Credentials*OnLine*
17085 Camino San Bernardo
San Diego, CA 92127
(800) 733-8737 / Fax (858) 673-3888

You are receiving this Application at the request of

CAMP LOWELL SURGERY CENTER

Credentials*OnLine* is a national centralized verification service and has contracts with multiple hospitals, managed healthcare organizations and clinics to perform credentials verification for providers applying to or currently on their staffs and/or panels.

Please complete and return this application within 10 days of receipt to Credentials***Online.*** **If you do not wish to have your credentialing file released to any of the above entities, please cross off the list above, sign and date this letter, and return it to us as soon as possible.**

Sign: _____ **Date:** _____

APPLICATION INSTRUCTIONS

Fill out the enclosed paper application:

1. Check all information carefully for completeness and accuracy. Your application may be pre-populated with information you have provided to us through an initial or reappointment application, or previously submitted on behalf of a healthcare organization within our network. **Note any changes or corrections on the application.**
2. Sign and date the *Authorization and Release of Information Form* and the *Attestation Questions* included in this packet. **Return everything by mail to our address or Fax to the number above.**
3. If you have any questions concerning the application process, please send an email to hsaunders@credentialsonline.com or call 800-733-8737 ext. 7245.

In addition you may send your completed application to

Barbara Marco, Administrator
Camp Lowell Surgery Center
4620 E. Camp Lowell Dr.
Tucson, AZ. 85712

Or you may fax to Camp Lowell Surgery Center @ 520 618-5891

INSTRUCTIONS

Before submitting the Application, make sure you have completed the following:

- Include an answer in **all** spaces.
- The provider has signed and dated both the attestation and release pages.

Before submitting the Application, make sure you have enclosed the following, *if applicable:*

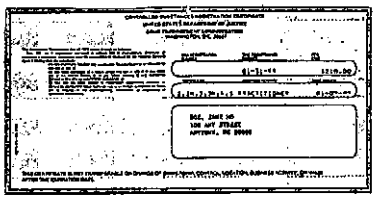
- Copy of the provider's state(s) license(s).
- Copy of current DEA certificate. (Must have a valid date.)
- Copy of Controlled Drug Substance Certificate and DEA information.
- Copy of the face sheet of your current professional liability insurance policy, indicating by name, provider(s) covered, coverage amounts, effective date, expiration date, and policy number. Attach previous carrier face sheet.
- Proof of professional liability insurance for non-physician providers who care for patients in your practice. Copy of certificate from the Specialty Board.
- Copy of Educational Commission of Foreign Medical Graduate Certificate - ECFMG, ***if applicable***.
- CME - Continuing Medical Education Certificates or Listing.
- Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school
  (CV must account for any gaps of 90 days or more).

Examples of documentation to attach to this application:

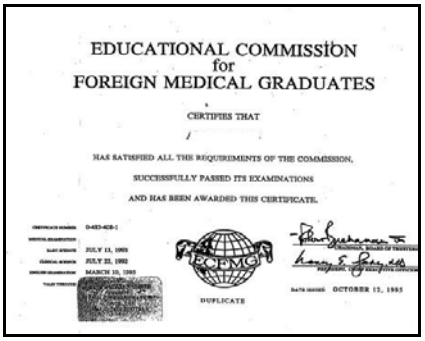
State License


The Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, California 95825-3236
Consumer Affairs
PHYSICIAN AND SURGEON
CERTIFICATE NO. EXPIRATION 05/31/2006
FALLBROOK, CA 92028
ORIGINAL ISSUANCE DATE 11/08/1973
RECEIPT NO. 07000165

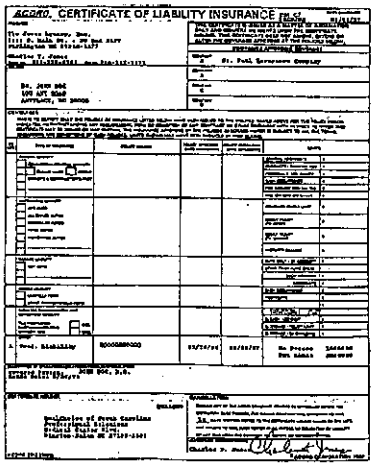
DEA Registration



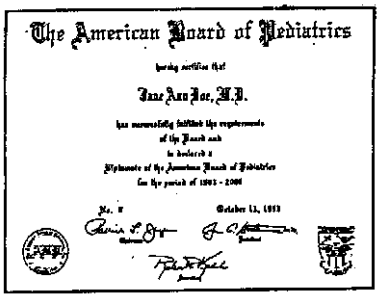
ECFMG Certificate


EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES
CERTIFIES THAT
HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,
SUCCESSFULLY PASSED ITS EXAMINATIONS
AND HAS BEEN AWARDED THIS CERTIFICATE.
ECFMG
DUPLICATE

Certificate of Insurance


ACORD CERTIFICATE OF LIABILITY INSURANCE

Board Certification


The American Board of Pediatrics

State CDS Certificate


TEXAS CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE

Reminder: If you are enrolled in an online application process such as **EchoApps or CAQH**, please obtain and submit a populated application from their site to begin processing. We cannot retrieve applications from these sources for you, nor can COL accept data summary profiles in lieu of an application.

Applications will not be processed without completed *Attestations Questions* and *Authorization and Release* .
Please do not delay return of your application if any other documents are pending.

CREDENTIALING APPLICATION

Credentials*OnLine*
17085 Camino San Bernardo, San Diego, CA 92127
(800) 733-8737; Fax (858) 673-3888

PERSONAL INFORMATION (REQUIRED)

Name: _____ Degree: _____
Last First Middle

List other names you have used: _____ Gender: _____

Date of Birth: _____ Professional Specialty: _____

SSN: _____ Medicare Provider No.: _____ Tax ID No: _____

CLIA: _____ Medicaid Provider No.: _____ NPI No.: _____

Foreign Language(s): _____ UPIN No. _____

OFFICE INFORMATION (REQUIRED)

Primary Office: _____
Corporate/Group Name Street Address Suite No.

_____
City State Zip Code Phone No. Fax No.

Type of Practice

Solo/Individual - _____ Same Specialty Group _____ Multi Specialty Group ____

Credentialing Contact:

Secondary Office or Mailing Address: **(circle one)** _____
Street Address/P.O. Box Number Suite No.

_____
City State Zip Code Phone No. Fax No.

Credentialing Contact:

Physicians providing coverage in your absence:

_____
Name Specialty Phone No.

_____
Name Specialty Phone No.

If additional space is required for addresses or covering physicians, please attach information on a separate page.

BOARD CERTIFICATION (Not applicable for chiropractors and podiatrists)

Name of Certifying Board: _____ Date Certified: _____
Expiration Date: _____

Name of Certifying Board: _____ Date Certified: _____
Expiration Date: _____

If you are not currently Board Certified, what is your intent and when will you be taking exams? _____

If additional space is required for board certification, please attach information on a separate page.

EDUCATION AND TRAINING (REQUIRED) Attach separate sheet if necessary

Undergrad Education

School | City/State | Graduation Date | Degree

Medical Education:

School | City/State | Graduation Date | Degree

ECFMG:

Certificate No. | Date Issued

Internship

Facility | City/State

Internship Specialty | Dates(mm/dd/yy)

Residency

Facility | City/State

Residency Specialty | Dates(mm/dd/yy)

Facility | City/State

Residency Specialty | Dates(mm/dd/yy)

Fellowship

Facility | City/State

Fellowship Specialty | Dates(mm/dd/yy)

EMPLOYMENT HISTORY (REQUIRED)

PLEASE NOTE: Your Curriculum Vitae does not replace the completion of this portion of your application. Must list chronologically at least the past five (5) years of work history and account for any gaps of six (6) months or longer.

Name	Status		From	To
Address		Phone	Fax	
Name and Address	Status		From	To
Address		Phone	Fax	
Name and Address	Status		From	To
Address		Phone	Fax	

Military Service

	Branch	From	To
	Branch	From	To

GAPS IN EMPLOYMENT

Explain	From	To
Explain	From	To

LICENSURE INFORMATION (REQUIRED)

License Number: _____ State: _____ Expiration Date: _____

Other State Licensure(s) (Please check whether the license is current or inactive):
State : _____Number: _____ Current _____ Inactive _____
State : _____Number: _____ Current _____ Inactive _____
State : _____Number: _____ Current _____ Inactive _____
CDS/State Pharmacy Board No._____ Expiration Date:_____
DEA Certificate:_____ Expiration Date:_____

PROFESSIONAL LIABILITY INSURANCE (REQUIRED) with Dates

Attach copy of face sheet of current insurance policy with dates.

Name of Carrier: _____ Policy Number: _____
Address: _____ Amounts of Coverage: _____

Issue Date: _____ Expiration Date: _____

PROFESSIONAL REFERENCES

Name	Full Address	Phone/Fax

HOSPITAL AFFILIATION (If Not Applicable, please indicate and state reason)

Primary Admitting Facility:

Hospital: _____

Name

_____

Address

Please list the name(s) and address(es) of any physician(s) who will admit patients for you:

Name	Address	Phone No.	Hospital
Name	Address	Phone No.	Hospital

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, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES	NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES	NO
C.	Have you **ever been** denied clinical privileges, membership, contractual participation or employment by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES	NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	YES	NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization***** **ever been** withdrawn on your request prior to the organization's final action?	YES	NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES	NO
G.	Have you **ever** had board certification revoked?	YES	NO
H.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES	NO
I.	Have you **ever been** charged with a criminal violation (felony or misdemeanor)?	YES	NO
J.	Have you ever practiced medicine without medical liability insurance?	YES	NO
K.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES	NO
L.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES	NO
M.	Have any professional liability claims or lawsuits **ever been** filed against you? If yes, please complete **Attachment A** for **each** past or current claim and/or lawsuit.	YES	NO
N.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES	NO
O	Have you ever been court-martialed, investigated, sanctioned, reprimanded or cautioned by any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from any military agency?	YES	NO

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), medical society, professional association, medical school faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release of any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____ **Date:** _____

Practitioner Credentialing Application
AUTHORIZATION AND RELEASE OF INFORMATION FORM
Modified Releases Will Not Be Accepted

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participation status with the Healthcare Organization(s)** with whom I have, or wish to establish, a contractual relationship as a network provider, staff physician, or other provider of professional medical services (initial credentialing/recredentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matters, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as a part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) to include **Credentials***OnLine* who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the Healthcare Organization(s), unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Signature _____ **Date _____**

Healthcare Organization (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), medical society, credentials verification organization (CVO), professional association, medical school faculty position or other health delivery entity or system).

MALPRACTICE INFORMATION REPORT

You must furnish the following information regarding each lawsuit or complaint and a copy of the complaint which indicated the case number and court location. It is your responsibility to provide external verification (attorney statement, court records, etc.) of your response. You may choose to have your attorney complete this form. Other comments may be provided on a separate sheet.

Month/year of incident **Where incident occurred**

Nature of incident (Complaint/Allegation):

Outcome of incident:

Dropped ___ Case dismissed all parties ___ Pending ___ Settled ___ Amount _____

Judgment for you ___ For Plaintiff ___ Amount_____

Other Explain:

Represented by legal counsel for this claim/malpractice lawsuit?

Yes ___ No ___ If "Yes" give name and address of Counsel

Name

Street City State Zip

Name of insurance company that provided coverage for this claim:

Insurance Company

Street City State Zip