

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this Credentialing application is true and complete. Any misrepresentation, misstatement, or omission from this credentialing profile system, whether intentional or not, may constitute sufficient cause for rejection of this verification resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

Signature of Applicant

Date

PRACTICE AND PROFESSIONAL INFORMATION

GENERAL INFORMATION

Provider:

Last Name First Name MI Suffix

List other names by which you have been known:

Last Name First Name MI Start Date End Date

Birth Date: Place of Birth:

(mm/dd/yyyy) City State Country

Gender: Male Female

U.S. Citizen? Yes No SSN _____

if no:

Do you have a legal right to reside permanently in the U.S.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a legal right to work in the U.S.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Resident Visa No	_____	

Mailing Address:

Street

City State Zip code

Telephone Number Fax Number Email

PROFESSIONAL LICENSES / IDS

License Type

State _____
License Number _____
Exp Date

License Unlimited: Yes No

Limitation

License Type

State _____
License Number _____
Exp Date

License Unlimited: Yes No

Limitation

License Type

State _____
License Number _____
Exp Date

License Unlimited: Yes No

Limitation

License Type

State _____
License Number _____
Exp Date

License Unlimited: Yes No

Limitation

License Type

State _____
License Number _____
Exp Date

License Unlimited: Yes No

Limitation

PROFESSIONAL / MEDICAL SPECIALTY

Primary Specialty

Specialty _____

Board Certified: Yes No

if Yes:

Board Name		
Certification Date	Recertification Date	Expiration Date

if No:

Have you taken or are you scheduled to take the board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Taken	Date Scheduled

Additional Specialty

Specialty _____

Board Certified: Yes No

if Yes:

Board Name		
Certification Date	Recertification Date	Expiration Date

if No:

Have you taken or are you scheduled to take the board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Taken	Date Scheduled

PROFESSIONAL LIABILITY INSURANCE

Current Policy

Carrier

Policy Number	Effective Date	Retroactive Date	Expiration Date
Coverage Type	Occurrence Limit	Aggregate Limit	

Street

City	State	Zip code
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Telephone Number	Fax Number	Email
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Coverage Limit Exceeded? Yes No

EDUCATION

Education Level _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Degree _____ Graduation Date _____ Start Date _____ End Date _____

If you are a graduate of a foreign medical school: _____
ECFMG Number _____ ECFMG Issue Date _____

Were you the subject of any disciplinary action during you attendance? Yes No

Education Level _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Degree _____ Graduation Date _____ Start Date _____ End Date _____

If you are a graduate of a foreign medical school: _____
ECFMG Number _____ ECFMG Issue Date _____

Were you the subject of any disciplinary action during you attendance? Yes No

TRAINING

Type

Institution Name

Street

City

State

Zip code

Telephone Number

Fax Number

Email

Specialty

Start Date

End Date

Department Chair or Program Director:

Last Name

First Name

MI

Degree

Did you successfully complete the program? Yes No

Were you the subject of any disciplinary action during you attendance? Yes No

Type

Institution Name

Street

City

State

Zip code

Telephone Number

Fax Number

Email

Specialty

Start Date

End Date

Department Chair or Program Director:

Last Name

First Name

MI

Degree

Did you successfully complete the program? Yes No

Were you the subject of any disciplinary action during you attendance? Yes No

CURRENT AFFILIATIONS

Type _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Specialty _____ Start Date _____

Department / Division _____ Membership Status _____

Limitations:

Type _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Specialty _____ Start Date _____

Department / Division _____ Membership Status _____

Limitations:

PREVIOUS AFFILIATIONS

Type _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Specialty _____ Start Date _____ End Date _____

Department / Division _____ Membership Status _____

Limitations:

Type _____ Institution Name _____

Street _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____ Email _____

Specialty _____ Start Date _____ End Date _____

Department / Division _____ Membership Status _____

Limitations:

WORK HISTORY

Work Place

Street

City State Zip code

Telephone Number Fax Number Email

Position Start Date End Date

Work Place

Street

City State Zip code

Telephone Number Fax Number Email

Position Start Date End Date

Work Place

Street

City State Zip code

Telephone Number Fax Number Email

Position Start Date End Date

DISCLOSURE QUESTIONS

Adverse 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 have you 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 which licenses providers? Yes No

3. Have you lost any board certification(s), and/or failed to recertify? Yes No

4. Have you been examined by a Certifying Board but failed to pass? Yes No

5. Has any information pertaining to you, including malpractice judgments 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 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 you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? Yes No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? Yes No

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 ambulatory surgery center privileges and/or your license? Yes No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? Yes No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other 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 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

Professional Liability Actions

1. Have any professional liability judgments 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

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

Criminal Actions

1. Have you been charged with or convicted of a 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 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 Conditions

1. Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? Yes No

Substance Abuse

1. Are you currently engaged in illegal use of any legal or illegal substances? Yes No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances? Yes No
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 N/A
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? Yes No

Investments

1. In the last five (5) years have you and/or a member of your family 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, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? Yes No

BUSINESS INFORMATION

SITE INFORMATION

Group / Practice Name

Building Name

Street

City

County

State

Zip code

Telephone Number

Fax Number

Email

Emergency Number

Answering Service

Pager

Mailing Address:

Name of Business Arrangement On SS4 or W-9 Form

Building Name

Street

City

State

Zip code

Billing Information:

Name of Business Arrangement On SS4 or W-9 Form

Building Name

Street

City

State

Zip code

Telephone Number

Fax Number

Tax Id

Administrator:

Last Name

First Name

MI

Telephone Number

Fax Number

Email

Group / Practice Name: _____

Credentialing Manager:

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Telephone Number	Fax Number	Email

Nurse Manager:

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Telephone Number	Fax Number	Email

Building Accessibility:

Public transportation? Yes No 24 hour number? Yes No

Lab Services:

_____	_____	_____
Certificate Type	Certificate Number	Certificate Expiration Date

Handicap Accessibility / Services:

Building? Yes No Parking? Yes No

Wheelchair? Yes No Restroom? Yes No

Sign Language? Yes No ADA? Yes No

TDD Number: _____

Additional Services:

Languages:

Group / Practice Name: _____

Specialty at this site: _____

- Accepting All New Patients? Yes No
- Accepting New Patients by Referral? Yes No
- Accepting New Medicare? Yes No
- Accepting New Medicaid? Yes No

Practice Restrictions / Limitations:

Application Return Methods

Regular Mail:

California Prison Health Care Services
Credentialing and Privileging Unit
PO Box 4038, Suite 315
Sacramento, CA 95812-4038

Overnight Mail:

California Prison Health Care Services
Credentialing and Privileging Unit
510 I Street, Suite 315
Sacramento, CA 95814

Facsimile:

(916) 324-6633 Attn: Credentialing and Privileging Unit

Email:

CAPrisonHCSCreden@cdcr.ca.gov