IOWA STATEWIDE UNIVERSAL
PRACTITIONER RECREDENTIALING APPLICATION

- **Type or print responses in ink. A CV or "See CV" may not be use in lieu of completing any answers on this application.**
- **Review or complete this form in its entirety and attach all requested documentation and explanations.**
- **If a question does not apply to you, answer with "Non-Applicable" or "N/A".**
- **If additional space is necessary to provide answers, attach additional sheet(s) of paper.**
- **All dates must be formatted as: Month/Date/Year (MM/DD/YEAR). Typing/printing "present" for Ending Dates is acceptable.**
- **This application must be signed and dated where indicated.**
- **Some of the following questions apply only to the time period since the last credentialing/recredentialing date. This practitioner's last credentialing/recredentialing date was: _____/_____/_____**

Please contact the following person regarding this application: Name: _____
Phone Number: (_____)_____ **Fax Number:** (_____)_____
E-mail Address: _____

SECTION A: DEMOGRAPHIC INFORMATION:

_____
Legal Last Name First Middle Professional Title/Degree

Other Known Names: _____ SSN: _____ Birth Date: _____/_____/_____

Are you a US Citizen? ☐ Yes ☐ No If no, do you have: ☐ Green Card or ☐ Work Permit (If yes, attach a notarized copy) ☐ Neither

(Explain Visa): Visa Type: _____ Visa Number: _____

Current Home Address: _____

_____

City: _____ State: _____ Zip Code: _____

(_____)_____ (_____)_____ _____
Phone Number Cell Phone Number E-Mail Address

Spouse/Significant Other's Full Name (if applicable): _____

SECTION B: OFFICE/PRACTICE SITE INFORMATION: ☐ PRIMARY ☐ ADDITIONAL/SATELLITE

Please provide information for every site at which you provide services (attach additional sheet(s) if necessary):

☐ Primary Care Provider (PCP) ☐ Co-Care Manager ☐ Specialist ☐ PCP & Specialist ☐ PCP Back-up Only ☐ Specialist Back-up

Practice Location Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____ Total # of hours in this office per week: _____

Provide billing and registration numbers (if applicable). These may be individual or group/clinic numbers:

Type	***Group Number***	***Individual Number***
Federal Tax Identification Number:		
Medicare Number:		
Medicaid Number:		
NPI Number		

For Directory Listing purposes - Gender: ☐ Male ☐ Female Are you accepting new patients? ☐ Yes ☐ No

Special Languages spoken/translated by you at this site: _____

List the name(s) of all provider back-ups (attach additional sheet(s) if necessary):

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Supervising/Collaborative Physician for non-physician applicant (attach additional sheet(s) if necessary):

Name: _____Title: _____ Specialty: _____ License #_____

Name: _____Title: _____ Specialty: _____ License #_____

Account/Billing Address if different than the practice location address above:

Address: _____City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____ Limitations in Practice: _____

SECTION C: LICENSURE and REGISTRATION INFORMATION (current/active licenses/registrations only):

Professional License #	*Degree*	*Name on License*	*State Issued*	*Country*	*Issue Date*	*Expiration Date*

Current Federal DEA and State Controlled Substance Certificate (SCSC) numbers and expiration dates (if none, explain on page 6):

Certificate	*State Issued*	*Certificate Number*	*Issue Date*	*Expiration Date*
Federal DEA				
Federal DEA				
State CSC				
State CSC				

SECTION D: CURRENT MALPRACTICE LIABILITY COVERAGE: Policy #: _____

Carrier Name: _____ Phone #: (_____)_____ Fax #: (_____)_____

Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Coverage Amounts: _____/_____

(Per Occurrence Per Aggregate)

SECTION E: PROFESSIONAL HISTORY: List all professional experience added since your last credentialing cycle (copy and attach additional sheets if necessary):

Type: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: _____ Position: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Email: _____

Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____ Phone #: (_____)_____ Fax #: (_____)_____

Type: ☐ **EMPLOYMENT** ☐ **ACADEMIC/FACULTY** ☐ **MILITARY** ☐ **PUBLIC HEALTH** ☐ **OTHER**

Location Name: _____ Position: _____

Address: _____ City: _____ State: _____ Zip Code: _____ Email: _____

Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____ Phone #: (_____)_____ Fax #: (_____)_____

SECTION F: HOSPITAL AND FACILITY PRIVILEGES: List all hospitals and facilities at which you have pending or currently hold privileges and describe the type(s) of privileges (copy and include additional sheets if necessary):

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

Hospital/Facility Name: ____ Phone #: (______)_______________ Fax #: (______)_____________

Address: ____________________________ City: _________________ State: ________ Zip Code: ________ Email: _______________________

Date From: ______/_______/________ To: _______/_______/_______ Staff Category (Active, Courtesy, etc.): ___________________________

SECTION G: CERTIFICATION: Provide the following information for each certification you have completed, or are eligible to complete since your last credentialing cycle:

☐ **NOT APPLICABLE**

☐ **CERTIFICATION/RECERTIFICATION:**

Board Name/Certificate Type/Issued By: _____

Board Specialty: _____

Subspecialty (if any): _____

Original Certification Date: _____/_____/_____ Recertification Date: _____/_____/_____ Expiration Date: _____/_____/_____

Board Name/Certificate Type/Issued By: _____

Board Specialty: _____

Subspecialty (if any): _____

Original Certification Date: _____/_____/_____ Recertification Date: _____/_____/_____ Expiration Date: _____/_____/_____

Board Name/Certificate Type/Issued By: _____

Board Specialty: _____

Subspecialty (if any): _____

Original Certification Date: _____/_____/_____ Recertification Date: _____/_____/_____ Expiration Date: _____/_____/_____

☐ **ELIGIBLE/ADMISSIBLE FOR CERTIFICATION:**

Board Name/Certificate Type: _____

Written Examination Completed or Scheduled: _____/_____/_____ Oral Examination Completed/Scheduled: _____/_____/_____

Admissibility Dates: From _____/_____/_____ to _____/_____/_____

SECTION H: EDUCATION/TRAINING: Provide the following information for any additional education/training received since your last credentialing cycle:

Type: _____(MA, PhD, Residency, Fellowship, etc.)

Institution Name:_____ Phone #: (_____)_____ Fax #: (_____)_____

Address: _____ City: _____ State/Country: _____ Zip Code: _____ Email: _____

Dates Attended: Beginning Date: _____/_____/_____ Ending Date: _____/_____/_____

Degree/Specialty: _____ Program Director's Name: _____

SECTION I: PEER REVIEW REFERENCES FOR HOSPITAL REAPPOINTMENT APPLICATION ONLY: Give three professional peer references that have personal knowledge of your recent clinical abilities, ethics, health status and can provide specific written comments on these matters upon request. The named individual must have acquired the requisite knowledge through recent observation of your professional ability. Do not include family or fellow students. Suggested peer references are: professors, practitioners in the same specialty, or department chairs.

☐ **NOT APPLICABLE**

Name: _____ Title: _____ Position/Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ E-mail: _____ Fax #: (_____)_____

Name: _____ Title: _____ Position/Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ E-mail: _____ Fax #: (_____) _____

Name: _____ Title: _____ Position/Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ E-mail: _____ Fax #: (_____) _____

Please be sure to carefully read and answer each question below, and explain *any* "yes" answers on page 6.
Note - A special form is attached for Malpractice Claim History on the attached Addendum A ➔➔

SECTION J: QUALITY FOCUSED QUESTIONS (SINCE YOUR LAST CREDENTIALING OR PRIVILEGING WITH THIS ENTITY):

**The questions below are for the time period since your last credentialing/recredentialing cycle.

1.	Have you voluntarily or involuntarily surrendered or relinquished a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification?……..	☐ YES ☐ NO
2.	Have you voluntarily or involuntarily had a state, district or federal professional license or registration (DEA or State Controlled Substance Certificate), board certification or any other certification revoked, suspended, limited, denied or refused by an Iowa licensing, state or federal drug administration, certifying board, or by such an entity in any other state(s)?……..	☐ YES ☐ NO
3.	Have there been any successful or are there any currently pending challenges, complaint(s), sanction(s), disciplinary actions(s), investigations or denials recommended or taken against your state, district or federal professional license(s), registrations (DEA or State Controlled Substance Certificate), board certification or any other certification(s)?……..	☐ YES ☐ NO
4.	Have you voluntarily or involuntarily withdrawn from a clinical, medical, dental or professional staff?……	☐ YES ☐ NO
5.	Have you voluntarily or involuntarily withdrawn a request for an increase in privileges?……	☐ YES ☐ NO
6.	Have you been refused membership on a clinical, medical, dental or professional staff (other than for a general closure of that staff to providers of your specialty)?……..	☐ YES ☐ NO
7.	Have you had a hospital, health care facility, or other health care organization invoke probation, issue a reprimand, impose proctoring (other than proctoring when privileges are initially granted), require a second opinion or initiate an investigation of your professional conduct or competency?……	☐ YES ☐ NO
8.	Are you currently performing or do you plan to perform any procedures for which you have ever been refused or lost privileges?……..	☐ YES ☐ NO
9.	Have you ever been the subject of a formal or public citation or warning or ever had a sanction of any kind imposed by any health care institution, health care organization, licensing authority or other governmental entity, or voluntarily or involuntarily resigned under threat of the same? ……	☐ YES ☐ NO
10.	Have your employment, medical staff appointment/membership, or clinical privileges been challenged or voluntarily or involuntarily suspended, reduced, revoked, refused (denied), relinquished, terminated, limited or lost at any hospital, healthcare plan or other healthcare facility or organization?……	☐ YES ☐ NO
11.	Have you been convicted of any crime related to your clinical, medical, dental or professional practice?	☐ YES ☐ NO
12.	Regarding Medicare, Medicaid, or any other governmental health-related programs, have you been convicted of a crime or been subjected to civil penalties, disciplinary proceedings, investigations, denial of or suspension from participation, or had any type of sanction?…….	☐ YES ☐ NO
13.	Do you have any felony, grand jury indictment, or other criminal charges pending?……	☐ YES ☐ NO
14.	Have you been convicted of, found guilty of or pled no contest to a felony, grand jury indictment or crime, other than a minor traffic violation?……..	☐ YES ☐ NO
15.	Do you presently have a physical, mental or emotional condition (including alcohol or drug dependence), or do you presently engage in the use of illegal substances that affects or is reasonably likely to affect your ability to perform your professional duties appropriately or which could adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients?.....	☐ YES ☐ NO
16.	Has your malpractice insurance been denied, suspended, limited, not renewed or terminated by a carrier?…….	☐ YES ☐ NO
17.	Have you had a malpractice case filed against you? (If yes, explain on Addendum A) ……	☐ YES ☐ NO

SECTION J: QUALITY FOCUSED QUESTIONS continued…

18. Have you had a malpractice judgment entered against you? (If yes, explain on Addendum A)……. ☐ YES ☐ NO

19. Have any malpractice settlements been made on your behalf? (If yes, explain on Addendum A)……. ☐ YES ☐ NO

20. Are there any open claims or pending malpractice cases presently filed against you? (If yes, explain on Addendum A) …….. ☐ YES ☐ NO

21. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank?……. ☐ YES ☐ NO

22. Have you been denied membership in or voluntarily or involuntarily been terminated by any professional organization?…… ☐ YES ☐ NO

23. Have you had any sanctions or disciplinary action executed against you by a Professional Standards Review Organization (PSRO), utilization or quality control Peer Review Organization (PRO), or any professional organization?…….. ☐ YES ☐ NO

24. Has your participation in a managed care plan or healthcare organization been limited, denied, or terminated, or have you been sanctioned by such an organization?…… ☐ YES ☐ NO

For any "YES" answers to the Quality Focused Questions above, please provide detailed explanation here, with the exception of any Malpractice Claim History (for Malpractice Claim History provide detailed information on the attached Addendum A).

Question #	Detailed Explanation

TO AVOID DELAY IN THE PROCESSING OF THIS APPLICATION
PLEASE BE SURE TO SIGN AND DATE FOR CERTIFICATION / ATTESTATION / and RELEASE BELOW AND ANY ADDENDUMS (if applicable).

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application;
- You may correct any erroneous information found in your credentialing files; and
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted.
- Upon request, you will be informed of the status of your recredentialing application.

I represent and warrant that all of the information provided and the responses given on this application are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of information could result in the rejection or termination of my participation in any plan, staff or panel, in addition to penalties provided by law. I hereby authorize the hospital, CVO, credentialing entity or managed care plan, or its delegated agents, staff and representatives to collect and review all records and documents, which may include records of previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank and Criminal Background Check investigations, that may be material to an evaluation of my professional qualifications and competence. I also understand that certain fields of data on this application contain time-sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize the entity to which this application is submitted, to collect from me and other sources this information on an as-needed basis, and understand and agree they may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application. I hereby release from liability the entity to which this application is submitted and their delegated agents, staff and representatives for their acts performed in good faith and without malice in connection with the evaluation of my application and my credentials and qualifications. It is my understanding that the entity to which this application is submitted shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, my designated entity, or as authorized under state or federal law or regulation. I further release from liability any and all individuals and organizations who provide information to the entity reviewing my credentials, and its agents, staff and representatives, when released in good faith and without malice, concerning my professional qualifications, competence, ethics and character, and I hereby consent to the release of such information for purposes consistent with this application. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

If making this application for hospital privileges, I acknowledge that I have been provided the Bylaws, Rules and Regulations of the hospital to which this application applies, and I agree to abide by them and the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for staff membership. I also pledge to provide or arrange for continuous care of my patients.

Practitioner Signature: _____ **Date:** _____/_____/_____

Practitioner Name (please type or print): _____

Practitioner Initials: _____

MALPRACTICE CLAIM HISTORY FORM

Practitioner Name: _____

☐ **NO ACTIVITY TO REPORT (Proceed to Signature Line Below)**

If you have any professional malpractice activity to report on this application, complete this page for each professional liability incident (copy and include additional sheets if necessary).

Description of allegation or action taken: _____

_____

Date of incident: _____/_____/_____ Date of claim or suit filed: _____/_____/_____

Location of incident: _____

Insurance carrier name: _____

Insurance carrier address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Describe your involvement with the patient's care. Your narrative must include the following at a minimum:

1) Condition and diagnosis at time of incident
2) Dates and description of treatment rendered
3) Condition of patient subsequent to treatment

_____

_____

_____

_____

_____

Your Status: ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify) _____

Claim Status: ☐ Open ☐ Pending ☐ Closed

If closed, indicate the date closed and case outcome: Date Closed: _____/_____/_____

☐ Dismissed with prejudice ☐ Settled with Prejudice ☐ Judgment for Defendant

☐ Dismissed without prejudice ☐ Settled without Prejudice ☐ Judgment for Plaintiff

Amount of settlement or judgment paid on your behalf (if any): $_____

Date of payment: _____/_____/_____

I certify that the information provided on this document is correct and complete to the best of my knowledge:

_____ _____

Practitioner's Signature Date