RowanMedicine Clinical Provider Application

FOR THIRD PARTY BILLING

☐ New/Initial ☐ Corrections (please type or print)

SECTION 1

Personal Information

Provider Name (Last) (First) (MI) (Jr., Sr., etc.)	Social Security Number	Personal Phone#: Internal Use only Personal Email: Internal Use only	
Provider's Full Name as it Appears on Medical License	Entire Social Security#		
Date of Birth (mm/dd/yyyy) Date of Birth	Place of Birth (City) City Where Born	Place of Birth (State) State Where Born	Place of Birth (Country) Country Where Born
Home Mailing Address Provider's Home # and Street Address	City Home Address (City)	State Home (St)	Zip Code Zip

Types of Other Names Used	Other Name(s) Used:	Gender:	Are You Eligible to Work in the United States?
☐ Professional Name ☐ Other (describe) ☐ Former or Maiden Name Mark if Provider has used a different name in the past	Provide other Names used in the past, could be maiden name or different name	☐ Male ☐ Female Provide provider's gender	☐ Yes ☐ No State if provider is eligible to work in USA Other Language(s)spoken: List Other languages spoken by provider Fluent: ☐ Yes ☐ No

Practice Location Information

Type of Service Provided: State in what capacity will the provider be rendering services so reimbursement can be processed accurately

☐ Primary Care Physician ☐ Specialist ☐Hospitalist (sees patients in hospital only, no outpatient services)

☐ Dual credential (PCP and Specialty) ☐APN ☐CNS ☐CNW ☐LAC ☐LCSW ☐LPC ☐LSAC ☐Other _____

Physician Group Name/Practice Name	Legal Business Name (Name that belongs to Tax ID#)		
SAME AS "Hiring Dept" on NEW Provider Notification Form	☐ RowanSOM _____ ☐ CARES Behavioral Health / ☐ CARES Medical ☐ NJISA (check applicable: ☐Geri / ☐ Neuro / ☐Psych) ☐ Rowan Wellness Center (check applicable: ☐CPS ☐ SHS)		
Primary Office Mailing Address WILL ALWAYS BE THE MANAGED CARE DEPT'S ADDRESS – 42 E. Laurel Rd, Suite #3200 ADDRESS WILL BE PREPRINTED ON APPLICATION	City Stratford	State NJ	Zip Code 08084
Office Street Address Primary practice street # & name where services will be rendered	City Primary practice city	State Primary practice State	Zip Code Primary practice zip
Primary Office Telephone No. Primary Practice Appointment Desk Phone Number	Primary Office Fax No. Primary Practice Fax# where patient/pharmacy requests can be sent		
Tax ID Number Primary Group Tax ID# that will be used to submit claims for reimbursement of services (SAME AS appear on W9 form) – A LIST WILL BE ATTACHED WITH GROUP'S LEGAL BUSINESS NAME, TAX ID# & GROUP'S NPI# FOR YOUR USE			
Expected start date __Provider's Official Start Date_____			
Physician Group Name/Practice Name for Secondary Location SAME AS "Hiring Dept" on NEW Provider Notification Form	Legal Business Name (Name that belongs to Tax ID#) ☐ RowanSOM _____ ☐ CARES Behavioral Health / ☐ CARES Medical ☐ NJISA (check applicable: ☐Geri / ☐ Neuro / ☐Psych) ☐ Rowan Wellness Center (check applicable: ☐CPS ☐ SHS)		
Secondary Office Address – Street Secondary practice street # & name where services will be rendered	City Secondary practice city	State Secondary practice State	Zip Code Secondary practice zip
Secondary Office Telephone No. Secondary Practice Appointment Desk Phone Number	Primary Office Fax No. Secondary Practice Fax# where patient/pharmacy req can be sent		
Tax ID Number Secondary Group Tax ID# that will be used to submit claims for reimbursement of services (SAME AS appear on W9 form) – see above for suggestion			

If you have additional offices, please submit an attachment containing the above information and check this box: ☐

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all states where you are currently or have previously been licensed.)

Type	State(s) of Registration	Do You Currently Practice In This State?	License/Certificate Number	Expiration Date	N/A
NJ License (type of license) ex: DO, MD, APN, CNS, LAC etc	NJ State License should be acknowledged here	☐ Yes ☐ No	NJ Medical License#	NJ Medical Lic Exp date	

License and Other Identification Numbers

(License Information - Include all license(s) and certifications in all states where you are currently or have previously been licensed.)

License	List other States licenses	☐ Yes ☐ No State if license is active	Other State License#	Other State Exp date	
NJ DEA Registration Certificate	List New Jersey	☐ Yes ☐ No License has to be active	DEA License#	DEA Exp date	
NJ CDS Registration Certificate	List New Jersey	☐ Yes ☐ No License has to be active	CDS License#	CDS Exp date	
Other (CDS/DEA) (Specify)	List other State CDS/DEA	☐ Yes ☐ No State if license is active	Other State CDS/DEA Lic#	Other State CDS /DEA Exp date	

National Provider ID (when available) Provider's Individual NPI#	User Name and Password NPI Log-on Information (User Name & Password) – see checklist for instruction on how to retrieve if unknown
CAQH ID Number Provider's Individual CAQH ID#	User Name and Password CAQH Log-on Information (User Name & Password) – see checklist for instructions on how to retrieve if unknown

Are you a participating Medicare Provider? ☐ Yes ☐ No (Need to know if provider was ever par with Medicare)	Medicare Provider No. Individual Medicare ID#	Are you a participating Medicaid Provider? ☐ Yes ☐ No (Need to know if provider was ever par with Medicaid)	Medicaid Provider No. Individual Medicaid ID#
International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No (Mark if provider is ECFMG graduate)		If yes, ECFMG Number ECFMG Certificate#	ECFMG Issue Date ECFMG Certificate Issue Date

Education

Undergraduate College/University College Name where provider attended	Degree Degree received from graduation	Attendance Dates (Month/Year) Dates from & to attended by (month/year)	
Address College street# and street name	City College City	State/Country College State	Zip Code College Zip
School Issuing Professional Degree (Medical, Dental, Chiropractic) Medical School where provider received medical education	Degree Medical School degree	Attendance Dates (Month/Year) Dates from & to attended by (month/year)	
Address Medical School street# and street name	City Medical School City	State/Country Medical School State	Zip Code Medical School Zip

If you have attended additional schools, please submit an attachment containing the above information and check this box: ☐

(section below should be completed in chronological order with the oldest training first and the newest training last)

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment (internship information should be filled in first or if no internship then residency)	Institution Name Name of facility where provider received training		
Address Street# & Name of where training was provider	City Training City	State Training State	Zip Code Training Zip
Specialty Training Specialty	Start Date (Month/Year) Start date of training	End Date (Month/Year) End date of training	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment (internship information should be filled in first or if no internship then residency)	Institution Name Name of facility where provider received training		
Address Street# & Name of where training was provider	City Training City	State Training State	Zip Code Training Zip
Specialty Training Specialty	Start Date (Month/Year) Start date of training	End Date (Month/Year) End date of training	

Post-Graduate Education ☐ Internship ☐ Fellowship ☐ Residency ☐ Teaching Appointment (internship information should be filled in first or if no internship then residency)	Institution Name Name of facility where provider received training		
Street# & Name of where training was provider	City Training City	State Training State	Zip Code Training Zip
Specialty Training Specialty	Start Date (Month/Year) Start date of training	End Date (Month/Year) End date of training	

If you completed additional training, please submit an attachment containing the above information and check this box: ☐

Other Graduate Level Education for which a Degree was obtained - type of program (Psychology, Public Health, MBA, etc.) Other education obtained higher than college degree	Institution Name Name of School where graduate education was obtained		
Address Graduate Education School Street# & Name	City Graduate School City	State School State	Zip Code School Zip
Degree Obtained List Degree Obtained	Date of Graduation (Month/Year) Graduation Date		

Professional/Medical Specialty Information

Primary Specialty (Primary Specialty that provider will be rendering services)	Board Certified? ☐ Yes ☐ No (Complete next sections if provider is board certified)	Name of Certifying Board Name of the Board issuing board certificate
Initial Certification Date Initial Date Board certification was issued	Recertification Date(s) *(if applicable)* Date Board certification was recertified	Expiration Date *(if applicable)* Board Certificate expiration date

If not Board Certified, indicate any of the following that apply: (COMPLETE IF PROVIDER IS ONLY BOARD ELIGIBLE IN PRIMARY SPECIALTY)

☐ I have taken exam, results pending for: _____ (board)

☐ I am intending to sit for the Boards on: _____ (date)

☐ I am not planning to take the Boards. Explanation: _____

Secondary Specialty (Secondary Specialty that provider will be rendering services)	Board Certified? ☐ Yes ☐ No (Complete next sections if provider is board certified in 2nd specialty)	Name of Certifying Board Name of the Board issuing Secondary board certificate
Initial Certification Date (Initial Date Secondary Board certification was issued)	Recert. Date(s) *(if applicable)*(Month/Year) Date Secondary Board certification was recertified	Expiration Date *(if applicable)* (Month/Year) Secondary Board Certificate expiration date

If not Board Certified, indicate any of the following that apply: (COMPLETE IF PROVIDER IS ONLY BOARD ELIGIBLE IN SECONDARY SPECIALTY)

☐ I have taken exam, results pending for: _____ (board)

☐ I am intending to sit for the Boards on: _____ (date)

☐ I am not planning to take the Boards. Explanation: _____

List Additional Areas of Professional/Practice, Interest or Focus (HIV/AIDS, etc.):
List areas of special interests that would allow patients to identify the provider

Certifications

If you hold the following certifications, provide expiration dates.

Basic Life Support (BLS)	☐ Yes	☐ No	Expiration Date: _____
Advanced Cardiac Life Support (ACLS)	☐ Yes	☐ No	Expiration Date: _____
Advanced Life Support in OB (ALSO)	☐ Yes	☐ No	Expiration Date: _____
Pediatric Advanced Life Support (PALS)	☐ Yes	☐ No	Expiration Date: _____
Cardio-Pulmonary Resuscitation (CPR)	☐ Yes	☐ No	Expiration Date: _____

Certification section that needs to be documented in provider's file as active or inactive

Hospital Affiliations and Privileges

Do you have hospital privileges? ☐ Yes ☐ No ☐ Pending (Applied) Does the provider have hospital privileges or have applied	If you do not admit patients, what admitting arrangements do you have? Name of covering provider. If provider does not have current admitting privileges, list the name of another provider within the group with the same specialty that will provide admitting hospital coverage, the provider must have FULL/ADMITTING hospital privileges where the new provider will be acquiring privileges

If you have privileges, please complete the section below. Include all hospitals where you have privileges.

Primary Hospital where you have admitting privileges If provider has privileges indicate Primary Hospital		Telephone Number Primary Hospital Phone#	
Address Hospital Street# & Name	City Primary Hospital City	State Primary Hospital State	Zip Code Primary Hospital Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No Indicate if privileges are full	Type of Privileges State if privileges are Active, Associate, Courtesy	Are Privileges Temporary? ☐ Yes ☐ No State if privileges are temporary	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital? If known what percentage is provider's hosp work
Other Hospital where you have privileges List secondary Hospital Name, if applicable		Telephone Number Secondary Hospital Phone#	
Address Secondary Hosp Street# & Name	City Secondary Hospital City	State Secondary Hospital State	Zip Code Secondary Hospital Zip Code
Full Unrestricted Privileges ☐ Yes ☐ No Indicate if privileges are full	Type of Privileges State if privileges are Active, Associate, Courtesy	Are Privileges Temporary? ☐ Yes ☐ No State if privileges are temporary	Of the total admissions to all hospitals in the past year, what percentage is to this specific hospital? If known what percentage is provider's hosp work

If you have additional hospital affiliations, please submit an attachment containing the above information and check this box: ☐

List all other hospitals where you have or are applying for privileges.

Hospital Name (Secondary) Follow the same format as above for any other hospital where privileges have been acquired in the past or currently applied			Dates of Affiliation (Month/Year)
Address	City	State	Zip Code
Hospital Name (Tertiary)			Dates of Affiliation (Month/Year)
Address	City	State	Zip Code

If you have additional hospital affiliations, please submit an attachment containing the above information and check this box: ☐

References

Please provide three professional references that are not partners in your own group practice and are not relatives.

Name & Phone Number (List 3 Names & Phone Number for references who are NOT affiliated with the RowanSOM group that the provider is joining)	Street Address City, State, Zip Code (List the Reference's full address, including state, city & zip code)

Work History			
Include chronological work history since completion of training.			
Practice/Employer Name Always Start with RowanSOM group that provider is joining		Start Date/End Date (Month/Year) Start date with RowanSOM	
Address RowanSOM group's Street# & Street Name (SAME AS Primary Address on New Provider Notification form)	City City	State State	Zip Code Zip Code
Practice/Employer Name List all employment history from the time provider finished medical training		Start Date/End Date (Month/Year) List date by month/year format	
Address Give employer's Street# & Street Name	City Employer's City	State State	Zip Code Zip Code
Practice/Employer Name Continue the same format as above until the end of medical training		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code
Practice/Employer Name		Start Date/End Date (Month/Year)	
Address	City	State	Zip Code

For additional work history, please submit an attachment containing the above information and check this box: ☐

Please provide an explanation of any gaps greater than six months in each work history.	
Start Date/End Date (Month/Year) List Date by month/year format	Explanation Give some explanation for GAP
Start Date/End Date (Month/Year) Follow the same format as above	Explanation
Start Date/End Date (Month/Year)	Explanation
Are you currently on active military duty or on military reserve? State whether in active military reserve ☐ Yes ☐ No	

Professional Liability Insurance Coverage History (10-year History)

Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Give the Insurance Carrier's Name in chronological order that was in effective before joining RowanSOM & state whether it's a self-insured policy		Telephone Number Insurance Carrier Phone#	Effective Date Insurance Carrier Effective Date	Expiration Date Insurance Carrier Expiration Date
Address Insurance Carrier's Street# & Street Address		City Insurance Carrier's City	State State	Zip Code Zip Code
Policy Number Insurance Carrier's Policy#	Amount of Coverage Per Occurrence $$ of Occurrence Coverage	Amount of Coverage Aggregate $$ of Aggregate Coverage	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier (give retro start date with insurance)
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Follow the same format as above for at least 10 yrs of history		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Follow the same format as above for at least 10 yrs of history		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Follow the same format as above for at least 10 yrs of history		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Follow the same format as above for at least 10 yrs of history		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier
Name of Previous Malpractice Insurance Carrier or Self-Insured Entity Follow the same format as above for at least 10 yrs of history		Telephone Number	Effective Date	Expiration Date
Address		City	State	Zip Code
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier

ROWAN UNIVERSITY
School of Osteopathic Medicine

MANAGED CARE ENROLLMENT PACKET CHECKLIST

THE FOLLOWING ITEMS *MUST* BE INCLUDED WITH ENROLLMENT PACKET:

- ☐ NJ MEDICAL LICENSE (IF APPLICABLE, PA LICENSE) (MUST provider current/active copy NJ & PA license)
- ☐ DEA LICENSE (MUST HAVE NJ ADDRESS DISPLAYED ON LICENSE) (MUST provide current/active copy of NJ DEA license with a NJ address displayed since the insurance carrier will not accept with an out of state address)
- ☐ CDS LICENSE (MUST provide current/active NJ CDS license)
- ☐ MEDICAL SCHOOL DIPLOMA (MUST provide a copy of medical school diploma)
- ☐ INTERNSHIP CERTIFICATE (Must provide internship certificate or combined intern/resident certificate)
- ☐ RESIDENCY CERTIFICATE (MUST provide resident certificate or combined intern/resident certificate)
- ☐ FELLOWSHIP CERTIFICATE (IF APPLICABLE) (MUST provide fellowship certificate if applicable)
- ☐ ECFMG CERTIFICATE (IF APPLICABLE) (MUST provide ECFMG certificate for out of the country graduate)
- ☐ BOARD CERTIFICATE (IF NOT BOARD CERTIFIED SEND BOARD ELIGIBILITY LETTER) (MUST provide board certificate for specialty or board eligibility letter stating that the provider is qualified to pursue board certification)
- ☐ RowanSOM MALPRACTICE COVERAGE LETTER (EFFECTIVE DATE SHOULD BE THE DATE OF HIRE) (MUST provide RowanSOM malpractice facesheet with Start Date as the effective date & current rolling expiration year)
- ☐ MALPRACTICE CLAIMS HISTORY REPORT FOR THE PAST 10 YEARS FOR SETTLED OR PENDING CLAIMS (MUST provide any SETTLED OR PENDING claims history for the past 10 years)
- ☐ HOSPITAL PRIVILEGES LETTER(S)
  - If physician has applied for privileges, indicate hospital name: Indicate if Provider has applied for hospital privileges & if yes where has the provider applied to
  - If provider will not acquire hospital privileges, indicate name of covering physician Indicate if Provider will not acquire hospital privileges, must indicate covering physician's name that will sign "Covering Arrangement"
- ☐ CURRENT CV– UNIVERSITY FORMAT (Provide current updated CV with RowanSOM group information displayed)
- ☐ NPI ID#, NPI USER NAME AND PASSWORD If NPI User Name and Password are unknown, the PROVIDER ONLY, must call the NPPES Customer Service at 800-465-3203 or via email at customerservice@npienumator.com & retrieve the log-on info)
- ☐ CAQH ID#, CAQH USER NAME AND PASSWORD If CAQH ID#, User Name and Password are unknown the PROVIDER ONLY must call CAQH Help Desk at 888-599-1771 or email at providerhelp@proview.caqh.org to retrieve the log-on info)
- ☐ SOCIAL SECURITY CARD – (Social Security Card for our files & Medicaid enrollment)
- ☐ DRIVER'S LICENSE - (Driver's License for our files for need of identification)
- ☐ PROVIDER NOTIFICATION FORM - (Form to be completed & signed by Business Administrator, needs to be included with enrollment packet since it provides vital information needed for enrollment paperwork)

SECTION 2 - DISCLOSURE QUESTIONS

Licensure (PROVIDER TO ANSWER QUESTIONS 1-26 & PROVIDE EXPLANATION FOR ANY "YES" ANSWERS)

1. Has your license, registration or certification to practice in your profession ever been voluntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? ☐ Yes ☐ No

2. Has there been a challenge to your licensure, registration or certification? ☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ Yes ☐ No

4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ☐ Yes ☐ No

5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ Yes ☐ No

Education, Training and Board Certification

6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? ☐ Yes ☐ No

7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No

8. Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No

9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No

DEA or CDS Certification/Authorization

10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? ☐ Yes ☐ No

Medicare, Medicaid or Other Governmental Program Participation

11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No

Other Sanctions or Investigations

12. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No

13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No

14.	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	☐ Yes	☐ No
15.	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?	☐ Yes	☐ No
16.	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?	☐ Yes	☐ No

Professional Liability Insurance Information and Claims History

17.	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	☐ Yes	☐ No
18.	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	☐ Yes	☐ No

Malpractice Claims History

19.	Have you ever had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case on the attached form located at the end of the Disclosure questions (list all separately).	☐ Yes	☐ No

For any malpractice actions, please complete addendum and check this box: ☐

(If answered "YES" MUST provide a claim history report form that is followed)

Criminal/Civil History
(Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all relevant circumstances, including the nature of the crime.)

20.	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	☐ Yes	☐ No
21.	In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	☐ Yes	☐ No
22.	Have you ever been court-martialed for actions related to your duties as a medical professional?	☐ Yes	☐ No

Ability to Perform Job

23.	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	☐ Yes	☐ No
24.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ Yes	☐ No
25.	Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?	☐ Yes	☐ No
26.	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	☐ Yes	☐ No

Adverse Legal Actions/Convictions (MUST 1 COMPLETE FOR EVERY MALPRACTICE CASE WITHIN THE LAST 10 YEARS WHETHER OPENED OR CLOSED)

1. Have you, under any current or former name or business identity, ever had an adverse legal action listed on this application imposed against you? ..... ☐ Yes ☐ No
2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PROVIDER'S INITIALS _____

Malpractice Actions Addendum (make necessary copies for each case).
Please provide an explanation for every case in the past 10 years.

Date of Occurrence:	
Date Claim Filed:	
Claim Settlement Date, if applicable:	
Claim Status: If case is pending, select	Open ☐ Closed ☐
Insurance Carrier involved:	
Address (city and state):	
Telephone Number:	
Policy Number:	
Settlement Amount:	
Resolution Method:	Arbitration ☐ Dismissal ☐ Judgment for Defendant ☐ Judgment for Plaintiff ☐ Mediation ☐ Settled ☐

Description of allegations:

Were you the primary defendant?	☐ Yes ☐ No
Number of other co-defendants:	
Your involvement in the case:	
Description of alleged injury to patient:	

Did the alleged injury result in death? ☐ Yes ☐ No

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

PROVIDER'S INITIALS _____ **DATE** _____

Malpractice Actions Addendum (make necessary copies for each case). (FOLLOWED SAME INSTRUCTIONS AS ABOVE) Please provide an explanation for every case in the past 10 years.	
Date of Occurrence:	
Date Claim Filed:	
Claim Settlement Date, if applicable:	
Claim Status: If case is pending, select Open	Open ☐ Closed ☐
Insurance Carrier involved:	
Address (city and state):	
Telephone Number:	
Policy Number:	
Settlement Amount:	
Resolution Method:	Arbitration ☐ Dismissal ☐ Judgment for Defendant ☐ Judgment for Plaintiff ☐ Mediation ☐ Settled ☐

Description of allegations:

Were you the primary defendant?	☐ Yes ☐ No
Number of other co-defendants:	
Your involvement in the case:	
Description of alleged injury to patient:	
Did the alleged injury result in death?	☐ Yes ☐ No
To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)?	☐Yes ☐No
PROVIDER'S INITIALS _____ **DATE** _____	

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's 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 the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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 clinical privileges or contract with me as a provider of services. I understand that my application for 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 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 Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups 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 information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for 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 Participation or had 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 Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

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 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. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for 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 of this irrevocable authorization. I understand that my failure to promptly provide another consent 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 Participation at or with the Entity. 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 current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or r _____ . This _____ that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.
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Signature* **Provider's Signature Above**

Name (print)* **Provider's Printed Name Above**

M M D D Y Y Y Y

DATE SIGNED*

SECTION 3 - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at UMDNJ-SOM FPP University Doctors to which you are applying (hereinafter, individually referred to as the "Entity"), and any of the Entity's 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 the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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 clinical privileges or contract with me as a provider of services. I understand that my application for 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.

Authorizations

Investigation Concerning Application for Participation: I hereby 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 Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups 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 information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for 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.

Release and Exchange of Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had 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 Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Provider Initials: PROVIDER'S INITIALS Date: _____

Releases

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.

Provider Initials: PROVIDER'S INITIALS Date: _____

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. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for 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. I understand that my failure to promptly provide another consent 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 Participation at or with the Entity. 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.

Attestation

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. I understand that corrections to the application are permitted at any time prior to a determination of 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 the information provided on this application may be shared with appropriate State and federal agencies.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further understand and agree that submitting false, misleading or incomplete information may result in the imposition of administrative, civil and/or criminal sanctions, in accordance with State and federal law.

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 (Print or Type) PROVIDER'S PRINTED FULL NAME	Social Security Number PROVIDER'S SS#
Signature PROVIDER'S SIGNATURE	Date