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	41				
43				SUBPART A: GENERAL	
10	43				

	ion 965.110 Definitions
45 46	Act – the Health Care Professional Credentials Data Collection Act [410 ILCS
17 17	517].
48	
19	Credentialing – the process of assessing and validating the qualifications of a
50	health care professional. (Section 5 of the Act)
51	T June 1
52	Credentials data – those data, information, or answers to questions required by a
53	health care entity, health care plan, or hospital to complete the credentialing or
54	recredentialing of a health care professional. (Section 5 of the Act)
54 55	
56	Health care entity – any of the following entities that require the submission of
57	credentials data in order for a health care professional to participate or provide
58	care as a part of, or in conjunction with, the health care entity:
59	
50	a health care facility or other health care organization licensed or
51	certified to provide medical or health services in Illinois, other than a
52	hospital;
53	
54	a health care professional partnership, corporation, limited liability
55	company, professional services corporation or group practice; or
56	
67	an independent practice association or physician hospital organization.
58	(Section 5 of the Act)
59 70	
70	Entities licensed under other Acts that conduct credentialing in order for a
71	health care professional to provide services, such as home health agencies,
72	hospices, post-surgical recovery care centers, and ambulatory surgical
73	treatment centers, are health care entities for the purposes of this Part.
74 75	Providers certified under the federal Medicare Program, such as Rural Health
	Clinics and End Stage Renal Disease treatment facilities, are also health care entities under this Part if they credential providers in order to provide services
76 77	in their facilities/programs.
77 78	in their racinties/programs.
78 79	Health care plan – any entity licensed by the Department of Insurance as a
30	prepaid health care plan or health maintenance organization or as an insurer that
31	requires the submission of credentials data. (Section 5 of the Act)
32	requires the submission of creatmans and. (Section 5 of the rice)
33	Health care professional – any person licensed under the Medical Practice Act of
34	1987 or any person licensed under any other Act subsequently made subject to the
34 35	Act. (Section 5 of the Act)
	··· (

87	Hospital – a hospital licensed under the Hospital Licensing Act or any hospital
88	organized under the University of Illinois Hospital Act. (Section 5 of the Act)
89	
90	Recredentialing – a process undertaken for a period not to exceed 3 years by
91	which a health care entity, health care plan, or hospital ensures that a health care
92	professional who is currently credentialed by the health care entity, health care
93	plan, or hospital continues to meet the credentialing criteria used by the health
94	care entity, health care plan, or hospital. (Section 5 of the Act)
95	
96	Single credentialing cycle – a process undertaken for a period not to exceed 3
97	years whereby, for purposes of recredentialing, each health care professional's
98	credentials data are collected by all health care entities and health care plans
99	during the same time period. (Section 5 of the Act)
100	
101	<i>Uniform health care credentials form – the form referenced in Section</i>
102	965. Appendix A to collect the credentials data commonly requested by health
103	care entities and health care plans for purposes of credentialing. (Section 5 of the
104	Act)
105	
106	<u>Uniform health care recredentials form – the form referenced in Section</u>
107	965.Appendix B to collect the credentials data commonly requested by health
108	care entities and health care plans for purposes of recredentialing. (Section 5 of
109	the Act)
110	
111	<u>Uniform hospital credentials form – the form referenced in Section 965.Appendix</u>
112	A to collect the credentials data commonly requested by hospitals for purposes of
113	<u>credentialing</u> . (Section 5 of the Act)
114	
115	<i>Uniform hospital recredentials form – the form referenced in Section</i>
116	965.Appendix B to collect the credentials data commonly requested by hospitals
117	for purposes of recredentialing. (Section 5 of the Act)
118	
119	<i>Uniform updating form – a standardized form</i> referenced in Section
120	965. Appendix C for reporting of corrections, updates, and modifications to
121	credentials data to health care entities, health care plans, and hospitals when
122	those data change following credentialing or recredentialing of a health care
123	professional. (Section 5 of the Act)
124	
125	Recredentialing the process by which a health care entity, health care plan, or
126	hospital ensures that a health care professional who is currently credentialed by
127	the health care entity, health care plan, or hospital continues to meet the
128	credentialing criteria used by the health care entity, health care plan, or hospital
129	no more than once every 2 years. (Section 5 of the Act)

130		
131	(Sour	ce: Amended at 48 Ill. Reg, effective)
132	G 0.5	
133	Section 965.	130 Use of Uniform Credentialing Forms
134 135	a)	A health care entity, a health care plan, or a hospital may accept or require
136	a)	credentialing data in an electronic format provided it contains the required conten
137		prescribed by the Department in Sections 965.APPENDIX A through C. The
138		Department shall establish uniform forms for the purpose of credentialing,
139		recredentialing, and information updates as required in Section 15 of the Act. The
140		forms shall be coordinated to avoid the need for duplication of effort and
141		information in submission.
142		
143	<del>b)</del>	Hard copies and/or electronic copies of the forms shall be provided by the
144	- /	credentialing entity to applicants and current providers for use in their process.
145		Copies may be obtained through the Department electronically via the website at
146		www.idph.state.il.us or in hard copy upon request. No health care entity, health
147		care plan, or hospital may require submission of the form in a specific format,
148		either paper or electronic, until a date has been established under this Part
149		whereby electronic submission can be required.
150		
151	<u>b</u> e)	All Beginning January 1, 2002, all health care entities, health care plans, and
152		hospitals that credential health care professionals shall only require the
153		submission of the following forms, as specified in Section 15 of the Act:
154		
155		1) For credentialing, the Uniform Health Care and Hospital Credentials Form
156		(Section 965. Appendix A):
157		
158		2) For recredentialing, the Uniform Health Care <u>and Hospital</u> Recredentials
159		Form (Section 965. Appendix B):
160		
161		3) For updating credentials information, the Uniform Updating Form
162		(Section 965. Appendix C):
163		
164		4) <u>Any additional credentials data requested; and Any additional credentials</u>
165		<del>data requested.</del>
166		
167		5) An online credential with required content as required by forms under this
168		Section.
169	•	
170	<del>d)</del>	Credentialing and recredentialing applications and forms distributed before
171		January 1, 2002 may continue to be accepted, but only through June 30, 2002.
172		Health care plans, health care entities, and hospitals need not require that the

forms adopted in this Part be filed for a health care professional whose credentialing is already in process prior to January 1, 2002.

- This Section does not prohibit or restrict the right of anya health care entity, health care plan or hospital to request additional information necessary for credentialing or recredentialing. (Section 15(i) of the Act) Nothing in this Part prohibits a pre-application process from being in place at a health care entity, health care plan, or hospital. Individual attestation and release forms may be unique to each health care plan, hospital, or health care entity as a part of the credentialing or recredentialing process.
- f) The forms adopted in this Part cannot be altered in structure. Nothing prohibits the use of pre-populated or double-sided forms as long as the structure of each page remains as adopted and as appearing on the Department website at www.idph.state.il.us.
- Nothing in the Act or this Part requires a health care entity, health care plan, or hospital to seek all of the credentials data that may be provided in the mandated credentials data gathering forms. The extent to which a health care entity, health care plan, or hospital requires a health care professional to complete the applicable sections of the forms is within the discretion of the health care entity, health care plan, or hospital. However, no health care entity, health care plan, or hospital may reject or deny a form that includes more information than the requirements of the individual health care entity, health care plan, or hospital.
- Each health care professional shall provide any corrections, updates, and modifications to their credentials data to ensure that all credentials data on the health care professional remains current. Any corrections, updates, and modifications shall be provided Keeping current and making changes in information, corrections, updates, and modifications to a health care professional's credentials data on file with health care entities, health care plans, and hospitals is the responsibility of the health care professional. Data and information changes shall be submitted by the health care professional in accordance with the following time frames:
  - 1) Within 5 business days for state health care professional license revocation, federal <u>Drug Enforcement Agency</u> drug enforcement agency license revocation, Medicare or Medicaid sanctions, revocation of hospital privileges, any lapse in professional liability coverage required by a health care entity, health care plan or hospital, or conviction of a felony.
  - 2) Within 45 days for any other change in the information from the date the

216 health care professional knew of the change. (Section 15(g) of the Act) 217 218 fi) All updates shall be made on the updating forms in Section 965. Appendix C-of 219 this Part. (Section 15(g) of the Act) Updated information will be based on the 220 information submitted to a health care plan, health care entity or hospital in the 221 form in Section 965. Appendix B of this Part. 222 223 Collection of the information contained in the forms under this Part does not g<del>j</del>) 224 require health care entities, health care plans or hospitals to use all of the data and 225 fields in the credentialing process. Nothing in the Act or this Part mandates 226 whether or how credentials data must be verified or assessed as part of the 227 credentialing process. All decisions about whether and how to verify and assess 228 any or all of the credentials data submitted to a health care entity, health care plan 229 or hospital by a health care professional is exclusively within the lawful discretion 230 of the health care entity, health care plan, or hospital that is credentialing that 231 health care professional. 232 233 hk) Nothing in the Act or this Part prohibits a hospital from granting disaster 234 privileges pursuant to the provisions of Section 10.4 of the Hospital Licensing 235 Act. When a hospital grants disaster privileges pursuant to Section 10.4 of the 236 Hospital Licensing Act, that hospital is not required to collect credentials data 237 pursuant to the Act. (Section 15(m) of the Act) 238 239 (Source: Amended at 48 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_) 240 241 **Section 965.140 Required Policies and Procedures** 242 243 Each health care entity, health care plan, hospital, or other credentialing entity a) 244 shall adopt on or before January 1, 2002 and implement a policy or policies on the 245 process of credentialing and credentials verification within their organization, 246 including requests for additional information and confidentiality of information. 247 248 Each health care entity and health care plan shall complete the process of b) 249 verifying a health care professional's credentials data in a timely fashion and 250 shall complete the process of credentialing or recredentialing of the health care professional within 60 days after the submission of all credentials data and 251 252 completion of verification of the credentials data to be used in credentialing to be 253 used in credentialing and recredentialing. (Section 15(f) of the Act) 254 255 c) Any credentials data collected or obtained by the health care entity, health care plan, or hospital shall be confidential, as provided by law, and otherwise may not 256 be redisclosed without written consent of the health care professional, except that 257 258 in any proceeding to challenge credentialing or recredentialing, or in any judicial

259		review, the claim of confidentiality shall not be invoked to deny a health care	
260		professional, health care entity, health care plan, or hospital access to or use of	
261	<del>-</del>		
262		care plan, or hospital from disclosing any credentials data to its officers,	
263		directors, employees, agents, subcontractors, medical staff members, any	
264		committee of the health care entity, health care plan, or hospital involved in the	
265		credentialing process, or accreditation bodies or licensing agencies. However,	
266		any redisclosure of credentials data contrary to this subsection is prohibited.	
267		(Section 15(h) of the Act)The credentialing data noted as "confidential	
268		information" in the uniform forms in this Part are confidential as provided by law,	
269		including, but not limited to, Section 15(h) of the Act, Section 10.4 of the	
270		Hospital Licensing Act [210 ILCS 85/10.4] and Part 21 of Article VIII of the	
271		Code of Civil Procedure [735 ILCS 5/Art. VIII, Part 21], and otherwise may not	
272		be redisclosed without written consent of the health care professional.	
273			
274	d)	To make the form beneficial and effective for health care professionals, health	
275	,	care entities, health care plans, and hospitals, additional commonly collected	
276		business data are also being collected in the form. Nothing in the Act or this Part	
277		shall be considered to prohibit sharing of business data for business purposes of	
278		the health care entity, health care plan, or hospital.	
279			
280	e)	Health care entities, health care plans, and hospitals may delegate credentialing	
281	• ,	and recredentialing activities.	
282		and recreating activities.	
283	(Source	e: Amended at 48 Ill. Reg, effective)	
284	(Source	or ramended at 10 mi regi, erreeu 10	
285		SUBPART B: ENFORCEMENT ACTION	
286		BOBITARY BY ENGLANDING THORION	
287	Section 965.3	00 Single Credentialing Cycle	
288	Section 70010	oo single creatiuming cycle	
289	a)	All health care entities and health care plans shall obtain recredentialing data on a	
290	u)	health care professional according to the single credentialing cycle beginning July	
291		1, 2002, except:	
292		1, 2002, except.	
293		1) when a health care professional submits initial credentials data to a health	
294		care entity or health care plan;	
295		care entity of hearth care plan,	
296		2) when a health care professional's credentials data change substantively; or	
297		when a health care professional's eledentials data change substantivery, of	
298		3) when a health care entity or health care plan requires recredentialing as a	
298		result of patient or quality assurance issues.	
300		result of patient of quality assurance issues.	
301	<b>b</b> )	Data collection for health care entities and health care plans will coincide with a	
201	b)	Data confection for health care entities and health care plans will confedde with a	

302 single credentialing cycle that entitles health care entities and health care plans to 303 collect recredentialing data once and not more than every 3 years, except as noted 304 in subsection (a). 305 306 Data collection: c) 307 308 1) will be based on the last digit of each health care professional's Social 309 Security number; 310 311 2) will provide for a one-monthone month notification period for each digit 312 during which each health care entity and health care plan notifies those 313 persons being recredentialed of the time period during which data are 314 expected to be submitted; and 315 316 3) will provide for a two-month 2 month collection period for each digit during which each health care entity and health care plan receives data 317 from those persons being recredentialed. 318 319 320 d) The single credentialing cycle reflects a six-month open "OPEN" period when 321 health care entities and health care plans cannot collect data from a health care 322 professional, except as noted in subsection (a). This period coincides with the 323 Illinois Department of Financial and Professional Regulation's licensing schedule 324 of physicians. 325 326 e) The single credentialing cycle is established as follows: 327 328 1) For the years 2020/2023<del>2005/2008</del> 329 **OPEN** July August **OPEN** September **OPEN** October **OPEN** November **OPEN** December **OPEN** 330 331 2) For the years 2021/2024<del>2003/2006/2009...</del> 332 January Notification (0's) Collection of data February Collection of data March April Notification (1's) Collection of data May Collection of data

June

July	Notification (2's)
August	Collection of data
September	Collection of data
October	Notification (3's)
November	Collection of data
December	Collection of data

3) For the years 2022/2025 2004/2007/2010...

January	Notification (4's)
February	Collection of data
March	Collection of data
April	Notification (5's)
May	Collection of data
June	Collection of data
July	Notification (6's)
August	Collection of data
September	Collection of data
October	Notification (7's)
November	Collection of data
December	Collection of data

4) For the years <u>2020/2023</u><del>2005/2008/2011</del>

January	Notification (8's)
February	Collection of data
March	Collection of data
April	Notification (9's)
May	Collection of data
June	Collection of data

f) Once recredentialing is begun in accordance with the single credentialing cycle, a health care entity or health care plan may continue to request data from a health care professional outside of the published single credentialing cycle if it is not submitted by the deadline date published in the schedule.

g) Nothing in this Section shall be construed to preclude, or otherwise exempt, a health care plan from monitoring, on an ongoing basis, in between recredentialing cycles, information on sanctions, limitations on licensure, and complaints against health care professionals consistent with guidelines issued by any entity that provides private accreditation to health care plans, or from meeting any quality assurance requirement of the entity related to credentialing for the purpose of

351		accreditation or otherwise.		
352 353	<b>b</b> )	The requirements of this Section apply only to health core plans and health core		
354	h)	The requirements of this Section apply only to health care plans and health care		
355		entities as defined in the Act [410 ILCS 517/5].		
356	(Sourc	ee: Amended at 48 Ill. Reg, effective)		
357	(Sourc	c. Amended at 40 m. Reg, effective)		
358	Section 065 3	310 Waiver from Single Credentialing Cycle		
359	Section 705.5	10 Warver from Single Credentialing Cycle		
360	a)	A health care entity or health care plan may apply to the Director via letter for an		
361	u)	exemption from the single credentialing cycle. The request for consideration		
362		shallshould be addressed to the Department's Office of Health Care Regulation,		
363		the Director's designee for administration of this program, the Office of Health		
364		Care Regulation.		
365				
366		1) The request for waiver of this provision shallmust be submitted toreceived		
367		by the Department on or before November 1 of the year prior to initiation		
368		of the established cycle.		
369				
370		2) The request for waiver must contain, at a minimum, the following:		
371		_/, 1		
372		A) a detailed explanation as to the undue hardship that would be		
373		created for the health care entity or health care plan in following		
374		the published single cycle.		
375				
376		B) a detailed explanation and outline of the plan for conducting and		
377		time frame involved in the process that would be utilized in place		
378		of the published single cycle by the requesting health care entity or		
379		health care plan.		
380		•		
381	b)	The Director willshall evaluate the request for exemption based upon whether the		
382		plan is a small or unique health care entity for which compliance with the single		
383		credentialing cycle presents an undue hardship.		
384				
385	c)	The Department will notify waiver applicants of approval or denial by December		
386		15 of the year prior to implementation of the single cycle.		
387				
388	d)	A denial of a waiver may be appealed in accordance with the procedures in		
389		Section 965.860 of this Part.		
390				
391	(Source	ee: Amended at 48 Ill. Reg, effective)		
392				

	Credentialing and Business Data Gathering Form
	STATE OF ILLINOIS
	Uniform Health Care and Hospital Credentials Health Care Professional Credentialing and
	Business Data Gathering Form
1	The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans that desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.
	INCEDITORIONIC
	INSTRUCTIONS
]	This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED REQUIRESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.
_	This form has been segmented into <u>two (2)</u> different Chapters, each containing various sections:
	Chapter A: General and Practice Information Chapter B: Business Information
	As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or section requirements for submission.
(	GENERAL INSTRUCTIONS: Wherever this application requests information but does not
	provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments that contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.
	Any credentials data collected or obtained by the health care entity, health care plan, or hospital
	shall be confidential, as provided by law, and otherwise may not be redisclosed without written
	consent of the health care professional, except that in any proceeding to challenge credentialing
	or recredentialing, or in any judicial review, the claim of confidentiality shall not be invoked to deny a health care professional, health care entity, health care plan, or hospital access to or use
	of credentials data. Nothing in this subsection prevents a health care entity, health care plan, or
	hospital from disclosing any credentials data to its officers, directors, employees, agents,
	subcontractors, medical staff members, any committee of the health care entity, health care plan,

136	or hospital involved in the credentialing process, or accreditation bodies or licensing agencies.
137	However, any redisclosure of credentials data contrary to this subsection is prohibited. (Section
138	15(h) of the Act) The data marked as "Confidential Information" shall be maintained in
139	confidence to the extent required by law. They may be used by the health care plan, entity or
140	hospital and by their agents for credentialing and internal business purposes. Other data
141	contained in this form may be released.
142	

443	ATTACHMENTS				
444 445 446	Attach Forms A-F as needed to support "yes" responses in the Professional History section and copies of the following:				
447 448	Curr	iculum Vitae			
449 450	CONFI	DENTIAL INFORMATION:			
451 452		All Current Professional Licenses			
453 454		Current Federal DEA License, If Ap	pplicable		
455 456		Current State Controlled Substances	s Licenses, If Applicable		
457 458 459 460		Current Professional Liability Insura with Effective Date, Expiration Date Aggregate			
461 462		Current CLIA Certificate, If Application	able		
463 464		Current W-9s, If Applicable			
465 466		ECFMG Certificate, If Applicable			
467 468 469		Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, <u>as</u> As Applicable			
470 471		AFFIRMATION OF	INFORMATION		
472 473 474 475 476 477 478 479	I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the <a href="Uniform Health Care and Hospital">Uniform Health Care and Hospital</a> <a href="Credentials">Credentials</a> <a href="Health Care Professional Credentialing and Business Data Gathering Update">Update</a> Form.				
480 481 482	I understand entity, or he	that this application does not entitle alth plan.	me to participation in any hospi	tal, health care	
483	Applicant's	Signature (or electronic signature)	Type or Print Name	Date	

484	**PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND
485	HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION
486	AND RELEASE OF INFORMATION.
487	

	PRA	CTICE AND	PROFES	SIONAL IN	FORMATI	ION	
		SECTION A	A. GENEF	RAL INFOR	MATION		
Name: _							
	Last	First	MI	C	MD/DO/DC MD/Other	C/PhD/MS	SW/DPM/
List other	names by which	you have bee	en known:				
				Last	ŀ	First	N
Birth Date		/dd/yy)	_ Place of	Birth: City	Sta	nte	Country <del>C</del>
Birth Date			Place of				
c $\square$	_	• • •	El	•	_	_	
Sex:	Male Fe	emale Lang	uage Fluen	cy of Applic		nglish L panish	Other_
Ha a	0 🗆 🕶					Jamsh	
U.S. Citize	en?	∐ No					
If "no",	do you have a le	egal right to re	eside perma	anently and v	work in the U	J.S.?	Yes
CONFIDE	ENTIAL INFO	RMATION					
	Resident Visa N	lo:					
		ion <del>Social</del>					
:	<u>Medical Educat</u>						
:	<u>Medical Educat</u> <del>Security Numbe</del>						
:		<del>*</del> :					10
1	<del>Security Numbe</del> Emergency Con	tact Person:	Last		First		MI
1	Security Numbe	tact Person:	Last ( )		First		MI
1	Security Numbe Emergency Con Telephone Num	tact Person:	( )	Daytin		( )	
: 1	Security Numbe Emergency Con Telephone Num	tact Person: ber:	( )	Daytin		( )	

Expiration Date:

495 Chapter A 496 497 SECTION B. PROFESSIONAL INFORMATION 498 **Unrestricted License Illinois Professional License Number: Unlimited**? ☐ No Yes If "no", please explain restriction(s)limitation **Current and Previous Professional Licenses in Other States** License # Exp. Date: (mm/dd/yy) If "no", please explain **Unrestricted License** Unlimited? restriction(s)limitation Yes No State: License # Exp. Date: (mm/dd/yy) If "no", please explain **Unrestricted License** Unlimited? restriction(s)limitation | Yes | No Exp. Date: State: License # (mm/dd/yy) If "no", please explain **Unrestricted License** Unlimited? Yes | No restriction(s)limitation Check here if you have appended additional information for this section. **CONFIDENTIAL INFORMATION** Current Federal DEA License Number: **Unrestricted License Unlimited**? l No DEA License Number Expiration Date: | Yes (mm/dd/yy) If "no", please explain restriction(s)<del>limitation</del>: Check here if you have appended additional information for this section. **Current and Previous State Controlled Substance Numbers:** CONFIDENTIAL INFORMATION State: CS License #: Expiration Date: State: CS License #: Expiration Date: (mm/dd/yy)

State: CS License #:

(mm/dd/yy)

Medicare Unique Pr	ovider ID# (UPIN):				
National Provider Id	lentification Numbe	er (NPI):			
Medicaid ID#:					
X-Ray Certification:	:				
State:	Certificate #	<u> </u>		Expiration Da	ate:
Check here if you have	e appended addition	al informati	on for this	section.	
Specialty I:					
Are you Board Certifie	ed in Specialty I?	Yes	☐ No		
If "yes", name of Certi	fying Board:				
Date of Certification:	(mm/yy)	Date of Rec	ertification	(if applicable):	(mm/yy)
If "no", have you taken	n or are you schedule	d to take the	Specialty B	oards Certifica	tion?
☐ Yes ☐ N	0				
If Certifying Boards ta	ken, give date:	(mm/y	y)		
Certification Expiration	n Date, If Any:	(mm/y	y)		
If not taken, date sched	duled to take Specialt	y Boards:	(mn	n/yy)	
Specialty/Subspecialty	и:				
Are you Board Certifie	ed in Specialty/Subsp	ecialty II?	Yes Yes	☐ No	

Date of Certification:	Date of Recertification (if applicable):
(mm/yy)	(mm/yy)
If "no", have you taken or are you schedul	ed to take the Specialty Boards Certification?
☐ Yes ☐ No	
If Certifying Boards taken, give date:	
	(mm/yy)
Certification Expiration Date, If Any:	
	(mm/yy)
If not taken, date scheduled to take Specia	
	(mm/yy)
Specialty/Subspecialty III:	
Are you Board Certified in Specialty/Subs	specialty III? Yes No
Are you Board Certified in Specialty III?	Yes No
If "yes", name of Certifying Board:	
Date of Certification:	Date of Recertification (if applicable):
(mm/yy)	(mm/yy)
	ed to take the Specialty Boards Certification?
∐ Yes	
If Certifying Boards taken, give date:	(mm/yy)
Certification Expiration Date, If Any:	(mm/yy)
If not taken, date scheduled to take Specia	lty Boards:
Specialty/Subspecialty IV:	
Are you Board Certified in Specialty/Subs	specialty IV? Yes No
Are you Board Certified in Specialty IV?	☐ Yes ☐ No

	If "yes", name of Certifying Board:	
	Date of Certification:	Date of Recertification (if applicable):
	(mm/yy)	(mm/yy)
	If "no", have you taken or are you schedu	aled to take the Specialty Boards Certification?
	☐ Yes ☐ No	
	If Certifying Boards taken, give date:	(mm/yy)
	Certification Expiration Date, If Any:	(mm/yy)
	If not taken, date scheduled to take Speci	alty Boards: (mm/yy)
501 502	Check here if you have appended additi	onal information for this section.

Please provide informat have received coverage	tion on all professional liability in the past 10 years.	y insurance carriers fro	m whom you
CURRENT PROFESSI	ONAL LIABILITY INSURA	NCE	
CONFIDENTIAL INFO	PRMATION:		
Address:	City		
		State	Zip
Policy Number (last 4 digits):	Original Effective	Evniration	Date:
(last 4 digits).	Datc.	Expiration (mm/dd/yy)	(mm/d
Policy Limits: Per Occ	currence: \$	Aggregate: \$	
Retroactive Date:			
	(mm/dd/yy)		
What type of coverage of have?	<u></u>	Occurrence	
	ayment of claim or settlement a	mount exceeded the limit	s of this cove
☐ Yes ☐ No			
	SIONAL LIABILITY INSURA	ANCE	
		ANCE	
PREVIOUS PROFESS		ANCE	
PREVIOUS PROFESS  CONFIDENTIAL INFO		ANCE	
PREVIOUS PROFESS  CONFIDENTIAL INF  Carrier:  Address:	ORMATION:		
PREVIOUS PROFESS  CONFIDENTIAL INFO  Carrier:	ORMATION:	State	Zip
PREVIOUS PROFESS  CONFIDENTIAL INF  Carrier:  Address:	ORMATION:		•

	(mm/dd/yy)		
What type of coverage do	you have? Claims I	Made Occurrence	
Has any judgement or pay  Yes No	ment of claim or settleme	nt amount exceeded the lim	its of this cove
PREVIOUS PROFESSIO		TRANCE	
CONFIDENTIAL INFOR	'MATION:		
Carrier:			
Address:			
Street	City	State	Zip
Policy Number	_	T	D .
(last 4 digits):	Date:	Expiratio (mm/dd/yy)	n Date:(mm/c
Policy Limiter Por Occur	rranga. \$	Aggregate: \$	
Policy Lillins. Per Occu.		Aggregate. \$	
Retroactive Date:	(11/		
	(mm/dd/yy)		
What type of coverage do	you have? Claims I	Made Occurrence	
Has any judgement or pay Yes No	ment of claim or settlement	nt amount exceeded the lim	its of this cove
	ONAL LIARILITY INS	URANCE	
PREVIOUS PROFESSI		URANCE	
		URANCE	
PREVIOUS PROFESSI  CONFIDENTIAL INFO			
PREVIOUS PROFESSI  CONFIDENTIAL INFO	RMATION:		
PREVIOUS PROFESSI  CONFIDENTIAL INFO	RMATION:		Zip
PREVIOUS PROFESSI  CONFIDENTIAL INFO  Carrier:  Address:  Street  Policy Number	RMATION:  City	StateExpiratio	n Date:
PREVIOUS PROFESSI  CONFIDENTIAL INFO  Carrier:  Address:  Street  Policy Number	RMATION:  City Original Effective	State	

		(mm/dd/yy)				
	Wha	at type of coverage do you have?	urrenc	e		
	Has	any judgement or payment of claim or settlement amount exceeded Yes No	d the l	imits o	of this o	coverage?
518	Che	eck here if you have appended additional information for this se	ection			
519	PRO	FESSIONAL LIABILITY ACTIONS				
520 521 522 523		u answer "yes" to any questions in this section, please complete e copies of FORM B, if needed, and complete one for each "yes"			Please	2
023	<u>1.</u>	Have any professional liability judgements ever been entered against you?		Yes		No
	<u>2.</u>	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?		Yes		No
	<u>3.</u>	Are there any currently pending professional liability suits, actions, and/or claims filed against you?		Yes		No
524 525 526 527 528		BILITY INSURANCE  u answer "yes" to this question, please complete FORM C.				
120		Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, had your professional liability insurance coverage canceled or non-renewed, or had limits reduced?		Yes		<u>No</u>

	MEI	DICAL/PRO	FESSIONAI	L SCHOOL	
Institution Name	e:				
Mailing Address					
	Stree	et .	City	State	Zip
Address 2:	Region	Country			
	<u>Region</u>	Country	_		
Telephone Num	ber: ( )		EmailFa Number	:: <u>()</u>	
Degree:	,	Year Gra	duated:	2	
Dates attended:					
	(m	ım/yy)	(mr	m/yy)	
•	_		•	ertified by the Educ	cational
Date Issued:		Serial Nu	imber for EC	FMG	
Were you the su					
•	•		<b>.</b>	n of a "yes" answer.	)
If you attended attach an explan		-		, please check here a	and

Mailing Address: _					
	Street	Cit	y	State	Zip
		<u>Email</u>	<del>ax</del>		
Telephone Number:	( )	Numbe	<del>y</del> :	<del>( )</del>	
Dates attended: Fr	om:	To:			
	(mm/yy)	(mr	n/yy)		
Type of internship:	Rotating S	Straight If s	traight, p	olease list spe	ecialty:
Did you successfully an explanation.	complete this program	?	□ No	If "no", p	lease attach
If more than one into	ernship, please check he ested above:	re and attach a	dditional	information	that duplicat
					9
Were you the subjec  ☐ Yes ☐ No	t of any disciplinary act  (Attach an explai				on?
	o (Attach an explai				on?
Yes No	o (Attach an explai	nation of a "yes	s" answei	r.)	on?
Yes No  FIRST RESIDENCE  Institution Name:	O (Attach an explai	nation of a "yes	s" answei	r.)	on?
Yes No	O (Attach an explai	nation of a "yes	s" answei	r.)	
FIRST RESIDENCE  Institution Name:  Department Chair on	O (Attach an explai	nation of a "yes	s" answei	r.)	
Yes No  FIRST RESIDENCE  Institution Name:	CY Program Director:	Last	s" answei	MI	Degree
FIRST RESIDENCE  Institution Name:  Department Chair on	O (Attach an explai	Last City	s" answei	r.)	
FIRST RESIDENCE  Institution Name:  Department Chair on	CY Program Director:  Street	Last  City  Em	s" answei	MI	Degree
FIRST RESIDENCE Institution Name: Department Chair or Mailing Address: Telephone Number:	(Attach an explancy Program Director:  Street	Last  City  Em	First  nailFax mber:	MI	Degree
FIRST RESIDENCE Institution Name: Department Chair or Mailing Address: Telephone Number:	CY Program Director:  Street	Last  City  Em Nu To:	First  nailFax mber:	MI	Degree
FIRST RESIDENCE Institution Name: Department Chair or Mailing Address: Telephone Number:	CY  Program Director:  Street  ( )	Last  City Em_Nu To:	First  nailFax mber:	MI State  ()	Degree

## SECOND RESIDENCY

Institution Name:					
Department Chair or P	rogram Director:				
•	<u>_</u>	Last	First	MI	Degree
Mailing Address:					
	Street	Ci	ty	State	Zip
Telephone Number: _	( )		EmailFax Number:	(	
Dates attended: From			То:	,	
	(mm/yy	y)		(mm/	yy)
Type of residency:					
Did you successfully c explanation.	omplete this progran	n? Yes	s No	If "no", plea	ase attach an
If more than two reside duplicates the informat			ch addition	al informatio	n that
Were you the subject o				this institution	on?
FIRST FELLOWSH	IP				
Institution Name:					
——————————————————————————————————————					
Department Chair of T	logram Director.	Last	First	MI	Degree
Mailing Address:					
	Street	Ci	ty	State	Zip
Telephone Number: _	( )		Email <mark>Fax</mark> Number:	<del>()</del>	
Dates attended: From	n:		То:		
	(mm/vy	v)	-	(mm/	/vv)

Type of fellowship:					
Did you successfully complete explanation.	e this program?	Yes	☐ No	If "no", plea	ase attach an
Were you the subject of any di				this institution	on?
SECOND FELLOWSHIP					
Institution Name:					
Department Chair or Program	Director:				
	J	Last	First	MI	Degree
Mailing Address:	Chroat	City		Ctata	7:-
	Street	City	mail <del>Fax</del>	State	Zip
Telephone Number: (	)		umber:	<del>(</del>	
Dates attended: From:		To	o:		
	(mm/yy)			(mm/	уу)
Type of fellowship:					
Did you successfully complete explanation.	e this program?	Yes	☐ No	If "no", plea	ase attach an
Were you the subject of any di	- ·			this institution	on?
If more than two fellowships, duplicates the information req			n addition	al informatio	n that
TEACHING EXPERIENCE	/FACULTY AP	POINTM	ENT (MO	OST RECEN	VT)
Institution Name:					
Department Chair or Program					
-	I	Last	First	MI	Degree
Mailing Address:					

	Street	City	r.	State	Zip
Telephone Number: (	)		ail <mark>Fax</mark> nber:		
(	/				
Dates: From: (mm/yy)	To:	_ Rank/Posi	tion, if app	olicable:	
(IIIII/yy)	(IIIII/yy)				
Were you the subject of any	disciplinary actio	n during vour	time at th	is instituti	ion?
Yes No (Attach				ns mstrut	on.
Tes 110 (Attach	an explanation of	a yes allsw	C1.)		
TEACHING EXPERIENC	E/FACULTY A	PPOINTME	NT (PRE	VIOUS)	
Institution Nomes					
Institution Name:					
Department Chair or Program	n Director:				
Department Chair or Program		Last	First	MI	Degree
Mailing Address					
Mailing Address:	Street	City		State	Zip
	Succe	•	ail <del>Fax</del>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2.16
Telephone Number: (	)	<u>EIII</u> Nur	<del>anrax</del> nber:	$\leftarrow$	
relephone rumber.			noci.		
Dates: From:	To:	Rank/Posit	tion, if app	olicable:	
Dates: From: (mm/yy)	To:	Rank/Posi	tion, if app	olicable:	
Were you the subject of any	disciplinary action	n during your	time at th		
	disciplinary action	n during your	time at th		
Were you the subject of any  Yes No (Attach	disciplinary action an explanation of	n during your a "yes" answ	time at the	is instituti	ion?
Were you the subject of any	disciplinary action an explanation of periences/faculty	n during your a "yes" answ appointments	time at the	is instituti	ion?

K. Pending

L. Other (Specify)

## MEMBERSHIP STATUS – USE FOR SECTIONS E, F AND G

Please use the following key to indicate <u>Membership Status</u> in <u>Sections</u>sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgical Treatment Center Practice) below:

- A. Active
- B. Courtesy
- C. Consulting
- D. Adjunct
- E. Suspended/ Terminated/ Resigned

- F. Active Provisional Staff
- G. Senior Staff
- H. Associate
- I. Provisional
- J. Affiliate

545 546	Chap	pter A					
547		SECTION E. HOSPITAL MEMBERSHIP – CURRENT AND PENDING					
<ul><li>548</li><li>549</li><li>550</li><li>551</li><li>552</li></ul>	priv	se list all hospitals at which you are ileges or have applications for prive hospitals.)					
	A.	Primary Hospital					
		Hospital Name:					
		Address:					
		Street	City	State	Zip		
		Membership Status (see above): _	Dates: Fi	rom (mm/yy)	To Present		
		Department/Division:	Medical Staff Office EmailFAX #:		<del>)</del>		
		Department Telephone #: _( Any limitations in your area of spe	ecialty at this hospital?	_			
	В.	Other Hospital					
		Hospital Name:					
		Address:					
		Street	City	State	Zip		
		Membership Status (see above):	Dates:	rom (mm/yy)	To Present		
			Medical Staff Office EmailFAX #:		<del>)</del>		
		Department Telephone #: _(	)				
		Any limitations in your area of spe	ecialty at this hospital?				
	C.	Other Hospital					
		Hospital Name:					

	Address:			
	Street	City	State	Zip
	Membership Status (see above):	Dates:	From (mm/yy)	To Present
		Medical Staff Off	ïce	
	Department/Division:	EmailFAX #:		$\rightarrow$
	Department Telephone #: (	)		
	Any limitations in your area of sp	ecialty at this hospital?		
	Check here if you have appended add	ditional information fo	or this section	
553				
554				

Zip

Zip

Zip

From (mm/yy) To (mm/yy)

Membership Status (see above): Dates:

Department/Division: <u>EmailFAX #</u>:

Medical Staff Office

JCAR7	17096	5-240	)495	8r02
	1020.	<i>) 4</i> T(	ノTノン	0102

	Department Telephone #:()	
563	Check here if you have appended additional information for this section	

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SECTION G. AMBULATORY SURGICAL TREATMENT CENTER PRACTICE

Please list all ambulatory surgical treatment centers where you currently have clinical privileges. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three ASTCs.)

## A. Primary Ambulatory Surgical Treatment Center ASTC Name: \_\_\_\_\_ Address: City Street Zip State Email**F AX#**: Membership Status (see above): Dates: From (mm/yy) To (mm/yy) **B.** Other Ambulatory Surgical Treatment Center ASTC Name: City Street State Zip Email**F** AX#: Membership Status (see above): \_\_\_\_\_ Dates: \_\_\_\_ From (mm/yy) To (mm/yy) C. Other Ambulatory Surgical Treatment Center ASTC Name: Address: Street City Zip State Email**F** Telephone #: ( ) Membership Status (see above): Dates: From (mm/yy) To (mm/yy)

573	Chapter A
574	
575	
576	

#### SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service) in the past 4 years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current workplace <mark>work</mark> <del>place</del> :				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>(</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	To Present	
Previous  workplacework  place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	_()	
Title or Professional Occupation:				
Time in this employment:	From:		To:	
		(mm/yy)		(mm/yy)
Previous workplacework place:				
Address:				
Street		City	State	Zip

Telephone Number: ( )		EmailFax Number:	<del>( )</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	_ To:	(mm/yy)
Previous workplacework place:		(		
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>()</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	_ To:	(mm/yy)
Previous workplacework place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>()</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	To:	
Previous workplacework place:		(		
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>( )</del>	

Title or Professional Occupation:	-			
Time in this employment:	From:		To:	
	_	(mm/yy)	_	
Previous  workplacework  place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:		
Title or Professional Occupation:				
Time in this employment:	From: _	(mm/yy)	_ To:	(mm/yy)
Previous workplacework place:		(11111111111111111111111111111111111111		(111112 ) ) )
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<u>(                                    </u>	
Title or Professional Occupation:				
Time in this employment:	From: _	(mana (my)	To:	(100 100   100 10
Previous workplacework place:		(mm/yy)		(mm/yy)
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>( )</del>	
Title or Professional Occupation:				
Time in this employment:	From:		То:	

	(mm/yy)	(mm/yy)
582 583	Check here if you have appended additional information for this section.	

584 Chapter A 585 586 SECTION I. PROFESSIONAL REFERENCES 587 Please list the names of three individuals who have personal knowledge (within the past 12 588 months) of your current clinical abilities, ethical character, and interpersonal skills, 589 590 preferably including at least one person with whom you have worked in the last 12 months, 591 and who would be willing to provide this information upon request. If you list partners, 592 relatives, or department chairpersons, please identify their relationship to you. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this 593 594 credentialing form. 595 596 **CONFIDENTIAL INFORMATION** First MI Degree Title: 1. Name: Last Mailing Address: Street State City Zip Email Fax Telephone Number: ( ) Number: Relationship: Years Known: Degree Title: 2. Name: \_\_\_\_\_Last First MI Specialty: Mailing Address: City State Zip Street Email Fax Telephone Number: ( ) <u>Number</u>: <del>( )</del> Relationship: \_\_\_\_\_ Years Known: 3. Name: \_\_\_\_

First MI

Street

Specialty:

Mailing Address:

Degree

City

State

Zip

				<u>Email</u> Fax	
	Telephone Number:	(	)	Number:	_ ()
	Relationship:			Years Known:	
597					

599 Chapter A 600 SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL 601 602 Submit with all applications. Please answer the following questions to the best of your 603 604 knowledge with a "yes" or "no". If you answer "yes" to any questions, please complete FORM A. Please make copies of FORM A as needed and complete one form for each "yes" 605 606 answer. 607 608 **Adverse or Other Actions** 609 1. Has your license to practice in any jurisdiction ever been Yes □ No denied, restricted, limited, suspended, revoked, canceled and/or subject to probation, either voluntarily or involuntarily, or has your application for a license ever been withdrawn? 2. Have you ever been reprimanded and/or fined, been the subject Yes No of a complaint, and/or been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency that licenses providers? 3. Have you ever had your board certification rescinded or elected Yes No not to recertify lost any board certifications, and/or failed to recertify? Have you ever been examined by a Certifying Board but failed 4. Yes No to pass? 5. Has any information pertaining to you, including malpractice Yes No judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? 6. Has your federal DEA number and/or state associated No Yes Controlled Substances Licensestate controlled substances <del>license</del> been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? 7. Have your privileges at any hospital or other health care setting No Yes ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied, or has probation ever been imposed? Have you or any of your hospital

or ambulatory surgical treatment center (ASTC) privileges

and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?

<u>8.</u>	Has your membership at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, not renewed, denied, or has probation even been imposed?	Yes	No
<u>9</u> 8.	Has your medical staff membership at any hospital or healthcare institution ever been voluntarily or involuntarily terminated? Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ASTC privileges for any reason?	Yes	No
<u>10</u> 9.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ASTC privileges and/or your license?	Yes	No
<u>11</u> <del>10</del> .	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs, or voluntarily withdrawn to avoid an investigation relating to those programs?	Yes	No
<u>12</u> <del>11</del> .	Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-partythird party payors, brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	Yes	No
12.	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	Yes	Ne
13.	Have you <u>ever</u> withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	Yes	No

	<u>14.</u>	Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation order, not renewed, denied renewal, or has probation ever been imposed?	Yes		<u>No</u>
	<u>15.</u>	Were you the subject of any disciplinary action(s) during your attendance at any academic or training institution, either during any formal education, training, or faculty appointments?	Yes		<u>No</u>
610 611 612 613 614 615	If yo	OFESSIONAL LIABILITY ACTIONS OU answer "yes" to any questions in this section, please complete es of FORM B, if needed, and complete one for each "yes" answ	M B.	Pleas	e make
	<del>1.</del>	Have any professional liability judgements ever been entered against you?	Yes		No
	2.	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?	<del>Yes</del>		No
	<del>3.</del>	Are there any currently pending professional liability suits, actions and/or claims filed against you?	Yes		No
	4.	Has any person or entity ever been sued for your clinical actions?	Yes		No
616 617 618	LIA	BILITY INSURANCE			
619 620	<del>If yo</del>	ou answer "yes" to this question, please complete FORM C.			
		Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled or non-renewed or limits reduced?	Yes		No
621 622 623	CRI	MINAL ACTIONS			
624 625 626		ou answer "yes" to any questions in this section, please complete es of FORM D, if needed, and complete one for each "yes" answer	<b>M D</b> .	Pleas	e make

627	<ol> <li>2.</li> </ol>	Have you ever been charged with or convicted of a felony or misdemeanorerime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this State or any other state or country?  Have you ever been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?		Yes		No No
627 628	MED	DICAL CONDITION				
629 630 631	If you	u answer "yes" to this question, please complete FORM E.				
031	emo abili safe	you <u>currently</u> have a <u>physical illness or mental illness or disability</u> results in your inability medical condition, physical defect or tional impairment that in any way impairs and/or limits your ty to practice medicine with reasonable <u>judgement</u> , skill, and ty? (See Medical Practice Act – 225 ILCS 60/22(a))  EMICAL SUBSTANCES OR ALCOHOL <u>USE DISORDERAL</u>	DUSE	Yes		No
	•	ou answer ''yes'' to any questions in this section, please complete copies of FORM F, if needed, and complete one for each ''yes			Pleas	se
	1.	Are you currently engaged in illegal use of any legal or illegal substances?		Yes		No
	<u>1</u> 2.	Do you currently overuse and/or abuse alcohol or any other controlled substances?		Yes		No
	<u>2</u> 3.	If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?		Yes		No
	<u>3</u> 4.	Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance <u>use disorderabuse</u> ?		Yes		No

### **INVESTMENTS**

	Apart from employment, in In the last 5 years have you and/or a member of your family ever purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgical centersurgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?	Yes	□ No
	If "yes", please provide explanation:		
632			

Primary Site	Group/Business Name								
	Building Name								
	Office Address – Number	and Street – Sui	te						
	City	County	State	Zip					
	( )								
	Main Telephone Number	Office Ada	ministrator – La	ast First Ml					
	Beeper Number	Fax Number	E-Mail						
	Beeper Tumber		2 1/1411						
	( )		)						
	Emergency Number	Aı	nswering Service						
Spe	Specialty practiced at this site:  Is your practice restricted within your specialty (e.g., by age or type of patient)?								
Is y									
Γ	Yes No If "yes"	", describe the res	strictions:						
L	·								
L									
-									
- Bri	efly describe your practice a	at this location, in	cluding any special	practice focus or					
	viene anti	at this location, in		practice focus or					

	Please pro	ovide the nu	mber of active	patients er	nrolled with yo	ou at this site:	
	-	ovide the bu	mber of patient siness hours, in	-			
	•		at this locatio		llowing table	. Write your	<del>specific</del>
	Monday	<u>Tuesday</u>	<u>Wednesday</u>	Thursda	<del>y</del> Friday	<u>Saturday</u>	<u>Sunday</u>
Hours:							
Please i	indicate sta	andard pati	ient waiting tir	nes to sch	edule an appo	ointment at th	nis site for:
					New Patien	<u>Exist</u>	ing Patient
	Emergen	cy Care				- <u></u>	
	Urgent C	are				. <u></u>	
	Symptom	natic Care (e	.g., sore throat)	)			
	Routine V	Visits (e.g., l	olood pressure	check)		. <u></u> -	
		ive Routine physical)	Care (e.g., scho	ool or		·	
Please ]	provide the	e following	regarding you	r practice	at this site:		
	Maximun	n Number o	f Appointments	s per Hour			
	_	_	ne in Office (fro o actual examir		led		
	Average Patient	-	me for Returni	•	acute or Urgen	t Situation:	
				E	Emergency Situ	nation:	
				R	Coutine Call:		

Please check all procedures you perform at this site:

Age-appropriate immunizations	☐ EKG	☐ Drawing blood
Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
Pulmonary function studies	Flexible sigmoidoscopy	Laceration repair
<ul><li>Office gynecology (routine pelvic/PAP)</li></ul>	Asthma treatment	Allergy skin testing
Osteopathic/chiropractic manipulation	IV hydration/ treatment	Physical therapy
Acupuncture	Pathology	
List any special skills or qualifications years ability to practice medicine or treat certain any special language skills, such as fluen language.	ain patients or classes of pat	ients. List separately
Special Skills of Practitioner:		
Special Skills of Staff:		
Languages Spoken by Practitioner Languages Written by Practitioner Practioner:	r:	
Languages Spoken by Staff:		
Languages Written by Staff:		
Is this practice site handicapped accessil  Building	ble (check all that apply)?  Parking	nair Restroom
Does this site employ paraprofessionals	for direct patient care?	Yes No
If "yes", is supervision always provided on	premises during paraprofessi	onal's direct patient
care? Yes No Do the paraprofessionals bill under any of	your Tax ID Numbers?	☐ Yes ☐ No
CONFIDENTIAL INFORMATION: If "	yes", list Tax ID Numbers use	ed:

Lab service at th	is site:	ı Yes 🔛	No If yes, o	eneck whether:	
Primary	<i>'</i>	Secondary	y $\square$	Tertiary	
CLIA Waiv	er: Y	es No	CLIA Expira	tion Date:	
	_		•		
Please provide the coverage for pati	_			-	rs who provide
Name:					
	Last		First	MI	Degree
Specialty:					
Address:				Talanhona	( )
Address.	Street	City	State Zip	_relephone.	( )
Availability:	Days	Nights	Weekends	Holidays	
CONFIDENTIAL	L INFORM	<b>ATION:</b> Tax	ID#:		
Name:					
·	Last		First	MI	Degree
Specialty:					
Address:				Telephone:	( )
	Street	City	State Zip		
Availability:	Days	Nights	Weekends	Holidays	
CONFIDENTIAL	L INFORM	ATION: Tax	ID#:		-
Name:	Last		First	MI	Degree
Specialty:					
Address:				Telephone:	( )
	Street	City	State Zip	_ •	
Availability:	Days	☐ Nights	Weekends	Holidays	

CONFIDEN	TIAL I	INFORM	ATION: Tax	ID#: _			
Name .							
:		Last		First		MI	Degree
Specialty: _							
Address: _						Telephone:	( )
		Street	City	State	Zip		
Availability:	[	Days	☐ Nights	Wee	kends	☐ Holiday	s
			ATION: Tax information al		icians/	practitioners v	who practice in this
1	Name:					Specialty:	
		Last	First	M	I		
1	Name:					Specialty:	
		Last	First	M	II	-	
1	Name:					Specialty:	
		Last	First	M	Ι _		

641 642	Chapter B					
643	SECTION L. PRIMARY SITE TAX INFORMATION					
644 645 646 647 648	Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)					
	Business Arrangement #1					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):  **CONFIDENTIAL INFORMATION:** Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:  ( )					
	Business Arrangement #2					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):					
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:  ( )					
	Business Arrangement #3					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):					
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:  ( )					

	Business Arrangement #4	
	Name of Business Arrangement on SS4 or W-9 For Type of Arrangement (e.g., solo or group practice PHO):	
	CONFIDENTIAL INFORMATION: Tax ID for	this Arrangement:
	Billing Address, if Different from Primary Site: Telephone Number, if Different from Primary Site:	
649	Site.	

Site	Group/Business N	ame				
	Building Name					
	Office Address – N	Number and S	Street – Suite			
	City	County	State		Zip	
	( )					
	Main Telephone N	umber	Office Administrator –	Last	First	I
	<del>()</del> Beeper Number		Fax Number	E-Mail		
	( )		( )			
C	Emergency Number		Answering			
	pecialty practiced at the					
Is		•	or specialty (e.g., by age	e or type of	patient)?	
	☐ Yes ☐ No	If "yes", des	cribe the restrictions:			

	Please provide the number of active patients	s enrol	led with you at t	this site:			
	Please provide the number of patient visits y	you ha	ve at this site pe	r year?			
	Please provide the business hours, including operation:	g days	of the week and	hours of			
	e your office schedule at this location in the n the appropriate spaces for each day.	e follo	wing table. Wr	<del>rite your sp</del> o	<del>ecific</del>		
	Monday Tuesday Wednesday Thur	<del>sday</del>	<u>Friday</u>	<u>Saturday</u>	<u>Sunday</u>		
Hours:							
Please i	Please indicate standard patient waiting times to schedule an appointment at this site for:						
			New Patient	Existi	ng Patient		
	Emergency Care	-					
	Urgent Care	-					
	Symptomatic Care (e.g., sore throat)						
	Routine Visits (e.g., blood pressure check)	-					
	Preventative Routine Care (e.g., school or annual physical)	<u>-</u>					
Please p	provide the following regarding your pract	ice at	this site:				
	Maximum Number of Appointments per Ho	our					
	Average Waiting Time in Office (from sche appointment time to actual examination)	duled					
	Average Response Time for Returning Patient Calls:	Acut	te or Urgent Situ	ıation:			
		Eme	rgency Situation	n:			
		Rout	tine Call:				

Please check all procedures you perform	at this site:						
Age-appropriate immunizations	☐ EKG	☐ Drawing blood					
Tympanometry/audiometry screening	X-rays	☐ Minor surgery					
Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair					
Office gynecology (routine pelvic/PAP)	Asthma treatment	Allergy skin testing					
Osteopathic/chiropractic manipulation	☐ IV hydration/ treatment	☐ Physical therapy					
☐ Acupuncture	Pathology						
List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.  Special Skills of Practitioner:							
Special Skills of Staff:							
Languages Spoken by Practitioner:							
Languages Written by Practitioner	:						
Languages Spoken by Staff:							
Languages Written by Staff:							
Is this practice site handicapped accessible Building	<b>ble</b> (check all that apply)? Parking	r Restroom					
Does this site employ paraprofessionals f	for direct patient care? Yes	☐ No					
If "yes", is supervision always provided on care?  Yes No	_	nal's direct patient					
Do the paraprofessionals bill under any of		es					
<b>CONFIDENTIAL INFORMATION:</b> If "	yes", list Tax ID Numbers used	:					

Lab service a	at this site: Yes No If "yes", check whether	··
Pri	imary Secondary Tertiary	
CLIA V	Waiver: Yes No CLIA Expiration Date:	
_	ide the following information about physicians/practition r patients enrolled at this site when you are not available.	_
Name:	Specialty:	
	Last First MI Degree Specialty:	
Address:		( )
Availability:	Days Nights Weekends Hol	lidays
CONFIDEN	TIAL INFORMATION: Tax ID#:	<u></u>
Name:	Specialty:	
	Last First MI Degree	
Address:		_( )
Availability:	Days Nights Weekends Hol	lidays
CONFIDEN	TIAL INFORMATION: Tax ID#:	<u></u>
Name:	Last First MI Degree Specialty:	
	Last Mis Degree	
Address:	Telephone: Street City State Zip	( )
Availability:	Days Nights Weekends Hol	lidays
CONFIDEN	TIAL INFORMATION: Tax ID#:	
Name:	Last First MI Degree Specialty:	
	Last First MI Degree	

Address:			Telephone:	_ ( )
	Street	City	State Zip	
Availability:	Days	Nights	Weekends	Holidays
CONFIDENT	TAL INFORM	IATION: Tax	ID#:	
Please provid office:	e the following	g informatior	about physicia	ns/practitioners who practice in this
Name				Specialty:
	Last	First	MI	
Name				Specialty:
	Last	First	MI	
Name				Specialty:
	Last	First	MI	

661	Chapter B					
662 663	SECTION N. ADDITIONAL SITE TAX INFORMATION					
664 665 666 667 668 669	Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site or more than 5 business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)					
	Business Arrangement #1 Site #:					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):					
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:  ( )					
	Business Arrangement #2 Site #:					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):					
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:					
	Business Arrangement #3 Site #:					
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):					
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:					
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary					

Site:

	Business Arrangement #4 Site #:
	Name of Business Arrangement on SS4 or W-9 Form:  Type of Arrangement (e.g., solo or group practice, IPA, PHO):
	CONFIDENTIAL INFORMATION: Tax ID for this Arrangement:
	Billing Address, if Different from Primary Site:  Telephone Number, if Different from Primary Site:  ( )
670 671 672 673	End <u>Uniform Health Care and Hospital Credentials</u> Credentialing and Business Data Gathering Form.
674 675	Attach Forms A-F As Required.

	D. If know	n: Contact:				
		Department/C	Committee:			
		Address:				
			Street	City	State	Zip
		Telephone Nu	ımber: ( )			
	Signature:			Dat	te:	
581	(or electronic si	gnature)				

685

686

### FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

App	licant Name:			
	Last	Firs	t	MI
A.	Plaintiff's Name:			
	Last		First	MI
	If court case, State/jurisdic	tion, Case Name & C	Case Number: _	
B.	Your Involvement in the C	are (Attending, Cons	sulting, Etc.):	
C.	Your Status in the Case (So Provider Practice Named in			-
D.	Allegations, including Patie	ent Outcome, If Ava	ilable:	
E.	Date of Incident (mm/yy)	F.	Date Filed (mm	/yy)
G.	Date Case Closed (mm/yy)	:		
	Case Resolution:			
	☐ Dismissed ☐ Settlement Out of Court	Judgement rt Pending	Arbitration  Mediation	_
H.	Amount Paid on Your Beh	alf (if any): \$		
I.	Professional Liability Insur	er Name (if one was		
J.	Insurer Telephone Number	: <u>(</u> )	Policy No K. (last 4 dig	
L.	Insurer Address (Street, Ci	ty, State, Zip Code):		

	Signature:	Date:	
687	(or electronic signature)		
688			

App	plicant Name:	
	Last First MI	
A.	History of Professional Liability Insurance (Please Check One)	
	Cancelled Voluntarily Non-Renewed	
	Cancelled Involuntarily Application Denied	
B.	Carrier Name:	
C.	Carrier Telephone Number: ( )	
D.	Policy Number (last 4 digits):	
E.	Carrier Address:	
	Street City State	Zip
F.	Dates of Coverage: From (mm/yy): To (mm/yy):	
G.	Circumstances Involved:	

### FORM D - CRIMINAL ACTIONS

 DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

licant Name:Last	First	MI
Date of Incident (mm/yy):		
Date of Complaint or Conviction (	(mm/yy):	
Date of Resolution (mm/yy):		
Type of Resolution (Dismissed, Pl	lea Bargain, Misdemeanor, Fe	elony):
Allegations:		
Details of Incident:		
Actions Taken Against You:		
Commant Status of Situation.		
Current Status of Situation:		

-	
	Date
Signature (or electronic signature):	:

## FORM E - MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

	L	ast	First	M	[	
Describe	e this medic	al condition	n:			
			his <u>current</u> condition a n or to perform a full r			
What is	the current	status of ye	our condition?			
What is	the current	status of ye	our condition?			
What is	the current	status of ye	our condition?			
Provide provide	the name ar	nd address (	of your personal phys r health condition.	ician/health c	are provid	er who
Provide provide	the name ar	nd address (	of your personal phys	ician/health c		er who
Provide	the name ar	nd address (	of your personal phys	ician/health c	are provid	er who
Provide provide Name	the name ar	nd address o	of your personal phys r health condition.	ician/health c	are provid	er who

# FORM F – CHEMICAL SUBSTANCES OR ALCOHOL <u>USE DISORDER ABUSE</u>

DUPLICATE this from as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Apj	plicant Name:				
		Last	First	MI	
Des	scribe the subst	tance(s) you use	: <u></u>		
A.			-		affect your current ull range of clinical
В.	Monitored by	State Board Ma	andate (Name and	Address)	
C.	Monitored Vo	oluntarily (Nam	e and Address)		
D.	Other inform	ation about the o	current status of yo	ur use of substance	es:
Е.	Abstinent sin	ce (mm/yy):			
F.	provide inforcan comment	mation about yo on what impact	our treatment for alc	cohol or chemical s your current/future	re provider who can substance(s) use and professional practice.
	]	Last	First	MI	Degree
	Address:				
		Street	City	State	Zip
	Telephone	(	)		

	Signature (or electronic signature):	Date:
712		
713	(Source: Amended at 48 Ill. Reg, effective _	)
71/		

715	Section 965.APPENDIX B <u>Uniform</u> Health Care <u>and Hospital Recredentials</u> Professional
716	Recredentialing and Business Data Gathering Form
717	
718	STATE OF ILLINOIS
719	
720	<u>Uniform</u> Health Care and Hospital Recredentials Professional Recredentialing and Business
721	Data Gathering Form
722	
723	The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this
724	form be collected from health care professionals by hospitals, health care entities, and health care
725	plans that desire to recredential such professional. Each hospital, health care entity, and health
726 727	care plan may also require completion of supplemental forms.
728	INSTRUCTIONS
728 729	INSTRUCTIONS
730	This form is for recredentialing only. Other forms are required for credentialing and for updating
731	information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY
732	THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED
733	TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR
734	REQUIREMENTS.
735	
736	This form has been segmented into 2 different Chapters, each containing various sections:
737	
738	Chapter A: General and Practice Information
739	Chapter B: Business Information
740	
741	As previously noted, please consult the specific credentialing entity instructions for their
742 743	individual Chapter or section requirements for submission.
743 744	GENERAL INSTRUCTIONS: Wherever this application requests information but does not
7 <del>44</del> 745	provide sufficient space to provide a complete response (for example, you have more licenses,
746	specialties, work history, etc.) provide attachments that contain all of the information requested
747	in the relevant section OR duplicate the relevant section as many times as necessary and attach it
748	to the back of this application.
749	••
750	Any credentials data collected or obtained by the health care entity, health care plan, or hospital
751	shall be confidential, as provided by law, and otherwise may not be redisclosed without written
752	consent of the health care professional, except that in any proceeding to challenge credentialing
753	or recredentialing, or in any judicial review, the claim of confidentiality shall not be invoked to
754	deny a health care professional, health care entity, health care plan, or hospital access to or use
755	of credentials data. Nothing in this subsection prevents a health care entity, health care plan, or
756 757	hospital from disclosing any credentials data to its officers, directors, employees, agents, subcontractors, medical staff members, any committee of the health care entity, health care plan.
111	- SUDCONTIGORY, MENICAL SIAN MEMBELS, AND COMBINITEE OF THE HEALTH CATE ENTITY MEALTH CATE DIAN.

758	or hospital involved in the credentialing process, or accreditation bodies or licensing agencies.
759	However, any redisclosure of credentials data contrary to this subsection is prohibited. (Section
760	15(h) of the Act) The data marked as "Confidential Information" shall be maintained in
761	confidence to the extent required by law. They may be used by the health care plan, entity or
762	hospital and by their agents for credentialing and internal business purposes. Other data
763	contained in this form may be released.
764	

	ATTACHMENTS
	Attach Forms A. F. or moded to support "year" manages in the Duefossional History section and
	Attach Forms A-F as needed to support "yes" responses in the Professional History section and
(	copies of the following:
	Curriculum Vitae
	Currentum vitae
	CONFIDENTIAL INFORMATION:
	0 0 1 (2 <del>2 2 2</del> 1 2 2 2 2 4 2 0 2 2 2 2 2 2 3 1 )
	All Current Professional Licenses
	Current Federal DEA Licenses, If Applicable
	Current State Controlled Substance Licenses, If Applicable
	Current Professional Liability Insurance Face Sheet or Declaration of Insurance with
	Effective Date, Expiration Date and Amount Displayed Per Occurrence and In Aggregate
	Current CLIA Certificate, If Applicable
	Current W. Oc. If Applicable
	Current W-9s, If Applicable
	ECFMG Certificate, If Applicable
	Let we certificate, if Applicable
	Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board
	Certifications, As Applicable
	Correspondent, 120 1-pp.1-oue-to
	AFFIRMATION OF INFORMATION
]	I represent and warrant that all of the information provided and the responses given are correct
	and complete to the best of my knowledge and belief. I understand that falsification or omission
	of information may be grounds for rejection or termination, in addition to any penalties provided
	by law. I further agree to promptly inform all entities to which this form was sent and not
	rejected of any change required to be updated by the <u>Uniform Updating</u> Health Care Professional
•	Credentialing and Business Data Gathering Update Form.
1	
	I understand that this application does not entitle me to participation in any hospital, health care
(	entity, or health plan.
-	
	Applicant's Signature (or electronic Type or Print Name Date
	signature)

**PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTI	TY, AND
HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATT	ESTATION
AND RELEASE OF INFORMATION FORM.	

1	PRACTICE AND PI	ROFESSION	AL INFORMATIO	)N	
,	PRACTICE AND PROFESSIONAL INFORMATION				
	SECTION A. GENERAL INFORMATION				
Name:					
Last	First	MI		Degree	
List other names by	y which you have bee	en known:			
		_	Last	First	N
If you have been k	nown by other names	, piease expiai	n wny your name cr	nanged:	
Birth Date:					
	(mm/dd/yy)				
Sex: Male	Female				
U.S. Citizen?	Yes No			_	_
U.S. Citizen?		eside permanei	ntly and work in the	U.S.? \[ \]	Yes 🔲 1
U.S. Citizen?	Yes No	-	ntly and work in the	U.S.?	Yes □ I
U.S. Citizen?  If "no", do you h	Yes No  nave a legal right to re	-	ntly and work in the	U.S.?	Yes 🔲 I
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical	Yes No  nave a legal right to re	-	ntly and work in the	U.S.?	Yes 🔲 I
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial				
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial Number:	-		U.S.?	Yes □ 1
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security  Emerger	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial Number:				
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security  Emerger  Telepho	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial Number: hcy Contact Person:	Last ( )	Fi	rst	MI
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security  Emerger  Telepho	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial Number: hcy Contact Person: ne Number:	Last ( )	Fi	rst 	MI
U.S. Citizen?  If "no", do you h  CONFIDENTIA  Resident  Medical  Security  Emerger  Telepho	Yes No have a legal right to re AL INFORMATION t Visa No: EducationSocial Number: hcy Contact Person: ne Number:	Last ( )	Fi Daytime Phone Fax Number:	rst 	

817 CHAPTER A:

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#### SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number If "no", please explain restriction(s) limitation	<u>Unrestricted</u> License <del>Unlimited</del> ?	☐ Yes ☐ No
<b>Current and Previous Professional L</b>	icenses in Other States	
State: License # Unrestricted License Unlimited? Yes N	Exp. Date:  If "no", please explain  o restriction(s)limitation	(mm/dd/yy)
State: License #  Unrestricted License Unlimited? Yes N	Exp. Date:  If "no", please explain  o <u>restriction(s)</u> limitation	(mm/dd/yy)
State: License #  Unrestricted License Unlimited? Yes N	Exp. Date:  If "no", please explain restriction(s)limitation	(mm/dd/yy)
Check here if you have appended ad	ditional information for this se	ection.
CONFIDENTIAL INFORMATION	V	
Current Federal DEA License Numb	er:	
DEA License Number Expiration Da  If "no", please explain restriction(s) limitation:	te: Unrestricte License-Uniterion	
restretion(s)		
Check here if you have appended ad		ection.
<b>Current and Previous State Controll</b>		
	NFIDENTIAL INFORMATION	-iti D-t
State: CS License	e #: Exp	oiration Date:(mm/dd/yy)
State: CS License	e #: Exp	oiration Date:
		(mm/dd/yy)

Medicare Unique Provider ID# (UPIN):	
National Provider Identification Number (NPI):	
Medicaid ID#:	
X-Ray Certification:	
State: Certificate #:	Expiration Date: (mm/do
Check here if you have appended additional information for COMPLETE FOR EACH SPECIALTY	or this section.
Specialty I:	
Are you Board Certified in Specialty I? Yes N	0
If "yes", name of Certifying Board:	
Date of Certification: Date of Recertification	tion (if applicable):(mm/dd.
If "no", have you taken or are you scheduled to take the Special	lty Boards Certification?
☐ Yes ☐ No	
If Certifying Boards taken, give date:  (mm/dd/yy)	_
Certification Expiration Date, If Any: (mm/dd/yy)	_
If not taken, date scheduled to take Specialty Boards:	(mm/dd/yy)

If "yes", name of Certifying Board:	
Date of Certification: (mm/dd/yy)	Date of Recertification (if applicable):(mm/dd/yy)
If "no", have you taken or are you schedule	ed to take the Specialty Boards Certification?
☐ Yes ☐ No	
If Certifying Boards taken, give date:	(mm/dd/yy)
Certification Expiration Date, If Any:	(mm/dd/yy)
If not taken, date scheduled to take Special	ty Boards:(mm/dd/yy)
Specialty/Subspecialty III:	
Are you Board Certified in Specialty III?	Yes No
If "yes", name of Certifying Board:	
Date of Certification: (mm/dd/yy)	Date of Recertification (if applicable): (mm/dd/yy)
If "no", have you taken or are you schedule	ed to take the Specialty Boards Certification?
☐ Yes ☐ No	
If Certifying Boards taken, give date:	(mm/dd/yy)
Certification Expiration Date, If Any:	(mm/dd/yy)
If not taken, date scheduled to take Special	ty Boards:
Specialty/Subspecialty IV:	
Are you Board Certified in Specialty IV?	☐ Yes ☐ No
If "yes", name of Certifying Board:	
Date of Certification: (mm/dd/yy)	Date of Recertification (if applicable):(mm/dd/yy)

If "no", have you taken or are you schedu	led to take the Specialty Boards Ce
Yes No	
If Certifying Boards taken, give date:	(mm/dd/yy)
Certification Expiration Date, If Any:	(mm/dd/yy)
If not taken, date scheduled to take Specia	alty Boards:(mm/dd/yy)

824 CURRENT PROFESSIONAL LIABILITY INSURANCE 825 826 **CONFIDENTIAL INFORMATION:** 827 Carrier: Address: Street City State Zip Policy Number (last 4 digits): Original Effect Date: Expiration Date: (mm/dd/yy) (mm/dd/yy) Policy Limits: Per Occurrence: \$ Aggregate: \$ Retroactive Date: \_\_\_\_\_\_(mm/dd/yy) What type of coverage do you Claims Made Occurrence have? Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage? Yes □ No 828 829 **PROFESSIONAL LIABILITY ACTIONS** 830 831 If you answer "yes" to any questions in this section, please complete FORM B. Please make copies of FORM B, if needed, and complete one for each "yes" answer. 832 833 Have any professional liability judgements ever been entered Yes <u>1.</u> No against you? 2. Have any professional liability claim settlements ever been paid Yes No by you and/or paid on your behalf? Are there any currently pending professional liability suits, Yes 3. No actions, and/or claims filed against you? 834 835 LIABILITY INSURANCE 836 If you answer "yes" to this question, please complete FORM C.

Have you ever been denied or voluntarily relinquished your	Yes	No
professional liability insurance coverage, and/or have you ever		
had your professional liability insurance coverage canceled or		
non-renewed or had limits reduced?		

#### MEMBERSHIP STATUS – USE FOR SECTIONS CAND DE, FAND G

Please use the following key to indicate <u>Membership Status</u> membership status in <u>Sections E sections C</u>(Hospital Membership – Current and Pending), <u>F (Hospital Membership – Previous)</u>, and <u>GP</u> (Ambulatory Surgical Treatment Center Practice) below:

- A. Active
- B. Courtesy
- C. Consulting
- D. Adjunct

841 842 E. Suspended/ Terminated/ Resigned

- F. Active Provisional Staff
- G. Senior Staff
- H. Associate
- I. Provisional
- J. Affiliate

- K. Pending
- L. Other (Specify)

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845 846 847

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SECTION C. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

#### A. Primary Hospital

	Hospital Name:			
	Address:			
	Street	City	State	Zip
	Membership Status (see above):	Dates:		To Present
		Fr	om (mm/yy)	
	Department/Division:	Medical Staff Office FAXEmail:	<u>( ) </u>	
	Department Telephone #: ( )		<u> </u>	
	Do you have admitting privileges a	at this hospital? Yes	☐ No	
	Any limitations in your area of spe-	cialty at this hospital?		
В.	Other Hospital			
	Hospital Name:			
	Address:			
	Street	City	State	Zip
	Membership Status (see above):	Dates:		To Present
	_	Fr	om (mm/yy)	_
	Department/Division:	Medical Staff Office  FAXEmail:	$\longleftrightarrow$	
	Department Telephone #: _()_		_	
	Do you have admitting privileges a	at this hospital? Yes	☐ No	
	Any limitations in your area of spe-	cialty at this hospital?		

# C. Other Hospital

Hospital Name:				
Address:				
Stree	et	City	State	Zip
Membership Status (see a	ıbove):	Dates:		_ To Present
			From (mm/yy)	
Department/Division:		Medical Staff Offic EmailFAX:	e	
Department Telephone #	: ( )			
Do you have admitting p	rivileges at th	is hospital? 🔲 Ye	es No	
Any limitations in your a	rea of special	ty at this hospital?		
eck here if you have anne	nded addition	nal information for	this section	٦

# SECTION D. AMBULATORY SURGICAL TREATMENT CENTER PRACTICE Please list all ambulatory surgical treatment centers where you currently have clinical privileges. Use the Membership Status key listed prior to Section Eat the top of page 7. (Include additional sheets if more than three ASTCs.)

#### A. Primary Ambulatory Surgical Treatment Center

	ASTC Nam	e:			
	Address:				
		Street	City	State	Zip
	<u>Email</u> F				
	<del>AX#</del> : <u>(</u>	<del>-)</del>	Telephone #:	( )	
	Membership	o Status (see above):	Dates:		
				From (mm/yy)	To (mm/yy)
В.	Other Amb	oulatory Surgical Treat	ment Center		
	A CTC Nome				
	ASIC Nam	e:			
	Address:				
	-	Street	City	State	Zip
	Email <b>F</b>				
	AX#: (_	<del></del>	Telephone #:	( )	
	Membership	o Status (see above):	Dates:		
				From (mm/yy)	To (mm/yy)
С.		oulatory Surgical Treat			
	ASIC Nam	e:			
	Address:				
		Street	City	State	Zip
	<u>Email</u> <b>F</b>				
	<u>AX</u> #: <u>←</u>	<del></del>	Telephone #:	( )	
	Membershij	o Status (see above):	Dates:		
				From (mm/yy)	To (mm/yy)

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SECTION E. WORK HISTORY 859

> List chronologically (most recent first) all work engagements (including employment, selfemployment, service as an independent contractor, and military service) in the past 4 years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

**Current** workplacework <del>place</del>: Address: Street Zip City State Email Fax Telephone Number: ( ) Number: Title or Professional Occupation: Time in this employment: From: \_\_\_\_\_\_ To Present (mm/yy) **Previous** workplacework <del>place</del>: Address: \_\_\_\_ Street City State Zip Email Fax Telephone Number: ( ) Number: Title or Professional Occupation: Time in this employment:

From:

(mm/yy)

To:

(mm/yy) **Previous** workplacework <del>place</del>: Address: Street City State Zip

Telephone Number: ( )		EmailFax Number:	<del>( )</del>	
Title or Professional Occupation:				
			To:	
Previous workplacework place:		(mm/yy)		(mm/yy)
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	$\overline{()}$	
Title or Professional Occupation:				
Time in this employment:		(mm/yy)		(mm/yy)
Previous workplacework place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<u> </u>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	To:	
Previous  workplacework  place:		· ·		
Address:				
Street		City	State	Zip
Telephone Number: ( )		<u>Email</u> Fax Number:	$\longleftrightarrow$	

Title or Professional Occupation:				
Time in this employment:	From:		_ To:	
		(mm/yy)		
Previous  workplacework  place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>( )</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	_ To:	(mm/yy)
Previous workplacework place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	<del>( )</del>	
Title or Professional Occupation:				
Time in this employment:	From:	(mm/yy)	To:	(mm/yy)
Previous  workplacework  place:				
Address:				
Street		City	State	Zip
Telephone Number: ( )		EmailFax Number:	$\leftarrow$	
Title or Professional Occupation:				
Time in this employment:	From:		To:	

	(mm/yy)	(mm/yy)
	Check here if you have appended additional information for this so	ection.
865 866		

SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING TRANING UPDATE 867 868 869 Please provide an update of your medical education and clinical training over the past four 870 years. Do not duplicate internship, residency, and fellowship information previously 871 **reported.** (Attached additional sheets if necessary.) 872 FIRST UPDATE Residency Other Fellowship **Institution Name:** Department Chair or Program Director: Last Name First Name MI Degree Mailing Address: Street City State Zip Email Fax Telephone Number: Number: Dates attended: From: mm/yy Rotating Type of internship: Straight If straight, please list specifically specificaly Did you successfully complete this program? If no, please list specialty: Yes □ No Were you the subject of any disciplinary action during your attendance at this institution? (Attached an explanation of a "Yes" answer.) ☐ Yes No SECOND UPDATE Fellowship Residency Other **Institution Name:** Department Chair and Program Director:

Last Name	First Name	MI	Degree
Mailing Address:			
Street	City	State	Zip
Dates attended: From:	Mm/yy To: Mm/yy		
Types of internship: R	otating Straight:		
If straight, please list specialt	y:		
Did you successfully complete	te this program?	□No	
Were you the subject of any of this institution? Yes (Attach an explanation of a "	disciplinary action during your No Yes" answer.)	attendance	
Check here if you have app	ended additional information	for this section:	

874 SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL 875 Submit with all applications. Please answer the following questions to the best of your 876 knowledge with a "yes" or "no". If you answer "yes" to any questions, please complete 877 878 FORM A. Please make copies of FORM A as needed and complete one form for each "yes" 879 answer. 880 881 **Adverse or Other Actions** 882 1. Has your license to practice in any jurisdiction ever been Yes □ No denied, restricted, limited, suspended, revoked, cancelled and/or subject to probation, either voluntarily or involuntarily, or has your application for a license ever been withdrawn? 2. Have you ever been reprimanded and/or fined, been the subject Yes No of a complaint, and/or been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency that licenses providers? 3. Have you ever had your board certification rescinded or elected Yes No not to recertifylost any board certifications, and/or failed to recertify? 4. Have you ever been examined by a Certifying Board but failed No Yes to pass? Has any information pertaining to you, including malpractice 5. Yes No judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? 6. Has your federal DEA number and/or state associated Yes No Controlled Substances Licensestate controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? 7. Have your privileges at any hospital or other health care setting Yes No ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied, renewal, or has probation ever been imposed? Have you or any of your hospital or ambulatory surgical treatment center (ASTC) privileges and/or membership been denied, revoked,

	suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?		
<u>8.</u>	Has your membership at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, not renewed, denied, or has probation ever been imposed?	Yes	No
<u>9</u> 8.	Has your medical staff membership at any hospital or healthcare institution ever been voluntarily or involuntarily terminated? Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ASTC privileges for any reason?	Yes	No
<u>10</u> 9.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ASTC privileges and/or your license?	Yes	No
<u>11</u> 40.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs, or voluntarily withdrawn to avoid an investigation relating to those programs?	Yes	No
<u>12</u> <del>11</del> .	Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-partythird party payors, brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	Yes	No
<del>12.</del>	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	Yes	Ne
13.	Have you <u>ever</u> withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	Yes	No

<u>14.</u>	Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation order, not renewed, denied renewal, or has probation ever been imposed?		<u>Yes</u>		]
	OFESSIONAL LIABILITY ACTIONS  u answer "yes" to any questions in this section, please complete	<del>: FOF</del>	<b>км в.</b> :	<del>Pleas</del>	e
copic	es of FORM B, if needed, and complete one for each "yes" answ	<del>er.</del>			
<del>1.</del>	Have any professional liability judgements ever been entered against you?		Yes		]
<del>2.</del>	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?		Yes		]
<del>3.</del>	Are there any currently pending professional liability suits, actions and/or claims filed against you?		Yes		-
4.	Has any person or entity ever been sued for your clinical actions?		Yes		:
LIA	BILITY INSURANCE				
<del>If yo</del>	u answer "yes" to this question, please complete FORM C.				
	Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled or non-renewed or limits reduced?		Yes		}
CRI	MINAL ACTIONS				
	u answer "yes" to any questions in this section, please complete es of FORM D, if needed, and complete one for each "yes" answ		<b>kM D.</b> 1	Pleas	e
1.	Have you <u>ever</u> been charged with or convicted of a <u>felony or misdemeanorerime</u> (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this State or any other state or country?		Yes		

TOA	Dage	0.0	240	1050	00
1( `A	R770	1965.	.240	4958	<r()′)< td=""></r()′)<>

		Have you <u>ever</u> been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?		Yes		No
900 901	MEI	DICAL CONDITION				
902 903	If yo	u answer "yes" to this question, please complete FORM E.				
904	that i	you <u>currently</u> have a <u>physical illness or mental illness or disability</u> results in your inability medical condition, physical defect or tional impairment that in any way impairs and/or limits your ty to practice medicine with reasonable <u>judgement</u> , skill, and y? (See Medical Practice Act – 225 ILCS60/22(a))		Yes		No
	СНІ	EMICAL SUBSTANCES OR ALCOHOL <u>USE DISORDER AB</u>	USE			
	-	ou answer "yes" to any questions in this section, please complet te copies of FORM F, if needed, and complete one for each "yes			Plea	se
	1.	Are you currently engaged in illegal use of any legal or illegal substances?		Yes		No
	<u>1</u> 2.	Do you currently overuse and/or abuse alcohol or any other controlled substance(s)?		Yes		No
	<u>2</u> 3.	If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?		Yes		No
	<u>3</u> 4.	Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance <u>use disorderabuse</u> ?		Yes		No
	INV	ESTMENTS				
	purch trade labor cente	e last 5 years have you and/or a member of your family <u>ever</u> hased or made an investment in (other than securities of a publicly ed company), or otherwise have a business interest in any clinical ratory, diagnostic or testing center, hospital, <u>surgical</u> <u>ersurgicenter</u> , and/or other business dealing with the provision of lary health services, equipment or supplies?		Yes		No
	If "y	es", please provide explanation:				

9

## SECTION H. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site	Group/Business Name  Building Name								
	Office Address – Number and Street – Suite								
	City	County	State		Zip				
	( ) Main Telephone N	Number	Office Administrator –	Last	First	MI			
	<del>( )</del> Beeper Number		( ) Fax Number	E-Mail					
	( )		( )						
	( ) ( ) Emergency Number Answering Service								
] - -	If "yes", describe any	y restriction	ns (e.g., appointment type	e, patient typ	pe):				
Plea	ease provide the number of patient visits you have at this site per year:								
ability to pra	actice medicine or t	reat certai	u or your office staff ha in patients or classes of y in a foreign language	patients. Li	st separat	ely			
Spec	cial Skills of Practition	oner:							
Spec	cial Skills of Staff:								
	guages Spoken by Pr								

	ages Written by ioner Practioner				
Langu	ages Spoken by	Staff:			
Langu	ages Written by	y Staff:			
			about physician when you are no		ers who provide
Name:					
	Last		First	MI	Degree
Specialty:					
Address:				Telephone:	( )
	Street	City	State Zip		
Availability:	Days	Nights	Weekends	Holiday	s
CONFIDENTI Name:	AL INFORMA	ATION: Tax	ID#:		
	Last		First	MI	Degree
Specialty:					
Address:					( )
	Street	City	State Zip	_ 1	
Availability:	☐ Days	Nights	Weekends	☐ Holiday	S
CONFIDENTI	AL INFORMA	ATION: Tax 1	ID#:		
Name:					
	Last		First	MI	Degree
Specialty:					
Address:				_Telephone:	( )
	Street	City	State Zip		
Availability:	Days	☐ Nights	Weekends	☐ Holiday	s

	CONFIDENTIAL INFORMATION: Tax ID#:	
914		
915		

Primary Site	Group/Business Name					
	Building Name					
	Office Address – Number	and Street – Suite				
	City Coun	ty State	Zip			
	_( )					
	Main Telephone Number	Office Administrato	r – Last First			
	<del>Comparison of the Comparison </del>	( )				
	Beeper Number	Fax Number	E-Mail			
	( ) Emergency Number	( )				
	Emergency Number	Answerin	g Service			
Are	e you currently accepting new patients at this location?   Yes   No					
	If "yes", describe any restric	etions (e.g., annointment	type natient type):			

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special	Skills of Prac	titioner:			
Special	Skills of Staff	f:			
Langua	ges Spoken by	y Practitioner:			
Langua	ges Written by	y Practitioner	:		
Langua	ges Spoken by	y Staff:			
-	tients enrolle	d at this site	about physician when you are no	-	ers who provide
	Last		First	MI	Degree
Specialty:					
Address:				_Telephone:	( )
	Street	City	State Zip		
Availability:	Days	☐ Nights	Weekends	Holiday	S
CONFIDENTIA	AL INFORMA	ATION: Tax 1	ID#:		
Name:					
Specialty:	Last		First	MI	Degree
Address:				Telephone:	( )
	Street	City	State Zip		
Availability:	☐ Days	Nights	Weekends	Holiday	s
CONFIDENTIA	AL INFORMA	ATION: Tax	ID#:		
Name:	Last		First	MI	Degree

	Address:					Telephone: ( )
		Street	City	State	Zip	
927	Availability:	Days	☐ Nights	☐ Wee	kends	Holidays
	CONFIDENTIAL	L INFORMA	<i>TION</i> : Tax I	D#:		
928						
	End Uniform Hea	Ith Care and	Hospital Reci	edentials	Recrede	entialing and Business Data
	Gathering Form.					
	Attach Forms A-F	As Required	d.			
929						
930						

Applie Applic Last Indica	es. Use reverse side of cant Name:  ate the number of ON tion Number:	First E of the questions in Sec	MI etion I to which you answe	red "yes":
Last Indica Quest	ate the number of ON tion Number:  Describe the circums	E of the questions in Sec	ction I to which you answe	·
Indica Quest	tion Number:  Describe the circums	E of the questions in Sec	ction I to which you answe	·
Quest	tion Number:  Describe the circums	-		·
A		stances surrounding this	occurrence. Please include	the data of th
-				the date of the
-				
В.	Provide an explanation taken.	on of any actions taken.	Please include the date the	action was
-				
- -				
C.	Provide the current st	tatus of the issue.		
-				
=				

Sign	<b>ature</b> (or elect	ronic signature)	ı <b>:</b>		Date :	
		Telephone N	Number: ( )			
			Street	City	State	Zip
		Address:				
		Department/	Committee:			
D.	If known:	Contact				

#### FORM B – PROFESSIONAL LIABILITY ACTIONS

938939940

941

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

App.	licant Name:			
	Last	Firs	st	MI
A.	Plaintiff's Name:			
	Last	F	First	MI
	If court case, Case Name &	Case Number:		
В.	Your Involvement in the Ca	re (Attending, Cons	sulting, Etc	)
C.	Your Status in the Case (Sol Provider Practice Named in			-
D.	Allegations, including Patier	nt Outcome, If Ava	ilable:	
E.	Date of Incident (mm/yy)	F.	Date Filed	(mm/yy)
G.	Date Case Closed (mm/yy):			
	Case Resolution:			
	<ul><li>☐ Dismissed</li><li>☐ Settlement Out of Court</li></ul>	☐ Judgement ☐ Pending	_	tration
H.	Amount Paid on Your Behal	If (if any): \$		
I.	Professional Liability Insure	er Name (if one was		
J.	Insurer Telephone Number:	( )		cy Number <u>4 digits)</u> :
L.	Insurer Address (Street, City	, State, Zip Code):		

Signature (or electronic signature):	Date:	
	•	

App	licant Name:				
	La	ast	First	MI	
A.	History of Professi	onal Liability l	Insurance (Pleas	e Check One)	
	Cancelled Vol	untarily [	Non-Renewe	ed	
	Cancelled Invo	oluntarily [	Application	Denied	
3.	Carrier Name: Carrier Telephone				
<b>C.</b>	Number: Policy Number	( )			
Э.	(last 4 digits):				
Ξ.	Carrier Address:				
	Dates of	Street From	City	State	Zip
₹.	Coverage:	(mm/yy):		_ To (mm/yy): _	
Э.	Circumstances Invo	1 J.			

Medical Practice Privileges Affected as a Result of This Situation:

I.

	Date
Signature (or electronic signature):	:

**Date:** \_\_\_\_\_

			FORM E	E – MEDICAL CON	NDITION
				y to complete a sepa ll space is needed.	rate sheet for EACH condition. U
Appl	icant Nam	ne:			
A.	Describe condition	this medic	ast al	First	MI
В.					affect your current ability to practic range of clinical activities?
<del>C.</del>	What is to condition	the current n?	status of yo	<del></del>	
<u>C</u> ₽.				of your personal phy r health condition.	sician/health care provider who can
	Name				Telephone Number
	Last	First	MI	Degree	
	Last	Tilst	WII	Degree	( )
	Last	First	MI	Degree	
Signa	ature (or e	electronic si	gnature):		Date:

## FORM F – CHEMICAL SUBSTANCES OR ALCOHOL <u>USE DISORDER ABUSE</u>

DUPLICATE this from as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

App	plicant Nam	ne:				
		Last	First	M	I	
Des	scribe the su	ıbstance(s) you use	:			
A.		xtent does, or could practice medicine in				
В.	Monitored	by State Board Ma	andate (Name and	Address)		
C.	Monitored	l Voluntarily (Name	e and Address)		_	
D.	Other info	rmation about the c	current status of yo	our use of substanc	es:	
E.	Abstinent (mm/yy):	since				
F.	provide in	e name and address formation about yo on what impact (if a	ur treatment for al	cohol or chemical	substance use and	l can
	Name:					
		Last	First	MI	Degree	
	Address:	Street	City	State	Zip	
	Telephone		City	State	Στρ	

Signature (or electronic signature):	Date:
(0	
(Source: Amended at 48 Ill. Reg, effective	)
Section 965.APPENDIX C Uniform Updating Health C	re Professional Undate Data
Gathering Form	ire Froressional Opdate Data
activiting Politi	
STATE OF ILLINOI	S
Uniform Updating Health Care Professional Up	<del>date Data Gathering</del> Form
•	5
The Health Care Professional Credentials Data Collection	on Act [410 ILCS 517] requires that
this form be collected from health care professionals by	hospitals, health care entities, and
health care plans that desire to recredential the professi	
entity, and health care plan may also require completion	of supplemental forms.
INSTRUCTIONS	
This form is for updating only. Other forms are require	d for credentialing and for
recredentialing.	
The date are all all a UC and dankal Information U all all h	
The data marked as "Confidential Information" shall be	
extent required by law. They may be used by the health by their agents for credentialing and recredentialing and	
by their agents for credentialing and recredentialing and	i internal business purposes.
AFFIRMATION OF INFOR	MATION
I represent and warrant that all of the information provided	and the responses given are correct
and complete to the best of my knowledge and belief. I und	
of information will be grounds for rejection or termination,	1 1
law. I further agree to promptly inform all entities to which	· · · · · · · · · · · · · · · · · · ·
of any change required to be updated by the Uniform Upda	ing Health Care Professional
Credentialing and Business Data Gathering Update Form.	
I understand that this application does not antitle to	ainstion in any bossital basith
I understand that this application does not entitle me to part entity, or health plan.	cipation in any nospital, nearth care
chary, or hearth plan.	
Applicant's Signature (or electronic Type	or Print Name Date
signature)	
<del></del>	
**PLEASE BE ADVISED THAT EACH HOSPITAL, H	EALTH CARE ENTITY, AND

		NOTIFICATION OF C	HANGES	
Provider's Name:				
	Last	First	MI	Degree
Date Completed:				
1		(mm/yy)		
Date of Birth:		\ <b>33</b> /		
_		(mm/yy)		
Illinois Profession	al License	Number:		
Medical Education				
Security Number:				
Recredentialing ar	<del>id Busines</del> appropri	e <u>Uniform</u> Health Care <u>and Sanda Gathering</u> Form (sate).		
Recredentialing ar attached (check as	<del>id Busines</del> appropri	e <mark>s Data Gathering</mark> Form o		
Recredentialing ar attached (check as ATTACH	<del>id Busines</del> appropria MENTS	<del>s Data Gathering</del> Form ( ate).	contain updated in	
Recredentialing arttached (check as  ATTACH  Section	nd Busines appropria MENTS A.	Section 1 Sectio	c <b>ontain updated i</b> r	nformation ar
ATTACH  Section  Section	nd Busines appropria MENTS A. B.	General Information Professional Information	contain updated in n Current & Pending	<b>nformation a</b>
ATTACH  Section  Section  Section	nd Busines appropria MENTS A. B. C.	General Information Professional Information Hospital Membership –	contain updated in n Current & Pending	<b>nformation a</b>
ATTACH  Section Section Section Section Section Section Section	nd Busines appropria MENTS A. B. C. D.	General Information Professional Informatio Hospital Membership – Ambulatory Surgical Tr	n Current & Pending reatment Center Pra	<b>nformation an</b> g actice
ATTACH  Section Section Section Section Section Section Section Section Section	A. B. C. D. E.	General Information Professional Information Hospital Membership – Ambulatory Surgical Tr Work History Medical Education/Clin Professional History: C	n Current & Pendingreatment Center Practical Training Upda	<b>nformation an</b> g actice
ATTACH  Section	A. B. C. D. E. F.	General Information Professional Information Hospital Membership – Ambulatory Surgical Tr Work History Medical Education/Clin Professional History: C Primary Site Informatio	n Current & Pending reatment Center Pranical Training Upda Confidential	<b>nformation an</b> g actice
ATTACH  Section	A. B. C. D. E. F. G.	General Information Professional Information Hospital Membership – Ambulatory Surgical Tr Work History Medical Education/Clin Professional History: C	n Current & Pending reatment Center Pranical Training Upda Confidential	nformation and an angle of the state of the
ATTACH  Section	A. B. C. D. E. F. G. H.	General Information Professional Information Hospital Membership – Ambulatory Surgical Tr Work History Medical Education/Clin Professional History: C Primary Site Informatio	n Current & Pending reatment Center Practical Training Upda Confidential on tion	nformation and a sectice atte
ATTACH  Section	A. B. C. D. E. F. G. H.	General Information Professional Information Hospital Membership – Ambulatory Surgical Tr Work History Medical Education/Clin Professional History: C Primary Site Informatio	n Current & Pending reatment Center Practical Training Upda Confidential on tion	nformation and an angle of the state of the