

PLEASE MAINTAIN A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES

Dear Doctor:

Please carefully read the following instructions regarding the attached application.

This application must be typed or **legibly printed**. You may attach a C.V., but this form must be completed. If more space is needed than provided, attach additional sheets. Please account for all time periods since medical school.

Please allow at least four (4) months for the processing of your application.

Attach copies of the following documents:

- Current Nevada Medical License
- Current Federal DEA
- Current State Pharmacy License
- Current Professional Liability Insurance
- ECFMG Certificate (if a foreign grad.)
- ABMS Certificate
- DD Form 214 (if military experience)
- Copy of a current call schedule
- Copy of current Curriculum Vitae (include month/year)

Please return your completed application with documentation to WellHealth Quality Care

Attn: Vanessa Garcia 10100 W Charleston Blvd Ste. 210 Las Vegas, NV 89135

If you have any questions, please call 702-832-2544 or email WH_Credentialing@hcpnv.com.



For Credentialing Staff Use Only

Specialty _____

Date Application Received _____

Date Application Signature _____

Attach a recent 2" x 2" passport size photograph for the master file and each facility marked on this application

PERSONAL DATA

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

1. Name _____

2. Other Name(s) Previously Used _____ Effective Date _____

3. Social Security Number _____ 4. UPIN# _____ 5. Medicaid # _____

6. Medicare # _____ 7. NPI (National Provider Identifier) _____

8. Tax ID# _____ Name Affiliated w/Tax ID# _____

8A. Other Tax ID's (Attach separate sheet if applicable)

9. Place of Birth _____ Date of Birth _____

10. Gender _____ 11. Citizenship _____

12. If Not US Citizen: Visa # _____ Status _____ Expiration Date _____

13. Name of Spouse/Significant Other _____

14. Local Residence

Complete Address

Telephone Number

E-Mail Address

15. Date of Relocation to NV (If Applicable) _____ Date Expected to Begin Practice _____

Specialty _____ Staff Status Requested _____

Current Address (if different from above) _____

16. Alternate Care of Hospitalized Patients: If you do not apply for admitting privileges, list the name/names of physicians or groups with whom you have established a current hospital admission coverage agreement:

OFFICE INFORMATION

17. Local Primary Practice/Group Name _____

Complete Office Address _____

Office Phone _____ FAX Number _____ E-Mail _____

Preferred Method of Contact _____ Phone _____ FAX _____ E-Mail _____

16A. Other Practice Locations (Please attach a separate sheet)

18. Office/Credentialing Contact Name & Address _____

Title _____ Phone Number _____ FAX Number _____ E-Mail Address _____

19. Secondary/Billing Office Address _____

Office Phone _____ FAX Number _____ E-Mail _____

20. Practitioner's Beeper/Cell Number _____ Answering Service Number _____

21. Practitioner Call Coverage _____

22. Are you currently accepting new patients into your practice? _____ YES _____ NO
(If NO, your name may not appear in the Managed Care directory)

23. Office Hours _____ Monday _____ Tuesday _____ Wednesday
_____ Thursday _____ Friday _____ Saturday _____ Sunday

24. Describe after-hours patient care operation. _____

25. Any practice restrictions? (Specify) _____

26. Office accessible to disabled pursuant to ADA guidelines? _____ YES _____ NO

27. Languages (other than English) Spoken in Your Office

a. _____ By _____
Provider _____

b. By Staff _____

28. Do you wish to have these languages listed in a Provider Directory? _____ YES _____ NO

29. Do you accept Medicare assignment? _____ YES _____ NO

30. Is your office within twenty (20) minutes of the facilities at which you have privileges? _____ YES _____ NO

31. Office Laboratory services provided? _____
32. Office Radiology services provided? _____
33. Additional office testing available? _____
34. Surgical facilities/services provided at the office? _____
35. Do you wish to be listed (for Managed Care) as _____PCP _____Specialist _____Both

PROFESSIONAL LICENSES

Attach copies of license(s)

36. Nevada Medical/Dental/AHP license # _____ Date Issued _____ Date Expires _____

Other State Licenses:

State	Number	Issue Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEA AND NEVADA STATE PHARMACY REGISTRATION

Attach copies of certificates

37. Federal DEA Registration # _____ Date Expires _____

Nevada State Pharmacy # _____ Date Expires _____

Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____

38. Examinations Taken – Attach Copies

ECFMG No _____	Date of Certification _____
FLEX Exam _____	Date Taken _____
USMLE No. _____	Date Taken _____
National Board of Medical Examiners _____	Date Taken _____

39. Other Training or Certification (Check and complete all that apply, attach copies for hospitals only)

TYPE	Date of Certification	Expiration Date
CPR	_____	
ACLS	_____	_____
ATLS	_____	_____
BLS	_____	_____
NALS	_____	_____
PALS	_____	_____
OTHER	_____	_____

EDUCATION/TRAINING

40. Pre-Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone

Fax

From: Mo/Yr

To: Mo/Yr

Degree Earned

41. Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone

Fax

From: Mo/Yr

To: Mo/Yr

Degree Earned

42. **Internship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

43. **Internship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

44. **Residency** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

45. **Other Residency** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

Fax

FROM: Mo/Yr

TO: Mo/Yr

Program Director

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

46. **Fellowship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

47. **Fellowship** (if applicable)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

48. **Fifth Pathway (Required to be completed by Non-USA Grads in lieu of ECFMG Certification)**
(if applicable)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

OTHER POST GRADUATE EDUCATION

List in chronological order and include copies of certificates

49.

Facility Name		Specialty & Degree Awarded
Mailing Address		
Phone		FAX
FROM: Mo/Yr	TO: Mo/Yr	Program Director

50.

Facility Name		Specialty & Degree Awarded
Mailing Address		
Phone		FAX
FROM: Mo/Yr	TO: Mo/Yr	Program Director

BOARD CERTIFICATIONS

Attach copy of certificate(s)

This section pertains to specialty boards that are organized and recognized by the American Board of Medical Specialties or American Osteopathic Association. (AHPs List Board certification as applicable)

51. _____

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If **not** certified, indicate current status _____

If **not** certified, are you scheduled to take the exam? If so, when? _____

52.

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If you have ever failed a board examination, please indicate Board and date _____

53.

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If you have ever failed a board examination, please indicate Board and date _____

54. Other Board Certification _____

MILITARY SERVICE

Attach copy of discharge papers.

55. Have you ever served or are you currently serving in the United States Military? _____ YES _____ NO

If YES, Branch of Service _____

FROM _____ / _____ TO _____ / _____ Type of Discharge _____

DD214 (provide copy with application)

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

EMPLOYED FACULTY POSITIONS AND ACADEMIC AFFILIATIONS

List in chronological order. Do not include hospital staff memberships or surgical center affiliations.

56. _____
Facility Name

Mailing Address

Phone Number _____ FAX Number _____

Position _____ Department _____

Reason for Leaving _____

57. _____
Facility Name

Mailing Address

Phone Number _____ FAX Number _____

Position _____ Department _____

Reason for Leaving _____

58. _____
Facility Name

Mailing Address

Phone Number _____ FAX Number _____

Position _____ Department _____

Reason for Leaving _____

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of medical/dental/AHP school. For any time period not covered by an affiliation or training, please provide a written explanation.

59. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

60. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

61. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

62. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

63. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

64. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

65. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

66. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

HOSPITAL AND OTHER HEALTH CARE ENTITY MEMBERSHIPS

List ALL hospitals and surgical centers where you currently have or have had affiliation, membership and/or have been granted privileges. If you have withdrawn an application or you are no longer affiliated with a hospital or surgical center, provide an explanation on a separate page. If an explanation is attached, make sure the original entry is denoted. For any time period not covered by an affiliation or training, please provide a written explanation.

67. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

 Person to Contact for Verification

 Mailing Address

 Phone Number FAX Number

 Staff Category () Check here if explanation is attached

68. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

 Person to Contact for Verification

 Mailing Address

 Phone Number FAX Number

 Staff Category () Check here if explanation is attached

69. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

 Person to Contact for Verification

 Mailing Address

 Phone Number FAX Number

 Staff Category () Check here if explanation is attached

70. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Staff Category _____ () Check here if explanation is attached

71. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Staff Category _____ () Check here if explanation is attached

72. Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Staff Category _____ () Check here if explanation is attached

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Attach copy of present policy face sheet and list **ALL** insurance carriers for the past 10 years. Attach additional sheets if necessary.

73. Present Carrier for Nevada Practice _____

Mailing Address

Phone Number

FAX Number

Policy #

Effective Date

Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

74. Previous Carrier _____

Mailing Address

Phone Number

FAX Number

Policy #

Effective Date

Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

75. Previous Carrier _____

Mailing Address

Phone Number

FAX Number

Policy #

Effective Date

Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

76. Previous Carrier _____

Mailing Address

Phone Number

FAX Number

Policy #

Effective Date

Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

CONTINUING MEDICAL EDUCATION/CEU

77. Attach documentation of continuing medical education/CEU courses attended during the previous two (2) years, if applicable. Indicate which is specialty specific. Approved documentation includes a copy of CME/CEU Certificates or a list from a recognized professional organization such as AOA, AAFP, AMA, AAOS, etc.

PEER REFERENCES

MD/DO, DDS/DMD, etc.: List the names and complete information of three (3) peer references, other than associates, relatives, prospective associates or training directors with equivalent licensure (MD/DO, DDS/DMD, etc.) who have, within the past three (3) years, personal knowledge of your current clinical abilities, ethical character and ability to work with others. At least two of the references should be of your same specialty.

AHPs: List three physicians who are familiar with your clinical abilities and recent practice. Note: references will be evaluated primarily by the extent of direct clinical observation and other work with the applicant. If you are applying for CRNFA privileges, some Entities require each physician to complete a Statement of Physician Sponsorship form (contact Entity for form).

78. _____
Peer Reference **Specialty**

 Complete Mailing Address

 Phone Number FAX Number

79. _____
Peer Reference **Specialty**

 Complete Mailing Address

 Phone Number FAX Number

80. _____
Peer Reference **Specialty**

 Complete Mailing Address

 Phone Number FAX Number

PRACTITIONER QUESTIONNAIRE

81. If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status.

- A. Has your license to practice medicine in any jurisdiction **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you **ever** been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- C. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends **ever** been commenced? YES NO
- D. Have you **ever** voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? YES NO
- E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- F. Have you **ever** voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? YES NO
- G. Has your membership or status in any state or local professional society or other comparable medical organization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO

- H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs **ever** been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- I. Has a letter of concern or reprimand **ever** been issued to you? YES NO
- J. Have you **ever** been denied professional liability insurance or has your policy **ever** been canceled? YES NO
- K. (1) Have you **ever** been named in a complaint based on allegations of professional negligence or professional misconduct or have you **ever** received notice of an intent to commence litigation of that type? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** YES NO
- (2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** YES NO
- L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges? YES NO
- M. Has your specialty board certification or eligibility **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- N. Has your Drug Enforcement Agency or other controlled substances authorization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- O. Have you **ever** been convicted of a criminal offense other than a minor traffic violation? YES NO
- P. Are you now or have you **ever** been addicted to a controlled substance or alcohol? **If the answer to this question is yes, please provide the name, address and a full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. An organization may require that you complete a Health Status Form which provides the name and title of the individual/organization (counselor/diversion program/treating provider) who can advocate on behalf of your sobriety status.** YES NO
- Q. Do you currently use illegal drugs? YES NO
- R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care meeting the standards controlling the award of privileges and status that you seek? YES NO
- S. Would you require an accommodation in order for you to exercise medical staff duties or the privileges requested safely and completely? YES NO



Standard Authorization, Attestation and Release for Health Plans, Health Insurers and Health Care Organizations

(Not for Use for Employment Purposes)

Purpose of Form

This form has been developed for use by Nevada health plans and health insurers, and may be used by hospitals and other healthcare organizations. Its purpose is to provide a single consolidated form for use by applicants for participation as a provider (hereinafter, "Participation") with health plans or health insurers and may be used for hospital and other healthcare organization medical staff membership and clinical privileges (hereinafter, sometimes, "Membership"). This form, once properly completed will be accepted by all Nevada health plans and health insurers and may be accepted by hospitals and other healthcare organizations (hereinafter, collectively referred to as "Entities").

Acknowledgements and Agreements with respect to Health Plans and Health Insurers

I understand and agree that, as part of the credentialing application process for Participation at or with each health plan or health insurer and any of their affiliated Entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by them for determining initial and ongoing eligibility for Participation.

Acknowledgements and Agreements with respect to Healthcare Organizations

By filing this application, I agree to be bound by the bylaws, rules and regulations, policies, and code of conduct of each and every medical center, medical staff and other healthcare organizations to which I am applying in Nevada. I understand that I have an opportunity to review those bylaws, rules and regulations and policies.

I understand that it is my responsibility to assure that a copy of this application is sent to each and every healthcare organization to which I wish to apply.

I understand that my misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership and privileges. I also 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.

I recognize that as the applicant I bear the burden of demonstrating that I am qualified and remain qualified for the award of membership and privileges in accord with the criteria and standards described in the applicable bylaws and comparable documents, and I recognize that I have the burden of resolving any reasonable doubts about my qualifications for membership and privileges.

In order to facilitate the evaluation of this application and the assessment of any subsequent exercise of privileges, I agree to meet and cooperate with the various officers, representatives and committees charged with responsibility for credentialing and peer review activities.

I understand that the evaluation of credentials shall be accomplished in a professional manner, and that I will be afforded an appropriate review in the event that action on this application is adverse in accordance with the bylaws or rules pertaining to each organization.

As part of this application, I pledge that if I am granted the requested membership and privileges, I will maintain an ethical practice in accord with applicable bylaws, and specifically that I will: a) Refrain from fee splitting or other inducements relating to patient referral; b) Provide for the continuous care and

supervision of my patients; c) Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical practitioner who is not qualified to undertake this responsibility and who is not adequately supervised; d) Seek consultations whenever necessary or requested by the patient or family; e) Abide by all applicable and generally recognized ethical principles applicable to my profession and to each and every healthcare entity to which I am applying; and f) Maintain the confidentiality of patient information received by both paper and electronic means.

Furthermore, should I be granted the requested membership and privileges, I will accept appropriate committee assignments and otherwise assist, as requested, in the discharge of medical staff responsibilities.

Acknowledgements and Agreements with Respect to all

Entities Independent Action, No Employment

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 Membership or Participation. I understand that my application for Membership or Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Membership or Participation

I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated Entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Membership or Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Membership or Participation

I authorize any third party, including, but not limited to, individuals, agencies, medical groups, Entities responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Membership or Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any Entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information

I hereby further authorize any third party at which I currently have Membership or Participation or had Membership or Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Membership or Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: a) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Membership or Participation or impose a corrective action plan; b) any other disciplinary



action involving me, including, but not limited to, discipline in the employment context; or c) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I had knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Authorization of Release Among Entities

Moreover, I consent to the communication and release of information and documents (including medical staff records and patient care records) among the Entities to which I apply and the release of the same by and to any and all other hospitals, medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurers, licensing authorities, specialty boards, health maintenance organizations, health plans, health insurers, medical groups, ambulatory or outpatient care center, clinics, independent practice associations and any and all other sources that may be available for the purpose of evaluating my professional education, training, experience, character, conduct and judgment. In this regard, care shall be taken to safeguard the privacy of medical information and the confidentiality of medical staff information and medical records

I specifically authorize the transmission of this application and all supporting documentation, and all information collected during the credentialing process, to each and every component of the Entities in which I have sought Membership or Participation, and I further fully authorize the release of that documentation or information to any health plan, health insurer, hospital, medical staff, medical group or other health care entity that may seek it as part of an authorized credentialing or peer review process.

Required HIPAA Privacy Rule, Nevada Law Provisions

I understand and agree that some of the information to be disclosed pursuant to this Authorization may include information that is "protected health information" under 45 CFR parts 160 and 164, and may also include information protected under Nevada or other federal law ("other confidential medical information"); including blood, breath or urine test results, communicable disease information, information about sexually transmitted disease, (including HIV and AIDS), information about mental health treatment I have sought and/or received, and/or information about drug and/or alcohol abuse treatment I have sought and/or received.

This authorization will expire upon my retirement from medical practice. I acknowledge: a) that I have the right to revoke the authorization as it relates to protected health information and/or other confidential medical information at any time, and b) that I understand that once protected information is disclosed, it may no longer be protected by federal privacy law. I may revoke this authorization in this regard only in a writing sent by certified mail to the organization to which I originally furnished this Statement. The revocation will be effective only upon receipt.

Release from Liability

I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit any other applicable immunities provided by law for peer review and credentialing activities.

I fully release from liability any person or entity, including any and all representatives of the Entities and any representative, agent or component thereof, that requests or provides information in connection with the evaluation of my application, credentials and practice, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. Moreover, I fully release from liability the participating Entities to which I am applying and any Agent or component thereof, and all other persons or Entities



participating in the evaluation of my credentials and practice from any and all liability for their actions and decisions, to the fullest extent allowed by applicable statutes, regulations and judicial decisions.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. Except with respect to its application to protected health information or other confidential medical information, I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Membership or Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. With respect to protected health information or other confidential medical information, this Authorization may be revoked and provided above. However, I understand that my revocation of this Authorization with respect to protected health information or other confidential medical information or my failure to promptly provide another consent with respect to any other information may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Membership or Participation at or with the Entity and will result in the cessation of any action on my application for Membership or Participation. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. Further, I specifically agree to notify the Entities to which I am applying immediately upon notification upon any significant change or any formally recommended change in licensure status, or any actual or formally recommended denial, suspension or revocation of privileges or membership or status by another healthcare entity, or cancellation or interruption of my professional liability insurance coverage. I understand that corrections to the application are permitted at any time prior to a determination of Membership or Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission, as determined solely by the Entity, in my application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Membership or Participation; and/or immediate suspension or termination of Membership or Participation and will result in the cessation of any action on my application for Membership or Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name: _____

Signature _____ **Date** _____



MALPRACTICE CLAIM INFORMATION WORKSHEET

Please duplicate this form and complete for EACH case. Also, for each case that has been settled or dismissed, supply court documentation.

- Practitioner Name _____
1. Patient Name _____
 2. Diagnosis _____
 3. Your involvement in the case (attending, consulting, etc.) _____
 4. Allegation(s) _____
 5. Clinical Case Summary (Include additional pages or inserts if necessary) _____
 6. Patient Outcome _____
 7. Other Pertinent Details _____
- | | | |
|---------------------------|------------------|-------|
| | Date Closed | |
| 8. Date of Incident _____ | Date Filed _____ | _____ |
9. Resolution of Case (dismissed, settled out of court, litigated, other) **NOTE: All cases litigated must include legal documentation.**
- _____
10. Settlement amount paid on your behalf, if any _____
11. Professional liability insurer involved:
- A. Name of Insurer _____
 - B. Address of Insurer _____
 - C. Policy Number _____

Name: _____

Signature _____ **Date** _____

No claims to report
Regardless of whether you have had any claims, this form must be signed and dated.