[Publication Instructions: Strike current application and replace with new application]

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

State Board of Health

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

6 CCR 1014-4

[Editor's Notes follow the ext of the rules at the end of this CCR Document.]

Adopted by the State Board of Health July 20, 2016; effective, December 15, 2016

This is the Colorado healthcare professional credentials application. The Colorado legislature has mandated that all health care entities and all health care plans engaged in the collection of information to be used in the process of credentialing of health care professionals use this form (C.R.S. § 25-1-108.7).

This uniform application has been designed to allow each credentialing entity to receive from you core credentialing information needed in common by all of them, without duplication.

THIS UNIFORM APPLICATION HAS BEEN DESIGNED TO ALLOW EACH PRACTITIONER TO COMPLETE A SINGLE FORM WITH CORE INFORMATION FOR SUBMISSION TO EACH CREDENTIALING ENTITY TO WHICH THE PRACTITIONER IS APPLYING. This application need not be used for case specific temporary privileges.

Each credentialing entity may require additional, non – duplicative credentials information, if it is deemed by them to be essential to the completion of their credentialing process.

A healthcare professional by law, means any physician, dentist, dental hygienist, chiropractor, podiatrist, psychologist, advanced practice nurse, optometrist, physician assistant, licensed clinical social worker, child health associate, marriage and family therapist, or any other health care professional who is registered, certified or licensed by the state of Colorado, who practices, or intends to practice, in Colorado, and who is subject to credentialing.

Those credentialing entities that are required to use this uniform application are:

1) A health care facility or other health care organization licensed or certified to provide medical or health services in Colorado;
2) A health care professional partnership, corporation, limited liability company, professional services corporation or group practice;
3) An independent practice association or physician-hospital organization;
4) A professional liability insurance carrier; or

5) An insurance company, health maintenance organization, or other entity that contracts for the provision of health benefits.

No State of Colorado licensing or certification board is required to use this uniform application.

The reason Colorado has mandated the use of this uniform application is to reduce health care costs and duplication.

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

This application form should be used for both initial credentialing and re-credentialing purposes. PRIOR TO COMPLETING THIS APPLICATION FORM, PLEASE READ AND OBSERVE THE FOLLOWING:

GENERAL INSTRUCTIONS

1. Please type or print your responses legibly.
2. Please note that modification to the wording or format of this Application will invalidate it. Use of any form of correctional fluid or tape is not acceptable.
3. All information requested must be FULLY and TRUTHFULLY provided.
4. Any changes to your responses must be lined through, initialed and dated. Use of any form of correctional fluid or tape is not acceptable.
5. If an entire section does not apply to you, then please check the box provided at the top of that section to indicate that the section does not apply to you.
6. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Residencies and Fellowships"), it is not necessary to mark "N/A" in each unneeded answer blank.
7. Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.
8. **If you need more space to answer a question completely, please attach additional paper. Include the section and page number of the question being answered as well as your name (printed), on each additional sheet. Attach all additional sheets to this application.**
9. After the Application has been completed in its entirety but *before* you sign and date it, MAKE A COPY OF THE APPLICATION TO RETAIN IN YOUR FILES AND/OR COMPUTER FOR FUTURE USE. In so doing, at the time of a submission to all Credentialing Entities as identified on Page 1, all you will need to do is to check to ensure that all the information remains complete, current and accurate before signing and forwarding the Application as needed.
10. Any gaps of time greater than thirty (30) days from completion of health care professional school to the present date must be accounted for before your Application will be considered complete.
11. Please sign and date the Application prior to mailing.
12. Please sign and date Schedule A.
13. Mail the Application, Schedule A, any attached sheets prepared in order to answer any question(s) completely as well as a copy of all applicable enclosures listed on pages 3 and 26 to the Healthcare Entity to which you are submitting this application.
14. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law and that they will conform to both HIPAA, ADA and other applicable laws and regulations.
15. All signatures *must be* original or electronic equivalent. Stamp signatures are not acceptable.

GENERAL INSTRUCTION – continued

If requested by your credentialing entity for purposes of credentialing or re-credentialing, please include a current copy of the following documents:

A. State Professional License(s).
B. Federal Narcotics License (DEA Registration).
C. All applicants must submit a resume or curriculum vitae, whichever is appropriate, with complete professional history in chronological order (month and year).
D. Diplomas and/or certificates of completion (e.g., medical school, internship, residency, fellowship, nursing, dental or other healthcare professional school).
E. Diplomat of National Board of Medical Examiners or Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable).
F. Specialty/Subspecialty Board Certification or letter from Board(s) stating your status (if applicable).
G. Certificate of Insurance.
H. Military Discharge Record (Form DD-214) (if applicable).
I. Certificates for Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP).
J. CME transcripts/certificates

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION FORM

I. Identifying Information ***Please provide your full legal name.***

A. Last Name(include suffix, Jr., Sr., III): First: Middle: Title:

B. Other name used (e.g., maiden name, nickname)? ☐Yes ☐ No
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:

C. Home Address:

City: State: Zip:

D. Home Telephone Number: Cell Phone: Email Address:

E. Social Security Number: Place of birth: National Provider Identifier Number:

II. Current Practice Setting(s) *Use additional copies of this Part II to list any additional practice sites*

A. Primary Practice Location

Name of Clinical Practice: _____

Clinical Practice Street Address: _____

_____

Type of Practice Setting:
☐ Solo
☐ Group/Single Specialty
☐ Group/Multi-Specialty
☐ Hospital Based
☐ Other

Start Date at Location (mm//yy): _____

City: _____ County: _____ State: __ Zip: _____

Office Telephone Number: _____ Office Fax Number: _____ Patient Appointment Telephone Number: _____

Mailing Address (if different from above):

_____

City: _____ St: __ Zip: _____

Office Manager/Administrative Contact: _____
Office Manager's Telephone Number: _____
Office Manager's Fax Number: _____
Email Address: _____

Credentialing Contact: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Answering Service Number: _____ Pager Number: _____

Office Email Address**:** _____ Practice Website**:** _____

Federal Tax ID Number for this Practice Address: _____

Name Affiliated with Tax ID Number: ____

Practice National Provider Identifier Number: _____

Applicant's Medicare Provider Number: _____ Applicant's Colorado Medicaid Provider Number: _____

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday _____ am pm . . . to _____ am pm
Tuesday _____ am pm. . . to _____ am pm
Wednesday _____ am pm . . . to _____ am pm
Thursday _____ am pm . . . to _____ am pm
Friday _____ am pm . . . to _____ am pm
Saturday _____ am pm . . . to _____ am pm
Sunday _____ am pm. . . to _____ am pm

Languages:
Please list all languages other than English (including sign language and type) available in this office.

Billing Address – *if different from your primary practice site address*:

City: _____ St: __ Zip**:** _____

B. Other Practice Location ☐Not Applicable

Name of Clinical Practice:

Clinical Practice Street Address:

Type of Practice Setting: ☐Group/Multi-Specialty ☐ Solo ☐ Hospital Based ☐ Group/Single Specialty ☐Other

Start Date at Location (mm/yy): _____

City: County: State: Zip:

Office Telephone Number: Office Fax Number: Patient Appointment Telephone Number:

Mailing Address (if different from above):

City: _____ St: __ Zip: _____

Name of Office Manager/Administrative Contact: _____
Office Manager's Telephone Number: _____
Office Manager's Fax Number: _____

Answering Service Number: _____ Pager Number: _____
Office Email Address**:** ____

Federal Tax ID Number for this Practice Address: _____

Name Affiliated with Tax ID Number: ____

Practice National Provider Identifier Number: _____

Medicare Provider Number: _____ Colorado Medicaid Provider Number: _____

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday _____am pm . . . to _____ am pm

Tuesday _____ am pm. . . to _____ am pm

Wednesday _____ am pm . . . to _____ am pm

Thursday _____ am pm . . . to _____ am pm

Friday _____ am pm . . . to _____ am pm

Saturday _____ am pm . . . to _____ am pm

Sunday _____ am pm. . . .to _____ am pm

Languages: *Please list all languages other than English (including sign language & type) available in this office.*

_____

Billing Address – *if different from your primary practice site address*:

_____

City: _____ St: __ Zip**:** _____

III. Call Coverage ***Please list all persons with whom you have made arrangement for call coverage.***

☐Not Applicable If not applicable, please explain why:

_____

Name/Address:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV. Licenses/Registrations/Certificates ***List all state health care licenses, registrations, certificates and advanced practice registry as well as other relevant numbers, including pending, expired and inactive.***

Practice Type–MD, DO, RN, APN etc: _____ Specialty: _____

List all sub specialties or areas of interest/emphasis: _____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active
☐ Inactive/Expired
☐ Pending
Year Relinquished: ____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active
☐ Inactive/Expired
☐ Pending
Year Relinquished: ____

Type of License, Certificate or Registration: _____
Number: _____
State/Institution: _____
Expiration Date (mm/yy): _____ Year Obtained: ____
☐ Active
☐ Inactive/Expired
☐ Pending
Year Relinquished: ____

DEA Registration Number: _____ Expiration Date (mm/yy): _____

Prescriptive Authority Number: _____(APN, NP, CNM, CNS, CRNA only) Date Issued(mm/yy): _____

V. Education Since High School. Check the appropriate box (i.e., undergraduate, graduate, medical/professional) for each school attended.

A. Foreign Medical Graduate ☐Not Applicable

Educational Commission for Foreign Medical Graduates (ECFMG) Number: _____ Date Issued (mm/yy): _____

Other:
Fifth Pathway ☐Yes ☐No If Yes, please provide name and address of institution:

_____

Date of Attendance: From (mm/yy): _____ To: _____

B. Education *List in chronological order beginning with the earliest. Use additional copies of this Part V B. to list additional education other than post graduate, CME or clinical training courses.*

☐Undergraduate ☐Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone #: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

☐Undergraduate ☐ Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone #: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐Medical /Professional

Complete School Name: _____

Degrees/Certification Received: _____ Graduation Date(mm/yy): _____

Course of Study or Major: _____

Address: _____

Email: _____ Telephone #: _____ Fax Number: _____

Dates Attended: From (mm/yy): _____ To: _____ Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).

C. Post Graduate Training *Check the appropriate box (i.e., internship, residency, fellowship) for each type of training. Use additional copies of this Part V C. to list additional post graduate training.* ☐ Not Applicable

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: ____

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: ____

☐ Internship ☐ Residency ☐ Fellowship

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Program Completed? ☐Yes ☐ No

If no, please attach Explanation Form(s).

Specialty: _____ Date of Completion (mm/yy): _____

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: ____

D. Other Clinical Training Programs *List those that are pertinent to your required privileges/practice (For example, preceptorship, procedural certificate course, etc.). Use additional copies of this part V. D to list additional clinical training.* ☐ Not Applicable

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Date of Completion(mm/yy): _____

Specialty: _____ Certificate Awarded: _____

Did you complete the program? ☐Yes ☐No If no, please attach Explanation Form(s).

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

Institution Name: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended (mm/yy): From: _____ To: _____ Date of Completion(mm/yy): _____

Specialty: _____ Certificate Awarded: _____

Did you complete the program? ☐Yes ☐No If no, please attach Explanation Form(s).

Name of Program Director: _____ Fax Number: _____

Telephone Number: _____ Email: _____

List Certifications (*provide copies – see page 3*)

☐ BLS (Basic Life Support) Expiration Date (mm/yy): _____
☐ ACLS (Advanced Cardiac Life Support) Expiration Date (mm/yy): _____
☐ ATLS (Advanced Trauma Life Support) Expiration Date (mm/yy): _____
☐ PALS (Pediatric Advanced Life Support) Expiration Date (mm/yy): _____
☐ NRP (Neonatal Resuscitation Program) Expiration Date (mm/yy): _____
☐ Other _____ Expiration Date (mm/yy): _____
_____ Expiration Date (mm/yy): _____
_____ Expiration Date (mm/yy): _____
_____ Expiration Date (mm/yy): _____

E. Faculty Positions *List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments. Use additional copies of part V. E and/or F to list additional faculty positions or CME.* ☐ Not Applicable

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From :_____ To: _____ Specialty: _____

Contact: _____ Email: ____

Address: _____

Telephone Number: _____ Fax Number: _____

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From :_____ To: _____ Specialty: _____

Contact: _____ Email: ____

Address: _____

Telephone Number: _____ Fax Number: _____

F. Continuing Medical Education *State the number of relevant CME or CEU credit hours you have received in the last 36 months.* ☐None

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

VI. Board and Professional Certification/Recertification *List all current and past Board certifications.*

Physicians: Please enter all Board Certifications and answer the questions below regarding such Board Certifications

Allied Health Professionals: Please enter all Professional and National Certifications and answer the questions below regarding such Certifications

Are you Board certified? ☐ Yes ☐ No ☐ Not Applicable

Name of Issuing Board	Specialty	Dt Certified	Dt Recertified	Expiration

Please answer the following questions. Attach explanation form(s) if necessary.

A. 1. If you are not currently certified, have you applied for the certification examination? ☐ Yes ☐ No

2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? ☐ Yes Date: ____ ☐ No

3. If you have applied for the certification examination, have you been accepted to take the certification examination? ☐ Yes ☐ No

4. If you have been accepted, when do you intend to take the examination? Date: ____

5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s).

6. If you are not currently certified, please provide the expiration date of admissibility. Date: ____

B. Have you ever had certification denied, revoked, limited, restricted, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty Board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s). ☐ Yes Date: ____ ☐ No

C. Have you ever voluntarily relinquished a certification, including any voluntary non-renewal of a time limited certification? If yes, please attach an Explanation Form(s). ☐ Yes Date: ____ ☐ No

D. Have you ever failed a certification exam? ☐ Yes ☐ No
If yes, explain: _____
_____
_____

VII. Current Hospital and Other Facility Affiliations

Please list in <u>reverse</u> chronological order the past ten years of all hospital and other facility affiliations beginning with all hospital applications in process: current hospital affiliation(s) second, previous hospital affiliations third and other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities) fourth. <u>Do not list residencies, internships, fellowships, or employment</u>. A resume is not sufficient for a complete answer to these questions. Submission date only required if pending.

Facility Name: ______________________________

Department: ______________________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ________________ To (mm/yy): ____________________

Address: ______________________________

Contact: ______________________________ Phone Number: ________________

Email: ______________________________ Fax Number: ________________

Facility Name: ______________________________

Department: ______________________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ________________ To (mm/yy): ____________________

Address: ______________________________

Contact: ______________________________ Phone Number: ________________

Email: ______________________________ Fax Number: ________________

Facility Name: ______________________________

Department: ______________________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ________________ To (mm/yy): ____________________

Address: ______________________________

Contact: ______________________________ Phone Number: ________________

Email: ______________________________ Fax Number: ________________

Facility Name: ______________________________

Department: ______________________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ________________ To (mm/yy): ____________________

Address: ______________________________

Contact: ______________________________ Phone Number: ________________

Email: ______________________________ Fax Number: ________________

VII. Current Hospital and Other Facility Affiliations - continued

Facility Name: ____________________

Department: ____________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ____________ To (mm/yy): ____________

Address: ____________________

Contact: ____________________ Phone Number: ____________________

Email: ____________________ Fax Number: ____________________

Facility Name: ____________________

Department: ____________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ____________ To (mm/yy): ____________

Address: ____________________

Contact: ____________________ Phone Number: ____________________

Email: ____________________ Fax Number: ____________________

Facility Name: ____________________

Department: ____________________ Staff Status: ____________________
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): ____________ To (mm/yy): ____________

Address: ____________________

Contact: ____________________ Phone Number: ____________________

Email: ____________________ Fax Number: ____________________

VIII. Professional Work History

Please list in reverse chronological order all professional work history during the past ten years not listed previously. Include any previous office addresses and any military experience and public health service. Explain below any gaps greater than thirty (30) days. Use additional copies of this part VIII to list additional professional work history. A curriculum vitae is not sufficient for a complete answer to these questions.

☐ Not Applicable

Name of Practice/Employer: ____________________

Title/Position held: ____________________

From (mm/yy): ____________ To (mm/yy): ____________ Reason for leaving?

____

____

____

Eligible for rehire? ☐ Yes ☐ No If No why, please attach Explanation Form.

Address: ____________________ City: ____________________

State/Country: ____________________ Zip: ____________________

Contact: ____________________ Fax Number: ____________________

Email: ____________________ Telephone Number: ____________________

VIII. Professional Work History - continued

Name of Practice/Employer: _____
Title/Position held: _____
From (mm/yy):_____ To (mm/yy): _____ Reason for leaving?

_____
_____
_____

Eligible for rehire? ☐Yes ☐ No If No why, please attach Explanation Form.

Address: _____ City: _____
State/Country: _____ Zip:_____
Contact: _____ Fax Number: _____
Email: _____ Telephone Number: _____

Name of Practice/Employer: _____
Title/Position held: _____
From (mm/yy):_____ To (mm/yy): _____ Reason for leaving?

_____
_____
_____

Eligible for rehire? ☐Yes ☐ No If No why, please attach Explanation Form.

Address: _____ City: _____
State/Country: _____ Zip:_____
Contact: _____ Fax Number: _____
Email: _____ Telephone Number: _____

IX. Peer References

Please list three (3) references, from professional peers (preferably no more than 1 partner) who through recent (last two years) observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. Prefer references be practitioners in your same professional discipline. Allied Health Professionals must list at least one physician reference.

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: from mm/yy to mm/yy_____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email:_____

IX. Peer References - continued

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: from mm/yy to mm/yy_____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____
Email:_____

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: from mm/yy to mm/yy_____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____
Email:_____

X. Professional Liability Insurance (*yours or your supervising agent*)

Insurance Carrier / Provider of Professional Liability Coverage:
_____

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

_____

Name of Local Contact : _____
(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

X. Professional Liability Insurance - continued

Please list all previous professional liability carriers within the past ten (10) years including any carriers during professional training if within the ten year period. Use additional copies of this Part X to list additional professional liability insurance. ☐ Not Applicable

Insurance Carrier / Provider of Professional Liability Coverage:

_____

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

_____

Name of Local Contact : _____
(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

Professional Insurance History: ***Please answer each of the following questions in full. If the answer to any question is "YES", or requires further information, please give a full explanation of the specific details and attach to the Application.***

1. Has your professional liability insurance coverage ever been terminated, not renewed, cancelled, limited, restricted, modified, or altered by action of the insurance company? ☐ Yes Date:_____ ☐ No

   If yes, please provide date, name of company(s), and basis for coverage change.

2. Have you ever been denied coverage? ☐ Yes Date:_____ If yes, please provide details. ☐ No

3. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes Date:_____ If yes, please identify procedures and provide details. ☐ No

Professional Claims History: ***If the answer to any of these questions is "Yes", please give a full explanation and attach to the Application.***

1. Have there *ever* been any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceeding involving you*?* ☐ Yes Date:_____ ☐ No

2. Are any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending?* ☐ Yes Date:_____ ☐ No

3. Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? ☐ Yes Date:_____ ☐ No

XI. QUESTIONS FOR HEALTH PLANS ONLY *Answer these questions only if you are applying to a Health Plan.*

1. Do you wish to be listed in the Health Plan Directory as a primary care practitioner?
☐ Yes ☐ No

2. Do you wish to be listed in the Health Plan Directory as a specialist?
☐ Yes ☐ No

3. List which specialty: _____

4. Please furnish a copy of your W-9 Federal Tax Form.

5. Does this site offer handicapped access for the following:

Building?	☐ Yes ☐ No
Parking?	☐ Yes ☐ No
Restroom?	☐ Yes ☐ No

Does this site offer other services for the disabled? ☐ Yes ☐ No

Text Telephone (TTY)?	☐ Yes ☐ No
American Sign Language?	☐ Yes ☐ No
Mental/Physical Impairment Services?	☐ Yes ☐ No

Accessible by public transportation? ☐ Yes ☐ No

Bus?	☐ Yes ☐ No
Light rail?	☐ Yes ☐ No
Regional train?	☐ Yes ☐ No

XII. Attestation Questions

This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application..

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons including dates, as specified in each question, on an Explanation Form and attach to the Application.

For the purpose of the following questions, the term "adverse action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, surrender, resignation, relinquishment, reprimand, censure, sanction, subject to probation, placed under special or intensified review, withdrawn or failed to proceed with an application, denied or recommended for denial, any such action pending or in progress, or non-renewal of membership, clinical privileges, academic affiliation or appointment or employment. "Adverse action" also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, admonishment, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

A. To your knowledge, have you ever been the subject of an **adverse action** (or is an investigation or **adverse action** currently pending) by:

1. a hospital or other healthcare facility (e.g., surgical center, nursing home, renal dialysis facility, etc.)? ☐ Yes Date: ____ ☐ No

2. an education facility or program (e.g., dental or other health care professional school, residency, internship, etc.)? ☐ Yes Date: ____ ☐ No

3. a professional organization or society? ☐ Yes Date:____ ☐ No

4. a professional licensing body (in any jurisdiction for any profession)? ☐ Yes Date:____ ☐ No

5. a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Preferred Hospital Organization (PHO), Provider-Sponsored Health Care Corporations (PSHCC), network, system, managed care organization, etc.)? ☐ Yes Date:____ ☐ No

6. a state or federal agency (DEA, etc.) regarding your prescription of controlled substances? ☐ Yes Date:____ ☐ No

B. To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity? ☐ Yes Date:____ ☐ No

XII. Attestation Questions - continued

C. 1.Have you ever voluntarily or involuntarily resigned, terminated or surrendered medical staff privileges or employment from a hospital, group practice or other health care facility or medical staff?
☐ Yes Date: ____ ☐ No

C. 2. If your answer to the above Question is Yes, was it to avoid disciplinary action or investigation or while under investigation, or is such an investigation pending? ☐ Yes ☐ No

D. Have you ever been suspended, fined, disciplined, investigated, expelled, sanctioned or otherwise restricted or excluded from participating in any private, federal or state health insurance program (for example, Medicare or Medicaid) or are any such proceedings in progress? ☐ Yes Date: ____
☐ No

E. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient or are any such proceedings in progress? ☐ Yes Date:____
☐ No

F. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or are you currently under indictment or currently have pending against you any such charges? ☐ Yes Date: ____
☐ No

G. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct or are you currently under indictment or currently have pending against you any such charges?
☐ Yes Date: ____
☐ No

H. In the last ten years, have you been found liable or responsible for or named in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct? ☐ Yes Date: ____
☐ No

I. Have you ever been court-martialed for actions related to your duties as a health care professional?
☐ Yes Date: ____
☐ No

XIII. ATTESTATION AND SIGNATURE

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement without right of hearing.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not per se an application for employment with the Entity and that acceptance of my application by the Entity may not result in my employment by the Entity.
8. I understand and agree that I will notify all credentialing entities to which I have submitted this Uniform Application of any and all changes to the information contained in this Application

This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

Schedule A

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM
Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

1. As an applicant for medical staff membership at the designated hospital(*s*) and/or participation status with the health care related organization(*s*) (e.g., *hospital, medical staff, medical group independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization network, medical society, professional association, medical school faculty position, other healthcare delivery entity or system, hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.
2. I also understand that I have the continuing responsibilities to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.
3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.
4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure for certification, and any other matter related to my qualification or matters addressed in this Application (my "Qualifications")
5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insures with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this application and my Qualifications.
6. I consent to and authorize the inspection of appropriate records and documents that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes). I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.
8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.
9. For Healthcare Entity membership and privileges, I acknowledge that I have been informed of or have been given the opportunity to review the medical staff bylaws, rules, regulations and policies of the entity and I hereby agree to abide by them. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession.
10. I acknowledge that any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Colorado law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.
11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluation undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.
12. I understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Please print your name: _____

Signature: _____ **Date:** _____

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CAUTION
READ THIS INSTRUCTION CAREFULLY

Complete Supplemental A, page 25, and Supplemental B, page 26 unless instructed otherwise by credentialing entity.

Supplemental A

Please answer these questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.

1. Citizenship: Are you a citizen of the United States? ☐ Yes ☐ No If no, please provide appropriate documentation.

2. Date of Birth: Month ___ Day __ Year ____ Gender: ☐ Male ☐ Female

3. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice your profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances and alcohol).

   ☐ Yes ☐ No

4. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

   ☐ Yes ☐ No

5. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

   ☐ Yes ☐ No

6. You must provide the following documents unless you are seeking to be employed by the credentialing entity.

   A. One recent passport size photograph of yourself or a copy of your current driver's license.

   B. Permanent Resident Card or Visa Status (if applicable).

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

Supplemental B

Health Status. ***Please answer each of the following questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.***

1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? *If the answer to this question is "YES", please give full explanation of the specific details on an Explanation Form and attach to the Application.*

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

2. Are you currently in a treatment or monitoring program(s) for a physical or mental condition that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this application?
   If the answer to this question is "YES", please give a full explanation of the specific details, including dates of treatment or monitoring on an Explanation Form and attach to the Application.

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

3. Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? *If reasonable accommodation is required, please specify such on an attached Explanation Form.*

   ☐ Yes ☐ No

4. Please document your current TB status by checking the applicable boxes below:

   ☐ I have had a TB test within the last 12 months and the test was negative. Documentation attached. I have not experienced new risk factors for TB nor am I experiencing symptoms of active TB since my last TB test.

   ☐ I have had a history of previous infection with Mycobacterium Tuberculosis or a positive TB test but I since have had a chest x-ray which was read as normal. Documentation attached. I currently have no symptoms of active disease and have not experienced new risk factors for TB in the past year.

   ☐ I currently have active TB disease which is being adequately treated. Applicable documentation is attached.

   ☐ Other_____

5. The Colorado Board of Health requires licensed health care facilities to annually report their health care worker influenza vaccination rate and achieve a vaccination rate of at least 90%. To facilitate compliance with this rule, some health care facilities may require annual influenza vaccination of employees and staff.

☐ If this facility must comply with the Colorado Board of Health requirements, I agree to provide proof of influenza vaccination or a medical exemption before practicing at this facility.

Please print your name: _____

_____ _____

Signature Date

REMEMBER TO SAVE THE COMPLETED APPLICATION