Culinary Health Fund
Administrative Services, LLC

1901 Las Vegas Blvd. So.
Suite 107
Las Vegas, Nevada 89104-1309
(702) 733-9938
www.culinaryhealthfund.org

Dear Provider:

Thank you for your interest regarding participation in the **Culinary Health Fund Administrative Services LLC provider network**. We have reviewed your request and invite you to complete our credentialing process. Please be aware, all providers must *successfully* complete our credentialing process prior to being added to our network.

Enclosed is a Credentialing Application to review and complete; this application is the state of Nevada mandated application. All elements in the application must be completed and/or acknowledged. If you feel a section does not apply, you must insert "N/A"– no section can be left blank. For your convenience, if you have an up-to-date state of Nevada application already completed, you may re-sign and re-date that application and submit it to the Culinary Health Fund in lieu of completing the one we have enclosed.

Copies of the following items must also be returned with your completed application:

1) Current license to practice

2) Certificate of Insurance (Malpractice Face Sheet)

3) DEA Registration, NV Pharmacy License (or Prescription Plan Designation) and CDS certificate, when applicable

4) Health Status Form and/or Designation of Credentialing Agent Form, as applicable

During the credentialing process all providers have the right to: Review information submitted to support their credentialing application; correct erroneous information; and receive the status of their credentialing application, upon request.

In the event that additional information is needed to complete your application, we will contact you. If we do not receive the additional information after three attempts, we will assume the provider is no longer interested in pursuing participation in our network and the application will be closed. This will result in a continued non-participation status for you.

Please return your completed application along with all other materials to the Culinary Health Fund Administrative Services LLC at:

Attn: Credentialing Department
1901 Las Vegas Blvd., #101
Las Vegas, NV 89104

Or, for a more *timely processing* you may fax/e-mail your application to: **702-892-7365 or** **contractsandcred@culinaryhealthfund.org** (Always keep a copy of all the information you submit to us for review.)

If you have any questions or concerns regarding the credentialing process, please contact us at 702-892-7313.

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 _____

3. Social Security Number_____4. UPIN#_____5. Medicaid _____

6. Medicare#_____7.NPI (National Provider Identifier)_____

8. Tax ID#_____Name Affiliated with 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_____

NCQA-accredited/certified organizations must comply with all applicable federal and state civil rights laws that prohibit discrimination on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, and make decisions in a nondiscriminatory manner. Providing race, ethnicity or language information is optional. CAQH does not participate in the organization's credentialing decision.

Race_____(ex:Caucasian, African-American, etc.) Ethnicity_____(ex:Spanish, Russian,etc.)

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)

_____

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

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

_____
Website URL
Preferred Method of Contact _☐_ Phone _☐_ FAX _☐_ E-Mail

18A. 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

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

30. Do you accept Medicare assignment? ☐ YES ☐ NO

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

32. Office Laboratory services provided?_____

33. Office Radiology services provided?_____

34. Additional office testing available?_____

35. Surgical facilities/services provided at the office?_____

36. Do you wish to be listed (for Managed Care) as ☐ PCP ☐ Specialist ☐ Both

PROFESSIONAL LICENSES

Attach copies of license(s)

37. 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

38. Federal DEA Registration #_____Date Expires_____

Nevada State Pharmacy #_____Date Expires_____

Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date

39. Examinations Taken – Attach Copies

ECFMG No_____ Date of Certification_____

FLEX Exam_____ Date Taken_____

USMLE No._____ Date Taken_____

National Board of Medical Examiners_____Date Taken_____

40. 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

41. Pre-Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Degree Earned

42. Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Degree Earned

43. **Internship** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

44. **Internship** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

45. **Residency** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

46. **Other Residency** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

~~FROM: Mo/Yr TO: Mo/Yr Program Director~~
Phone FAX

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

47. **Fellowship** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

48. **Fellowship** (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

49. **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

50. _____

Facility Name Specialty & Degree Awarded

_____

Mailing Address

_____

Phone FAX

_____

FROM: Mo/Yr TO: Mo/Yr Program Director

51. _____

Facility Name

_____

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)

52. _____

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?_____

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. _____

Name of Specialty Board

_____

Mailing Address

Date of Certification _____ Expiration Date_____

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

55. Other Board Certification_____

MILITARY SERVICE

Attach copy of discharge papers.

56. 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.

57. _____

Facility Name FROM: Mo/Yr TO: Mo/Yr

Mailing Address

Phone Number FAX Number

Position Department

Reason for Leaving

58. _____

Facility Name FROM: Mo/Yr TO: Mo/Yr

Mailing Address

Phone Number FAX Number

Position Department

Reason for Leaving

59. _____

Facility Name FROM: Mo/Yr TO: Mo/Yr

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.

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

67. _____

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.

68. **Hospital/SurgicalCenter**

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

73. **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.

74. **Present Carrier for Nevada Practice**_____

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 $_____

77. **Previous Carrier**_____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

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

CONTINUING MEDICAL EDUCATION/CEU

78. 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).

79.79. _____

Peer Reference Specialty

_____

Complete Mailing Address

_____

Phone Number FAX Number

80.80. _____

Peer Reference Specialty

_____

Complete Mailing Address

_____

Phone Number FAX Number

81.81. _____

Peer Reference Specialty

_____

Complete Mailing Address

_____

Phone Number FAX Number

PRACTITIONER QUESTIONNAIRE

82. **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 _____

   _____
8. Date of Incident _____ Date Filed _____ Date Closed _____
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. Policy #_____

    C.Address of Insurer _____

    _____

By submission of a blank form, I attest I have no pending or final claims.
Regardless of whether you have had any claims, **this form must be signed and dated.**

Name:_____

Signature_____ **Date**_____