GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM FOR REAPPOINTMENT

You will be contacted by the Hospital, Health Plan or Other Healthcare Organization, Hereinafter "Healthcare Entity(ies)" when it is time for your reappointment.

This Application Form for Reappointment has been designed and organized into two main parts: Part One and Part Two.

Part One is standardized for Healthcare Entity, and contains identical questions that Healthcare Entities need to ask as a part of their credentialing processes for reappointment. Part One is available on the Georgia Association Medical Staff Services (GAMSS) web site at www.gamss.org. Note: If using an electronic version of Part One, check your answers against the date of your last (re)appointment to the Healthcare Entity to which you are applying in order to ensure accuracy.

Part Two contains additional, customized or more specific questions that an individual Healthcare Entity needs you to answer for your Application Form for Reappointment to be considered complete by that Healthcare Entity. A Healthcare Entity will provide you with its Part Two when notifying you that your Application Form for Reappointment is due.

PREPARED AND ENDORSED BY MEMBERS OF:

GHA/AN ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS
GEORGIA IN-HOUSE COUNSEL ASSOCIATION
GEORGIA ASSOCIATION MEDICAL STAFF SERVICES
GEORGIA ASSOCIATION OF HEALTH PLANS

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM FOR REAPPOINTMENT

Prior to completing this application, please read and observe the following:

GENERAL INSTRUCTIONS

- Please type or print legibly your responses.
- Please note that modification to the wording or format of this Application Form for Reappointment will invalidate it.
- All information requested must be FULLY and TRUTHFULLY provided.
- Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- If there have been no changes in a section since the date of your last (re)appointment to this Healthcare Entity, then please check the box provided at the top of the section stating that there have been "No Changes."
- Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.
- **If more space than is provided on this Application Form for Reappointment is needed in order to answer a question completely, use the attached Explanation Form as necessary. Make as many copies of the Explanation Form as needed to fully answer each question. Include the section and page number of the question being answered as well as your name and Social Security Number on each Explanation Form. Attach all Explanation Forms to this Application.**
- After Part One of the Application Form for Reappointment has been completed in its entirety, but before you sign and date it or fill in the information below, make a copy to retain in your files and/or computer for future use.
- Please sign and date the Application Form for Reappointment.
- Please sign and date Schedule A and Schedule B. **Schedule B on this Application Form for Reappointment is the same as Schedule B for the original Credentialing Application Form. If you have maintained a current version of Schedule B for the original Credentialing Application Form, you may make a photocopy, sign and date the photocopy and submit it with your Application Form for Reappointment**.
- Identify the Healthcare Entity to which you are submitting this Application Form for Reappointment in the spaces provided below.
- Mail the Application Form for Reappointment, including Part One and Part Two, together with Schedules, any Explanation Form(s) prepared in order to answer any question(s) completely, and a copy of all applicable enclosures listed below to the Healthcare Entity.

A current copy of the following documents (if changed/or renewed from the date of your last (re)appointment) must be submitted with your Application Form for Reappointment:

- State Professional License(s)
- Federal Narcotics License (DEA Registration)
- Specialty/Subspecialty Board Certification or letter from Board(s) stating your status
- Declaration Page (Face Sheet) of Professional Liability Policy or Certificate of Insurance
- Permanent Resident Card or Visa Status
- Military Discharge Record (Form DD-214)

Name of Healthcare Entity to which you are submitting this Application Form for Reappointment:

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM FOR REAPPOINTMENT

***************PART ONE***************

If more space than is provided on the Application is needed in order to answer a question completely, please use the attached Explanation Form as necessary

I. IDENTIFYING INFORMATION *Please provide the practitioner's full legal name.*

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

II. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence
Name of Local Contact (e.g. Insurance Agent or Broker):		Mailing Address:
Contact Telephone Number: ( ) -		
Per claim limit of liability: $	Aggregate amount: $	
Effective Date (mm/yy): /	Expiration Date (mm/yy): /	Retroactive Date, if applicable (mm/yy): /

If you have changed your coverage since the date of your last (re)appointment, did you purchase tail and/or nose (prior occurrence/acts) coverage? If yes, please provide details/supporting data. If no, please explain why not on an Explanation Form of the Application.	☐ Yes ☐ No ☐ N/A

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

1.	Since the date of your last (re)appointment, has your professional liability insurance coverage been terminated or not renewed by action of the insurance company? If yes, please provide date, name of company(s), and basis for termination or non-renewal.	☐ Yes ☐ No
2.	Since the date of your last (re)appointment, have you been denied coverage? If yes, please provide details.	☐ Yes ☐ No
3.	Since the date of your last (re)appointment, has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? If yes, please identify procedures and explain.	☐ Yes ☐ No

Professional Claims History: (If the answer to any of these questions is "Yes," please complete a separate Professional Liability Claims Information Form for each. A Professional Liability Claims Information Form has been provided as Schedule B to this Application Form for Reappointment. Please make additional copies as necessary.)

1.	Since the date of your last (re)appointment, have there *been* any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? (Please include any change in the status of claims reported in your last application to this Healthcare Entity.)	☐ Yes ☐ No
2.	Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you currently pending?	☐ Yes ☐ No
3.	Since the date of your last (re)appointment, are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability?	☐ Yes ☐ No

III. BOARD CERTIFICATION/RECERTIFICATION ☐ NO CHANGES

Please answer the following questions:

A.	Since the date of your last (re)appointment, have you been examined by any specialty board, but failed to pass? If yes, please provide name of board(s) and date(s):	☐ Yes ☐ No
B.	1. If you are not currently certified, have you applied for the certification examination?	☐ Yes ☐ No
	2. If you have not applied for the certification examination, do you intend to apply? If yes, when? Date: /	☐ Yes ☐ No
	3. If you have applied for the certification examination, have you been accepted?	☐ Yes ☐ No
	4. If you have been accepted, when do you intend to take the examination?	Date: /
	5. If you don't intend to apply for the certification examination, please explain on an Explanation Form.	

C.	If you are not currently Board certified, please provide the expiration date of admissibility.	Date: /
D.	Since the date of your last (re)appointment, have you had board certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, or received a letter of reprimand from a specialty board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s).	☐ Yes ☐ No
E.	Since the date of your last (re)appointment to this Healthcare Entity, have you voluntarily relinquished a board certification, including any voluntary non-renewal of a time limited board certification? If yes, please attach Explanation Form(s).	☐ Yes ☐ No

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

A.	**RESIDENCIES AND FELLOWSHIPS** Since the date of your last (re)appointment, have you participated in any Residencies or Fellowships? If yes, attach information.	☐ Yes ☐ No
B.	**OTHER CLINICAL TRAINING PROGRAMS** Since the date of your last (re)appointment, have you participated in any other Clinical Training Programs? If yes, attach information.	☐ Yes ☐ No
C.	**CONTINUING MEDICAL EDUCATION (CMEs)** *If not listed on your Curriculum Vitae, please list on Explanation Form(s) all post graduate activities and scientific meetings that you have attended or for which you have received Category 1 credit since the date of your last (re)appointment, or provide copies of certificates.*	
D.	**PROFESSIONAL MEDICAL ASSOCIATIONS** *Please list on an Explanation Form, all professional organizations and societies (local, state and national) in which you have membership.*	

V. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Since the date of your last (re)appointment, have you had any changes in other state healthcare licenses, registrations and certificates? If yes, attach copies.	☐ Yes ☐ No
Please provide your **National Provider Identifier (NPI)** here:	

VI. HEALTH STATUS

Please answer each of the following questions in full.

1.	Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application Form for Reappointment? ***If the answer to this question is "YES," please give full explanation of the specific details on an Explanation Form and attach to this Application Form for Reappointment.*** (**Note:** Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol, drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)	☐ Yes ☐ No
2.	Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify on **an attached Explanation Form**.	☐ Yes ☐ No

VII. ATTESTATION QUESTIONS

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

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 an Explanation Form and attach to this Application Form for Reappointment.

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

A.	To your knowledge, since the date of your last (re)appointment, have you been the subject of an investigation or **adverse action** (or is an investigation or **adverse action** currently pending) by:	
	• a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis facility, etc.)?	☐ Yes ☐ No
	• an education facility or program (medical school, residency, internship, etc.)?	☐ Yes ☐ No
	• a professional organization or society?	☐ Yes ☐ No
	• a professional licensing body (in any jurisdiction for any profession)?	☐ Yes ☐ No
	• a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.)?	☐ Yes ☐ No
	• a state or federal agency (DEA, etc.) regarding your prescription of controlled substances?	☐ Yes ☐ No
B.	To your knowledge, since the date of your last (re)appointment, have you been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?	☐ Yes ☐ No

C.	Since the date of your last (re)appointment, has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility been denied in whole or in part or is any such action pending?	☐ Yes ☐ No
D.	Since the date of your last (re)appointment, have you resigned from a hospital or other health care facility medical staff to avoid disciplinary action, investigation or while under investigation or is such an investigation pending?	☐ Yes ☐ No
E.	Since the date of your last (re)appointment, have you been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *federal or state* health insurance program (for example, Medicare or Medicaid)?	☐ Yes ☐ No
F.	Since the date of your last (re)appointment, have you been suspended, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in any *private* health insurance program?	☐ Yes ☐ No
G.	Has any professional review organization under contract with Medicare or Medicaid made an adverse quality determination concerning your treatment rendered to any patient since the date of your last (re)appointment?	☐ Yes ☐ No
H.	Since the date of your last (re)appointment, have you been convicted of or entered a guilty plea for any criminal offense (excluding parking tickets)?	☐ Yes ☐ No
I.	Are any criminal charges currently pending against you?	☐ Yes ☐ No
J.	Since the date of your last (re)appointment, have you been arrested for or charged with a crime involving children?	☐ Yes ☐ No
K.	Since the date of your last (re)appointment, have you been arrested for or charged with a sexual offense?	☐ Yes ☐ No
L.	Since the date of your last (re)appointment, have you been arrested for or charged with a crime involving moral turpitude?	☐ Yes ☐ No
M.	Are you currently using illegal drugs or legal drugs in an illegal manner?	☐ Yes ☐ No

VIII. ATTESTATION AND SIGNATURE

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

1. The information in this entire Application Form for Reappointment, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application Form for Reappointment may constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.
3. A photocopy of this Application Form for Reappointment, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application Form for Reappointment on the most recent date indicated below and it continues to be true and complete.
5. I have reviewed the attached Delineation of Privileges Form (if applicable) and I affirm that I am currently clinically competent to perform all privileges requested.
6. While this Application Form for Reappointment is being processed, I agree to update the information originally provided in this form should there be any change in the information.
7. No action will be taken on this Application Form for Reappointment until it is complete and all outstanding questions with respect to the form have been resolved.
8. This attestation statement and Application Form for Reappointment must be signed no more than 180 days prior to the credentialing decision date.

Signature:

Printed Name:	**Date:**

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM FOR REAPPOINTMENT

EXPLANATION FORM

Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please provide your name and Social Security Number, together with the corresponding page and section number from the Application.

NAME:	SS#: .

Section #	Page #

Schedule A

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

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

1. As an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization, network, medical society, professional association, medical school faculty position, or other healthcare delivery entity or system (hereinafter referred to as a "Healthcare Entity")* indicated on this Form for Reappointment, I have the burden of producing adequate information for proper evaluation of this application form.

2. I also understand that I have the continuing responsibility to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.

3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this application form. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.

4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this application form (my "Qualifications").

5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this application form and my Qualifications.

6. I consent to and authorize the inspection of records and documents (including medical records and peer review information) that may be material to an evaluation of this application form and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this application form. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this application form.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

Schedule A--continued

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

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

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application form and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this application form and my Qualifications.

9. 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. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this application form and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application form. This Authorization and Release shall apply in connection with the evaluation and processing of this application form as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

Signature:	
Printed Name:	**Date:**

I grant permission for the release of the credentials information contained in this Application Form to the following Healthcare Entity(ies):

____

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Schedule B

Claim of

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; recredentialing, complete forms only for new/changed status claims since your last recredentialing. One case per sheet *(please photocopy if additional sheets are needed).*

PROVIDER'S NAME: *(Required even if N/A)*		**Does Not Apply** ☐ *Note: Signature Required even if checked.*

Name of Patient Involved	Age	Month and Year of Occurrence *(Event precipitating claim)*	Month and Year of Lawsuit	Insurance Carrier at Time
		/	/	

What is/was your status?	List other defendants:
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

CURRENT STATUS			
☐ **Still pending (as of) Date: /**		**Who is handling the defense of the case?**	
☐ **Trial date set - awaiting trial**		**Trial Date: /**	
☐ **Dismissed**		**Date of Dismissal: /**	
☐ **Defense Verdict**		**Date of Defense Verdict: /**	
☐ **Settled out of court**	**Date: /**	**Total Amount of Settlement:** $	**Amount Paid by You:** $
☐ **Judgment**	**Date: /**	**Total Amount of Judgment:** $	**Amount Paid by You:** $

This Professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete (even if N/A) to the best of my knowledge.

Signature: (Required)		**Date:**	

Schedule C

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

REGULATION ACKNOWLEDGEMENT

NOTICE TO PHYSICIANS

Medicare and Tri-Care payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

By my signature below, I acknowledge receipt of this notice.

Signature:	
Printed Name:	**Date:**