TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER u: MISCELLANEOUS PROGRAMS AND SERVICES

PART 965
HEALTH CARE PROFESSIONAL CREDENTIALS DATA COLLECTION CODE

SUBPART A: GENERAL

SUBPART B: ENFORCEMENT ACTION

AUTHORITY: Implementing and authorized by the Health Care Professionals Data Collection Act [410 ILCS 517].

SOURCE: Adopted at 24 Ill. Reg. 11476, effective August 24, 2001; amended at 26 Ill. Reg. 18416, effective December 15, 2002; expedited correction at 27 Ill. Reg. 14271, effective December 15, 2002; amended at 32 Ill. Reg. 4040, effective February 27, 2008; amended at 48 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 965.110 Definitions

Act – the Health Care Professional Credentials Data Collection Act [410 ILCS 517].

Credentialing – the process of assessing and validating the qualifications of a health care professional. (Section 5 of the Act)

Credentials data – those data, information, or answers to questions required by a health care entity, health care plan, or hospital to complete the credentialing or recredentialing of a health care professional. (Section 5 of the Act)

Health care entity – any of the following entities that *require the submission of credentials data* in order for a health care professional to participate or provide care as a part of, or in conjunction with, the health care entity:

a health care facility or other health care organization licensed or certified to provide medical or health services in Illinois, other than a hospital;

a health care professional partnership, corporation, limited liability company, professional services corporation or group practice; or

an independent practice association or physician hospital organization. (Section 5 of the Act)

Entities licensed under other Acts that conduct credentialing in order for a health care professional to provide services, such as home health agencies, hospices, post-surgical recovery care centers, and ambulatory surgical treatment centers, are health care entities for the purposes of this Part. 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 in their facilities/programs.

Health care plan – any entity licensed by the Department of Insurance as a prepaid health care plan or health maintenance organization or as an insurer that *requires the submission of credentials data.* (Section 5 of the Act)

Health care professional – any person licensed under the Medical Practice Act of 1987 or any person licensed under any other Act subsequently made subject to the Act. (Section 5 of the Act)

Hospital – a hospital licensed under the Hospital Licensing Act or any hospital organized under the University of Illinois Hospital Act. (Section 5 of the Act)

Recredentialing – a process undertaken for a period not to exceed 3 years by which a health care entity, health care plan, or hospital ensures that a health care professional who is currently credentialed by the health care entity, health care plan, or hospital continues to meet the credentialing criteria used by the health care entity, health care plan, or hospital. (Section 5 of the Act)

Single credentialing cycle – a process undertaken for a period not to exceed 3 years whereby~~,~~ for purposes of recredentialing, each health care professional's credentials data are collected by all health care entities and health care plans during the same time period. (Section 5 of the Act)

Uniform health care credentials form – the form referenced in Section 965.Appendix A *to collect the credentials data commonly requested by health care entities and health care plans for purposes of credentialing.* (Section 5 of the Act)

Uniform health care recredentials form – the form referenced in Section 965.Appendix B *to collect the credentials data commonly requested by health care entities and health care plans for purposes of recredentialing.* (Section 5 of the Act)

Uniform hospital credentials form – the form referenced in Section 965.Appendix A *to collect the credentials data commonly requested by hospitals for purposes of credentialing.* (Section 5 of the Act)

Uniform hospital recredentials form – the form referenced in Section 965.Appendix B *to collect the credentials data commonly requested by hospitals for purposes of recredentialing.* (Section 5 of the Act)

Uniform updating form – a standardized form referenced in Section 965.Appendix C *for reporting of corrections, updates, and modifications to credentials data to health care entities, health care plans, and hospitals when those data change following credentialing or recredentialing of a health care professional.* (Section 5 of the Act)

~~*Recredentialing – the process by which a health care entity, health care plan, or hospital ensures that a health care professional who is currently credentialed by the health care entity, health care plan, or hospital continues to meet the credentialing criteria used by the health care entity, health care plan, or hospital no more than once every 2 years.* (Section 5 of the Act)~~

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.130 Use of Uniform Credentialing Forms

a) A health care entity, a health care plan, or a hospital may accept or require credentialing data in an electronic format provided it contains the required content prescribed by the Department in Sections 965.APPENDIX A through C. ~~The Department shall establish uniform forms for the purpose of credentialing, recredentialing, and information updates as required in Section 15 of the Act. The forms shall be coordinated to avoid the need for duplication of effort and information in submission.~~

~~b)~~ ~~Hard copies and/or electronic copies of the forms shall be provided by the credentialing entity to applicants and current providers for use in their process. Copies may be obtained through the Department electronically via the website at www.idph.state.il.us or in hard copy upon request. No health care entity, health care plan, or hospital may require submission of the form in a specific format, either paper or electronic, until a date has been established under this Part whereby electronic submission can be required.~~

b~~c~~) All ~~Beginning January 1, 2002, all~~ health care entities, health care plans, and hospitals that credential health care professionals shall only require the submission of the following forms, as specified in Section 15 of the Act:

1) For credentialing, the Uniform Health Care and Hospital Credentials Form (Section 965.Appendix A);~~.~~

2) For recredentialing, the Uniform Health Care and Hospital Recredentials Form (Section 965.Appendix B);~~.~~

3) For updating credentials information, the Uniform Updating Form (Section 965.Appendix C);~~.~~

4) *Any additional credentials data requested; and*~~Any additional credentials data requested.~~

5) *An online credential with required content as required by forms under* this Section.

~~d)~~ ~~Credentialing and recredentialing applications and forms distributed before January 1, 2002 may continue to be accepted, but only through June 30, 2002. 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.~~

c~~e~~) This Section does not prohibit or *restrict the right of* any~~a~~ *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.~~

d~~g~~) 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.

e~~h~~) *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 Drug Enforcement Agency~~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*

health care professional knew of the change. (Section 15(g) of the Act)

f~~i~~) *All updates shall be made on the updating forms* in Section 965.Appendix C ~~of this Part~~. (Section 15(g) of the Act) Updated information will be based on the information submitted to a health care plan, health care entity or hospital in the form in Section 965.Appendix B ~~of this Part~~.

g~~j~~) Collection of the information contained in the forms under this Part does not require health care entities, health care plans or hospitals to use all ~~of~~ the data and fields in the credentialing process. Nothing in the Act or this Part mandates whether or how credentials data must be verified or assessed as part of the credentialing process. All decisions about whether and how to verify and assess any or all ~~of~~ the credentials data submitted to a health care entity, health care plan or hospital by a health care professional is exclusively within the lawful discretion of the health care entity, health care plan, or hospital that is credentialing that health care professional.

h~~k~~) *Nothing in the Act* or this Part *prohibits a hospital from granting disaster privileges pursuant to the provisions of Section 10.4 of the Hospital Licensing Act. When a hospital grants disaster privileges pursuant to Section 10.4 of the Hospital Licensing Act, that hospital is not required to collect credentials data pursuant to* the *Act*. (Section 15(m) of the Act)

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.140 Required Policies and Procedures

a) Each health care entity, health care plan, hospital, or other credentialing entity shall adopt ~~on or before January 1, 2002~~ and implement a policy or policies on the process of credentialing and credentials verification within their organization, including requests for additional information and confidentiality of information.

b) *Each health care entity and health care plan shall complete the process of verifying a health care professional's credentials data in a timely fashion and shall complete the process of credentialing or recredentialing of the health care professional within 60 days after the submission of all credentials data and completion of verification of the credentials data* to be used in credentialing~~*to be used in credentialing*~~ and recredentialing. (Section 15(f) of the Act)

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 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, or hospital involved in the credentialing process, or accreditation bodies or licensing agencies. However, any redisclosure of credentials data contrary to this* subsection *is prohibited.* (Section 15(h) of the Act)~~The credentialing data noted as "confidential information" in the uniform forms in this Part are confidential as provided by law, including, but not limited to, Section 15(h) of the Act, Section 10.4 of the Hospital Licensing Act [210 ILCS 85/10.4] and Part 21 of Article VIII of the Code of Civil Procedure [735 ILCS 5/Art. VIII, Part 21], and otherwise may not be redisclosed without written consent of the health care professional.~~

d) To make the form beneficial and effective for health care professionals, health care entities, health care plans, and hospitals, additional commonly collected business data are also being collected in the form. Nothing in the Act or this Part shall be considered to prohibit sharing of business data for business purposes of the health care entity, health care plan, or hospital.

e) Health care entities, health care plans, and hospitals may delegate credentialing and recredentialing activities.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

SUBPART B: ENFORCEMENT ACTION

Section 965.300 Single Credentialing Cycle

a) All health care entities and health care plans shall obtain recredentialing data on a health care professional according to the single credentialing cycle ~~beginning July 1, 2002~~, except:

1) when a health care professional submits initial credentials data to a health care entity or health care plan;

2) when a health care professional's credentials data change substantively; or

3) when a health care entity or health care plan requires recredentialing as a result of patient or quality assurance issues.

b) Data collection for health care entities and health care plans will coincide with a

single credentialing cycle that entitles health care entities and health care plans to collect recredentialing data once and not more than every 3 years, except as noted in subsection (a).

c) Data collection:

1) will be based on the last digit of each health care professional's Social Security number;

2) will provide for a one-month~~one month~~ notification period for each digit during which each health care entity and health care plan notifies those persons being recredentialed of the time period during which data are expected to be submitted; and

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 from those persons being recredentialed.

d) The single credentialing cycle reflects a six-month~~6 month~~ "OPEN" period when health care entities and health care plans cannot collect data from a health care professional, except as noted in subsection (a). This period coincides with the Illinois Department of Financial and Professional Regulation's licensing schedule of physicians.

e) The single credentialing cycle is established as follows:

1) For the years 2020/2023~~2005/2008~~

July	OPEN
August	OPEN
September	OPEN
October	OPEN
November	OPEN
December	OPEN

2) For the years 2021/2024~~2003/2006/2009…~~

January	Notification (0's)
February	Collection of data
March	Collection of data
April	Notification (1's)
May	Collection of data
June	Collection of data

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 2020/2023~~2005/2008/2011~~

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

accreditation or otherwise.

h) The requirements of this Section apply only to health care plans and health care entities as defined in the Act ~~[410 ILCS 517/5]~~.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.310 Waiver from Single Credentialing Cycle

a) A health care entity or health care plan may apply to the Director via letter for an exemption from the single credentialing cycle. The request for consideration shall~~should~~ be addressed to the Department's Office of Health Care Regulation, the Director's designee for administration of this program~~, the Office of Health Care Regulation~~.

1) The request for waiver of this provision shall~~must~~ be submitted to~~received by~~ the Department on or before November 1 of the year prior to initiation of the established cycle.

2) The request for waiver must contain, at a minimum, the following:

A) a detailed explanation as to the undue hardship that would be created for the health care entity or health care plan in following the published single cycle.

B) a detailed explanation and outline of the plan for conducting and time frame involved in the process that would be utilized in place of the published single cycle by the requesting health care entity or health care plan.

b) The Director will~~shall~~ evaluate the request for exemption based upon whether the plan is a small or unique health care entity for which compliance with the single credentialing cycle presents an undue hardship.

c) The Department will notify waiver applicants of approval or denial by December 15 of the year prior to implementation of the single cycle.

d) A denial of a waiver may be appealed in accordance with the procedures in Section 965.860~~ of this Part~~.

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.APPENDIX A Uniform Health Care and Hospital Credentials~~Professional Credentialing and Business Data Gathering~~ Form

STATE OF ILLINOIS

Uniform Health Care and Hospital Credentials~~Health Care Professional Credentialing and Business Data Gathering~~ Form

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.

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 two (2) 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,*

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

ATTACHMENTS

Attach Forms A-F as needed to support "yes" responses in the Professional History section and copies of the following:

☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

☐ All Current Professional Licenses

☐ Current Federal DEA License, If Applicable

☐ Current State Controlled Substances 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-9s, If Applicable

☐ ECFMG Certificate, If Applicable

☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, as ~~As~~ Applicable

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 Uniform Health Care and Hospital Credentials ~~Health Care Professional Credentialing and Business Data Gathering Update~~ Form.

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 signature)	Type or Print Name	Date

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

Chapter A

PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree MD/DO/DC/PhD/MSW/DPM/ DDS/DMD/Other

List other names by which you have been known: _____
Last First MI

If you have been known~~know~~ by other names, please explain why your name changed:

_____

Birth Date: _____ Place of Birth: _____
(mm/dd/yy) City State Country~~County~~

Sex: ☐ Male ☐ Female Language Fluency of Applicant: ☐ English ☐ Other_____ ☐ Spanish

U.S. Citizen? ☐ Yes ☐ No

If "no", do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: _____

Medical Education~~Social Security Number~~: _____

Emergency Contact Person: _____
Last First MI

Telephone Number: *( )* _____

Mailing Address: _____ *Daytime Phone:* *( )* _____

EMAIL Address: _____ *Fax Number:* *( )* _____

Check here if you have appended additional information for this Section. ☐

Chapter A

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No

If "no", please explain restriction(s)~~limitation~~ _____

Current and Previous Professional Licenses in Other States

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

Check here if you have appended additional information for this section. ☐

Current Federal DEA License Number: _____ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: _____ (mm/dd/yy) Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No

If "no", please explain restriction(s)~~limitation~~: _____

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: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____

(mm/dd/yy)

Please identify all limitations related to the above Controlled Substances Numbers and explain limitations

_____

_____

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification:

State: _____ Certificate #: _____ Expiration Date: _____ (mm/dd/yy)

Check here if you have appended additional information for this section. ☐

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Specialty I: _____

Are you Board Certified in Specialty I? ☐ Yes ☐ No

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled 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 Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty/Subspecialty II? ☐ Yes ☐ No

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled 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 Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty III: _____

Are you Board Certified in Specialty/Subspecialty III? ☐ Yes ☐ No

Are you Board Certified in Specialty III? ☐ Yes ☐ No

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled 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 Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty IV: _____

Are you Board Certified in Specialty/Subspecialty IV? ☐ Yes ☐ No

Are you Board Certified in Specialty IV? ☐ Yes ☐ No

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled 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 Specialty Boards: _____ (mm/yy)

Check here if you have appended additional information for this section. ☐

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Chapter A

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____

(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

Check here if you have appended additional information for this section. ☐

PROFESSIONAL LIABILITY ACTIONS

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.

1.	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?	☐ Yes	☐ No
3.	Are there any currently pending professional liability suits, actions, and/or claims filed against you?	☐ Yes	☐ No

LIABILITY INSURANCE

If you answer "yes" to this question, please complete FORM C.

	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	☐ No

Chapter A

SECTION D. EDUCATION AND TRAINING

If you have separated from a clinical training program prior to its conclusion, ~~If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please~~ explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: _____

~~Mailing~~ Address 1: _____
Street City State Zip

Address 2: _____
Region Country

Telephone Number: (____) _____ Email~~Fax Number~~: ~~(____)~~ _____

Degree: _____ Year Graduated: _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued: _____ Serial Number for ECFMG _____

Were you the subject of any disciplinary action during your time at this institution? ☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐

INTERNSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of internship: ☐ Rotating ☐ Straight If straight, please list specialty:

_____

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Did you successfully complete this program? ☐ Yes ☐ No If "no", please attach an explanation.

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

FIRST RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No If "no", please attach an explanation.

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

SECOND RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From _____ To: _____
(mm/yy) (mm/yy)

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No If "no", please attach an explanation.

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

FIRST FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No If "no", please attach an explanation.

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

SECOND FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No If "no", please attach an explanation.

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____

Street City State Zip

Telephone Number: ( ) Email~~Fax Number~~: ~~( )~~

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
(mm/yy) (mm/yy)

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) Email~~Fax Number~~: ~~( )~~

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
(mm/yy) (mm/yy)

Were you the subject of any disciplinary action during your time at this institution?
☐ Yes ☐ No (Attach an explanation of a "yes" answer.)

If more than two teaching experiences/faculty appointments, check here and attach additional information that duplicates the information above: ☐

MEMBERSHIP STATUS – USE FOR SECTIONS E, F AND G

Please use the following key to indicate Membership Status~~membership status~~ in Sections~~sections~~ E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgical Treatment Center Practice) below:~~.~~

A. Active	F. Active Provisional Staff	K. Pending
B. Courtesy	G. Senior Staff	L. Other (Specify)
C. Consulting	H. Associate	
D. Adjunct	I. Provisional	
E. Suspended/ Terminated/ Resigned	J. Affiliate	

Chapter A

SECTION E. 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
From (mm/yy)

Department/Division: _____ Medical Staff Office Email~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( ) _____

Any limitations in your area of specialty at this hospital? _____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____ To Present
From (mm/yy)

Department/Division: _____ Medical Staff Office Email~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( ) _____

Any limitations in your area of specialty at this hospital? _____

C. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____ To Present
From (mm/yy)

Department/Division: _____ Medical Staff Office Email~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( ) _____

Any limitations in your area of specialty at this hospital? _____

Check here if you have appended additional information for this section ☐

Chapter A

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status ~~membership status~~ key listed prior to Section E. (Include additional sheets if more than three hospitals.)

1. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office Email ~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( ) _____

2. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office Email ~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( ) _____

3. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office Email ~~FAX #~~: ~~( )~~ _____

Department Telephone #: ( )

Check here if you have appended additional information for this section ☐

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Chapter A

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: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section. ☐

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Chapter A

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~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **To Present**
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____

(mm/yy) (mm/yy)

Check here if you have appended additional information for this section. ☐

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Chapter A

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge ~~(within the past 12 months)~~ of your current clinical abilities, ethical character, and interpersonal skills, preferably including at least one person with whom you have worked in the last 12 months, and who would be willing to provide this information upon request. If you list partners, 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 credentialing form.~~

CONFIDENTIAL INFORMATION

1. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Relationship: _____ Years Known: _____

2. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Relationship: _____ Years Known: _____

3. Name: _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) Email~~Fax Number~~: ~~( )~~

Relationship: Years Known:

Chapter A

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

Submit with all applications. Please answer the following questions to the best of your 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" answer.

Adverse or Other Actions

1.	Has your license to practice in any jurisdiction ever been 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?	☐ Yes	☐ No
2.	Have you ever been reprimanded and/or fined, been the subject 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?	☐ Yes	☐ No
3.	Have you ever had your board certification rescinded or elected not to recertify~~lost any board certifications~~, and/or failed to recertify?	☐ Yes	☐ No
4.	Have you ever been examined by a Certifying Board but failed to pass?	☐ Yes	☐ No
5.	Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	☐ Yes	☐ No
6.	Has your federal DEA number and/or state associated Controlled Substances License~~state 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?	☐ Yes	☐ No
7.	Have your privileges at any hospital or other health care setting 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~~	☐ Yes	☐ No

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

8.	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
9~~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
10~~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
11~~10~~.	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
12~~11~~.	Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-party~~third 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~~	☐	~~No~~
13.	Have you ever 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

14. 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 ☐ No

15. 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 ☐ No

~~**PROFESSIONAL LIABILITY ACTIONS**~~

~~**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.**~~

~~1. 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?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~3. 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~~

~~**LIABILITY INSURANCE**~~

~~**If you 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~~

CRIMINAL ACTIONS

If you answer "yes" to any questions in this section, please complete FORM D. Please make copies of FORM D, if needed, and complete one for each "yes" answer

1. Have you ever been charged with or convicted of a felony or misdemeanor~~crime~~ (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 ☐ No

2. 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

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628 **MEDICAL CONDITION**
629
630 **If you answer "yes" to this question, please complete FORM E.**
631

Do you currently have a physical illness or mental illness or disability that results in your inability~~medical condition~~, ~~physical defect or emotional impairment that in any way impairs and/or limits your ability~~ to practice medicine with reasonable judgement, skill, and safety? (See Medical Practice Act – 225 ILCS 60/22(a)) ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER~~ABUSE~~

If you answer "yes" to any questions in this section, please complete FORM F. Please make copies of FORM F, if needed, and complete one for each "yes" answer.

~~1.~~ ~~Are you currently engaged in illegal use of any legal or illegal substances?~~ ☐ ~~Yes~~ ☐ ~~No~~

1~~2~~. Do you currently overuse and/or abuse alcohol or any ~~other~~ controlled substances? ☐ Yes ☐ No

2~~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

3~~4~~. Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance use disorder~~abuse~~? ☐ 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 center~~surgicenter~~, and/or other business dealing with the provision of ancillary health services, equipment or supplies?

☐ Yes ☐ No

If "yes", please provide explanation: _____

_____

_____

_____

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Chapter B

SECTION K. 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 Number

Office Administrator – Last First MI

~~( )~~ ~~Beeper Number~~

( ) Fax Number

E-Mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)?

☐ Yes ☐ No If "yes", describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If "yes", describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Please provide the business hours, including days of the week and hours of operation: _____

~~**Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day.**~~

~~Monday~~ ~~Tuesday~~ ~~Wednesday~~ ~~Thursday~~ ~~Friday~~ ~~Saturday~~ ~~Sunday~~

~~Hours:~~

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing 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)	_____	_____

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour _____

Average Waiting Time in Office (from scheduled appointment time to actual examination) _____

Average Response Time for Returning Patient Calls:

Acute or Urgent Situation: _____

Emergency Situation: _____

Routine 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~~Practioner~~: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If "yes", is supervision always provided on premises during paraprofessional'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 used:

_____ _____ _____ _____

Lab service at this site: ☐ Yes ☐ No If "yes", check whether:

☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No CLIA Expiration Date: _____

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#:
Please provide the following information about physicians/practitioners who practice in this office:

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

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Chapter B

SECTION L. PRIMARY SITE TAX INFORMATION

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 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: ( ) _____

Chapter B

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice. If there is more than one additional site, copy and complete this section for each additional site.

Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) Main Telephone Number

Office Administrator Last First MI

~~( ) Beeper Number~~

( ) Fax Number

E-Mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)?

☐ Yes ☐ No If "yes", describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If "yes", describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year? _____

Please provide the business hours, including days of the week and hours of operation: _____

~~**Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day.**~~

~~Monday~~ ~~Tuesday~~ ~~Wednesday~~ ~~Thursday~~ ~~Friday~~ ~~Saturday~~ ~~Sunday~~

~~Hours:~~

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing 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)	_____	_____

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour _____

Average Waiting Time in Office (from scheduled appointment time to actual examination) _____

Average Response Time for Returning Patient Calls:

Acute or Urgent Situation: _____

Emergency Situation: _____

Routine 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 (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? Yes ☐ No

If "yes", is supervision always provided on premises during paraprofessional'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 used:

________________ ________________ ________________ ______________

Lab service at this site: ☐ Yes ☐ No If "yes", check whether:

☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No CLIA Expiration Date: ________________

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: ________________________________ Specialty: __________________
Last First MI Degree

Address: ________________________Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: ________________

Name: ________________________________ Specialty: __________________
Last First MI Degree

Address: ________________________Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: ________________

Name: ________________________________ Specialty: __________________
Last First MI Degree

Address: ________________________Telephone: ( ) ________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: ________________________________

Name: ________________________________ Specialty: __________________
Last First MI Degree

Address: _____ Telephone: ( )_____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID#: _____

Please provide the following information about physicians/practitioners who practice in this office:

Name _____ Specialty: _____
Last First MI

Name _____ Specialty: _____
Last First MI

Name _____ Specialty: _____
Last First MI

Chapter B

SECTION N. ADDITIONAL SITE TAX INFORMATION

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: ( ) _____

End Uniform Health Care and Hospital Credentials~~Credentialing and Business Data Gathering~~ Form.

Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

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

Applicant Name:

Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes":
Question Number: _____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact: _____

Department/Committee: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____

Signature: _____ **Date:** _____

(or electronic signature)

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.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, State/jurisdiction, Case Name & Case Number: _____

_____

B. Your Involvement in the Care (Attending, Consulting, Etc.): _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Named in Suit, Etc.) _____

D. Allegations, including Patient Outcome, If Available:

_____

_____

_____

E. Date of Incident (mm/yy) _____ F. Date Filed (mm/yy) _____

G. Date Case Closed (mm/yy): _____

Case Resolution:

☐ Dismissed ☐ Judgement ☐ Arbitration ☐ Other
☐ Settlement Out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $ _____

I. Professional Liability Insurer Name (if one was involved): _____
Policy Number

J. Insurer Telephone Number: ( ) _____ K. (last 4 digits): _____

L. Insurer Address (Street, City, State, Zip Code): _____

_____

Signature: _____ **Date:** _____

(or electronic signature)

FORM C – LIABILITY INSURANCE

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.

Applicant 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: _____

_____

Signature (or electronic signature)**:** _____ **Date:** _____

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.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

_____

E. Allegations: _____

_____

_____

_____

F. Details of Incident: _____

_____

_____

_____

G. Actions Taken Against You: _____

_____

_____

_____

H. Current Status of Situation: _____

_____

_____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

Signature (or electronic signature)**:** _____ **Date:** _____

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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.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

_____

_____

_____

_____

B. To what extent does ~~or could~~ this current condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

_____

~~C.~~ ~~What is the current status of your condition?~~ _____

_____

_____

_____

C~~D~~. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name **Telephone Number**

_____ ( ) _____
Last First MI Degree

_____ ( ) _____
Last First MI Degree

Signature (or electronic signature)**:** _____ **Date:** _____

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER~~ABUSE~~

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.

Applicant Name: _____
Last First MI

Describe the substance(s) you use: _____

A. To what extent does, or could, your use of this (these) substance(s) affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

B. Monitored by State Board Mandate (Name and Address)

_____

_____

C. Monitored Voluntarily (Name and Address)

_____

_____

D. Other information about the current status of your use of substances:

_____

E. Abstinent since (mm/yy): _____

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance(s) use and can comment on what impact (if any) it has on your current/future professional practice. Please attach additional pages if more than one provider needs to be listed.

Name: _____
Last First MI Degree

Address: _____
Street City State Zip

Telephone Number: ( ) _____

Signature (or electronic signature)**:** _____ **Date:** _____

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.APPENDIX B Uniform Health Care and Hospital Recredentials~~Professional Recredentialing and Business Data Gathering~~ Form

STATE OF ILLINOIS

Uniform Health Care and Hospital Recredentials~~Professional Recredentialing and Business Data Gathering~~ Form

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 recredential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for recredentialing only. Other forms are required for credentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED 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 2 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,*

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

ATTACHMENTS

Attach Forms A-F as needed to support "yes" responses in the Professional History section and copies of the following:

Curriculum Vitae

CONFIDENTIAL INFORMATION:

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-9s, If Applicable

ECFMG Certificate, If Applicable

Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

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 Uniform Updating~~Health Care Professional Credentialing and Business Data Gathering Update~~ Form.

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 signature)	Type or Print Name	Date

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

CHAPTER A:

PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree

List other names by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

_____

Birth Date: _____
(mm/dd/yy)

Sex: ☐ Male ☐ Female

U.S. Citizen? ☐ Yes ☐ No

If "no", do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: _____

Medical Education~~Social Security Number~~: _____

Emergency Contact Person: _____
Last *First* *MI*

Telephone Number: ( ) _____

Mailing Address: _____ Daytime Phone: ( ) _____

Fax Number: ( ) _____

EMAIL Address: _____

Check here if you have appended additional information for this section. ☐

CHAPTER A:

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No

If "no", please explain restriction(s)~~limitation~~ _____

Current and Previous Professional Licenses in Other States

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)
Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)
Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)
Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No If "no", please explain restriction(s)~~limitation~~ _____

Check here if you have appended additional information for this section. ☐

CONFIDENTIAL INFORMATION

Current Federal DEA License Number: _____

DEA License Number Expiration Date: _____ (mm/dd/yy) Unrestricted License ~~Unlimited~~? ☐ Yes ☐ No

If "no", please explain restriction(s)~~limitation~~: _____

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: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____

(mm/dd/yy)

Please identify all limitations related to the above Controlled Substances Numbers and explain limitations

_____

_____

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification:

State: _____ Certificate #: _____ Expiration Date: _____
(mm/dd/yy)

Check here if you have appended additional information for this section. ☐

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821 **COMPLETE FOR EACH SPECIALTY**
822

Specialty I: _____

Are you Board Certified in Specialty I? ☐ 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 scheduled 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 Specialty Boards: _____ (mm/dd/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty II? ☐ 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 scheduled 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 Specialty 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 scheduled 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 Specialty Boards: _____ (mm/dd/yy)

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 scheduled 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 Specialty Boards: _____
(mm/dd/yy)

Check here if you have appended additional information for this section. ☐

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CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effect Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

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.

1. 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? ☐ Yes ☐ No
3. Are there any currently pending professional liability suits, actions, and/or claims filed against you? ☐ Yes ☐ No

LIABILITY INSURANCE

If you 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 you ever had your professional liability insurance coverage canceled or non-renewed or had limits reduced?	☐ Yes	☐ No

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840

MEMBERSHIP STATUS – USE FOR SECTIONS ~~C AND D~~E, F AND G

Please use the following key to indicate Membership Status~~membership status~~ in Sections E ~~sections C~~(Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G~~D~~ (Ambulatory Surgical Treatment Center Practice) below:~~.~~

A. Active	F. Active Provisional Staff	K. Pending
B. Courtesy	G. Senior Staff	L. Other (Specify)
C. Consulting	H. Associate	
D. Adjunct	I. Provisional	
E. Suspended/ Terminated/ Resigned	J. Affiliate	

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
From (mm/yy)

Department/Division: _____ Medical Staff Office ~~FAX~~Email: ~~( )~~ _____

Department Telephone #: ( ) _____

Do you have admitting privileges at this hospital? ☐ Yes ☐ No

Any limitations in your area of specialty at this hospital? _____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____ To Present
From (mm/yy)

Department/Division: _____ Medical Staff Office ~~FAX~~Email: ~~( )~~ _____

Department Telephone #: ( ) _____

Do you have admitting privileges at this hospital? ☐ Yes ☐ No

Any limitations in your area of specialty at this hospital? _____

C. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____ To Present
From (mm/yy)

Department/Division: _____ Medical Staff Office ~~( )~~ Email~~FAX~~: _____

Department Telephone #: ( ) _____

Do you have admitting privileges at this hospital? ☐ Yes ☐ No

Any limitations in your area of specialty at this hospital? _____

Check here if you have appended additional information for this section ☐

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850

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 E~~at the top of page 7~~. (Include additional sheets if more than three ASTCs.)

A. Primary Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email~~F~~
~~AX#~~: ~~( )~~ _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section. ☐

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SECTION E. 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~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To Present
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace~~work place~~: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____

(mm/yy) (mm/yy)

Check here if you have appended additional information for this section. ☐

865
866

SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING~~TRANING~~ UPDATE

Please provide an update of your medical education and clinical training over the past four years. Do not duplicate internship, residency, and fellowship information previously reported. (Attached additional sheets if necessary.)

FIRST UPDATE

☐ Fellowship ☐ Residency ☐ Other

Institution Name: _____

Department Chair or Program Director:

_____

Last Name First Name MI Degree

Mailing Address: _____

Street City State Zip

Telephone Number: ( ) _____ Email~~Fax Number~~: ~~( )~~ _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of internship: ☐ Rotating ☐ 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: _____ To: _____
Mm/yy Mm/yy

Types of internship: ☐ Rotating ☐ Straight:

If straight, please list specialty: _____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance this institution? ☐ Yes ☐ No
(Attach an explanation of a "Yes" answer.)

Check here if you have appended additional information for this section: ☐

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SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL

Submit with all applications. Please answer the following questions to the best of your 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" answer.

Adverse or Other Actions

1.	Has your license to practice in any jurisdiction ever been 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?	☐ Yes	☐ No
2.	Have you ever been reprimanded and/or fined, been the subject 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?	☐ Yes	☐ No
3.	Have you ever had your board certification rescinded or elected not to recertify~~lost any board certifications~~, and/or failed to recertify?	☐ Yes	☐ No
4.	Have you ever been examined by a Certifying Board but failed to pass?	☐ Yes	☐ No
5.	Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	☐ Yes	☐ No
6.	Has your federal DEA number and/or state associated Controlled Substances License~~state 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?	☐ Yes	☐ No
7.	Have your privileges at any hospital or other health care setting 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,~~	☐ Yes	☐ No

~~suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?~~

8.	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
9~~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
10~~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
11~~10~~.	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
12~~11~~.	Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-party~~third 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~~	☐ ~~No~~
13.	Have you ever 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

14. 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 ☐ No

~~**PROFESSIONAL LIABILITY ACTIONS**~~

~~**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.**~~

~~1. 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?~~ ☐ ~~Yes~~ ☐ ~~No~~

~~3. 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~~

~~**LIABILITY INSURANCE**~~

~~**If you 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~~

CRIMINAL ACTIONS

If you answer "yes" to any questions in this section, please complete FORM D. Please make copies of FORM D, if needed, and complete one for each "yes" answer

1. Have you ever been charged with or convicted of a felony or misdemeanor~~crime~~ (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 ☐ No

2. 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

MEDICAL CONDITION

If you answer "yes" to this question, please complete FORM E.

Do you currently have a physical illness or mental illness or disability that results in your inability~~medical condition~~, ~~physical defect or emotional impairment that in any way impairs and/or limits your ability~~ to practice medicine with reasonable judgement, skill, and safety? (See Medical Practice Act – 225 ILCS60/22(a)) ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER~~ABUSE~~

If you answer "yes" to any questions in this section, please complete FORM F. Please make copies of FORM F, if needed, and complete one for each "yes" answer.

~~1. Are you currently engaged in illegal use of any legal or illegal substances?~~ ☐ ~~Yes~~ ☐ ~~No~~

1~~2~~. Do you currently overuse and/or abuse alcohol or any ~~other~~ controlled substance(s)? ☐ Yes ☐ No

2~~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

3~~4~~. Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance use disorder~~abuse~~? ☐ Yes ☐ No

INVESTMENTS

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 center~~surgicenter~~, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ Yes ☐ No

If "yes", please provide explanation: _____

_____

_____

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 Number

Office Administrator – Last First MI

~~( )~~ ~~Beeper Number~~

( ) Fax Number

E-Mail

( ) Emergency Number

( ) Answering Service

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If "yes", describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

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~~Practioner~~: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

911

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

912

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty:

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

913

CONFIDENTIAL INFORMATION: Tax ID#: _____

SECTION I. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice. If there is more than one additional site, copy and complete this section for each additional site.

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 Number

Office Administrator – Last First MI

~~( )~~ ~~Beeper Number~~

( ) Fax Number

E-Mail

( ) Emergency Number

( ) Answering Service

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If "yes", describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

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: _____

924

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

925

CONFIDENTIAL INFORMATION: Tax ID#: _____

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

926

CONFIDENTIAL INFORMATION: Tax ID#:

Name: _____
Last First MI Degree

Specialty: _____

Address: _____ Telephone: ( ) _____
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

***CONFIDENTIAL INFORMATION**:* Tax ID#: _____

End Uniform Health Care and Hospital Recredentials~~Recredentialing and Business Data Gathering~~ Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

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

Applicant Name:

Last First MI

Indicate the number of ONE of the questions in Section I to which you answered "yes":
Question Number: _____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact

Department/Committee: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____

Signature (or electronic signature)**:** _____ **Date:** _____

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.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, Case Name & Case Number: _____

_____

B. Your Involvement in the Care (Attending, Consulting, Etc.) _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Named in Suit, Etc.) _____

D. Allegations, including Patient Outcome, If Available:

_____

_____

_____

E. Date of Incident (mm/yy) _____ F. Date Filed (mm/yy) _____

G. Date Case Closed (mm/yy): _____

Case Resolution:

☐ Dismissed ☐ Judgement ☐ Arbitration ☐ Other
☐ Settlement Out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $ _____

I. Professional Liability Insurer Name (if one was involved): _____

Policy Number

J. Insurer Telephone Number: ( ) _____ K. (last 4 digits): _____

L. Insurer Address (Street, City, State, Zip Code):

_____

Signature (or electronic signature)**:** _____ **Date:** _____

FORM C – LIABILITY INSURANCE

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.

Applicant 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: _____

_____

Signature (or electronic signature)**:** _____ **Date:** _____

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.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

_____

E. Allegations: _____

_____

_____

_____

F. Details of Incident: _____

_____

_____

_____

G. Actions Taken Against You: _____

_____

_____

_____

H. Current Status of Situation: _____

_____

_____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

_____

Signature (or electronic signature)**:** _____ **Date:** _____

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.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

B. To what extent does ~~or could~~ this current condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

~~C. What is the current status of your condition?~~ _____

C~~D~~. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name				**Telephone Number**
Last	First	MI	Degree	( )
Last	First	MI	Degree	( )

Signature (or electronic signature)**:** _____ **Date:** _____

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER~~ABUSE~~

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.

Applicant Name: _____
Last First MI

Describe the substance(s) you use: _____

A. To what extent does, or could, your use of this (these) substance(s) affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

_____

B. Monitored by State Board Mandate (Name and Address)

_____

_____

C. Monitored Voluntarily (Name and Address)

_____

_____

D. Other information about the current status of your use of substances:

_____

E. Abstinent since (mm/yy): _____

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: _____
Last First MI Degree

Address: _____
Street City State Zip

Telephone Number: ( ) _____

Signature (or electronic signature)**:** _____ **Date:** _____

(Source: Amended at 48 Ill. Reg. _____, effective _____)

Section 965.APPENDIX C Uniform Updating~~Health Care Professional Update Data Gathering~~ Form

STATE OF ILLINOIS

Uniform Updating~~Health Care Professional Update Data Gathering~~ Form

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 recredential the professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for updating only. Other forms are required for credentialing and for recredentialing.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and recredentialing and internal business purposes.

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 will be grounds for rejection or termination, in addition to 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 Uniform Updating~~Health Care Professional Credentialing and Business Data Gathering Update~~ Form.

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 signature)	Type or Print Name	Date

****PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND**

HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION.

NOTIFICATION OF CHANGES

Provider's Name: _____
Last First MI Degree

Date Completed: _____
(mm/yy)

Date of Birth: _____
(mm/yy)

Illinois Professional License Number: _____

Medical Education~~Social Security~~ Number: _____

The following sections of the Uniform Health Care and Hospital Recredentials~~Professional Recredentialing and Business Data Gathering~~ Form contain updated information and are attached (check as appropriate).

ATTACHMENTS

- ☐ Section A. General Information
- ☐ Section B. Professional Information
- ☐ Section C. Hospital Membership – Current & Pending
- ☐ Section D. Ambulatory Surgical Treatment Center Practice
- ☐ Section E. Work History
- ☐ Section F. Medical Education/Clinical Training Update
- ☐ Section G. Professional History: Confidential
- ☐ Section H. Primary Site Information
- ☐ Section I. Additional Site Information

The updated sections are attached and the particular items updated in those sections are highlighted.

(Source: Amended at 48 Ill. Reg. _____, effective _____)