Date Qualification Expires __ __ - __ __ - __ __ __ __

Classifications:

___ Yes ___ No Are you certified in CPR? Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Basic Life Support (BLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Advanced Cardiac Life Support (ACLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Health Care Provider (CoreC) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Advanced Trauma Life Support (ATLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Neonatal Advanced Life Support (NALS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Pediatric Advanced Life Support (PALS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Other_____ Expires __ __ - __ __ - __ __ __ __

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

___ Solo ___ Partnership ___ Single-Specialty Group ___ Multi-Specialty Group Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ___ Yes ___ No Reference Lab? ___ Yes ___ No On Site? ___ Yes ___ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

___ Yes ___ No Radiology
___ Yes ___ No EKG
___ Yes ___ No Audiology
___ Yes ___ No Treadmill
___ Yes ___ No Sigmoidoscopy
___ Yes ___ No Wheelchair/handicapped access?
___ Yes ___ No Other services for the disabled?
If yes, please list:_____
___ Yes ___ No Other:_____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

___ Yes ___ No Does this office meet all state and local fire, safety and sanitation requirements?

___ Yes ___ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

___ Yes ___ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

___ Solo ___ Partnership ___ Single-Specialty Group ___ Multi-Specialty Group ___ Other (specify) _____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ___ Yes ___ No Reference Lab? ___ Yes ___ No On Site? ___ Yes ___ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

___ Yes ___ No Radiology
___ Yes ___ No EKG
___ Yes ___ No Audiology
___ Yes ___ No Treadmill
___ Yes ___ No Sigmoidoscopy
___ Yes ___ No Wheelchair/handicapped access?
___ Yes ___ No Other services for the disabled?
If yes, please list: _____
___ Yes ___ No Other: _____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

___ Yes ___ No Does this office meet all state and local fire, safety and sanitation requirements?

___ Yes ___ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

___ Yes ___ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:
Practitioners are reminded that each organization <u>will</u> require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.