CREDENTIALING APPLICATION FOR CLINICAL FACULTY APPOINTMENT

CMU CENTRAL MICHIGAN UNIVERSITY | College of Medicine

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Return all completed applications to: Faculty & Staff Affairs | CMED South, 2520 S. University Park Drive, Bldg D., Mount Pleasant, MI 48859

If a particular field is not applicable to you, please indicate with "N/A".

SECTION 1 – DEMOGRAPHICS

APPLICANT INFORMATION							
Last Name		First		M.I.		Degree(s)	
Other names used							
Street Address				Apartment/Unit #			
City		State		ZIP			
Telephone Number		E-mail Address					
Birth Date		Birth Place					
Languages		Social Security No.					
Specialty		Sub Specialties					
OFFICE INFORMATION							
Name of Practice/Affiliation or Clinic Name:		Department Name					
Primary Office Street Address							
City		State		ZIP			
Office Manager		Telephone Number		Fax Number			

SECTION 2 - EMPLOYMENT

WORK HISTORY/INSTITUTIONAL AFFILIATIONS (Attach additional sheet if necessary)							
This section must be completed. Chronologically list all work history activities and institutional affiliations since completion of professional education (use extra sheets if necessary). Include all employment and affiliations with hospitals, other corporations, the military, or governmental agencies. Account for all periods of time between the date of medical/professional school graduation to the present, including dates, activity, and names where applicable.							
Employer/Hospital/ Institution/Practice				Contact Person			
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							

Employer/Hospital/ Institution/Practice						Contact Person	
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							
Employer/Hospital/ Institution/Practice						Contact Person	
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							
Employer/Hospital/ Institution/Practice						Contact Person	
Department/Specialty				Staff Category (Hospital)			
From (MM/YYYY)		To (MM/YYYY)		Telephone Number		Fax Number	
Address (street, city, state, zip code)							
Reason For Leaving:							

TIME INTERVALS

Please account for all periods of time between date of medical/professional school graduation to present not covered elsewhere in this application. Include dates, activity and names where applicable (use extra sheets if necessary).

Suspended from Practice	From (MM/YYYY)		To (MM/YYYY)	
Loss of License	From (MM/YYYY)		To (MM/YYYY)	
Served in Military	From (MM/YYYY)		To (MM/YYYY)	
Personal Leave	From (MM/YYYY)		To (MM/YYYY)	
Other (Please describe)	From (MM/YYYY)		To (MM/YYYY)	

SECTION 3 – ADDITIONAL LICENSURE/REGISTRATIONS & CERTIFICATIONS

LICENSURE

Physicians at CMU College of Medicine are responsible for obtaining the appropriate licensures to practice medicine in the State of Medicine and are also responsible for maintaining active and current licensure for patient care. Licensed status must be maintained for the duration of your appointment.

ECFMG No.	☐ or NA		
Individual BCBSM No.		HIPAA Taxonomy Codes	
National Provider Identification No. (NPI)		CHAMPS Domain Administrator/Phone Number	

OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS, etc. (Attach copy of certificate if applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

SECTION 4 – PROFESSIONAL REERENCES

PROFESSIONAL REFERENCES/LETTERS OF RECOMMENDATION

List three professional references not including relatives, your own employees, and not provided by the head or member of the department/specialty office to which you are applying. They must attest to your medical knowledge, research experience (if applicable), clinical skills and professionalism, and have been written within the last two years from your proposed start dates at the CMU College of Medicine. At least one reference must be an individual practicing in a similar field.
NOTE: References must be from individuals who, through recent observation, are directly familiar with your work. ***References for CMU Medical Education Partners trained applicants cannot be from the director of the program for which they are applying.***

Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number
Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number
Name	Title	Telephone Number
Address (street, city, state, zip code)		Fax Number

SECTION 5 – PROFESSIONAL LIABILITY

PROFESSIONAL LIABILITY CARRIER INFORMATION

Does your current professional liability insurance cover you in all of your practice locations? ☐ YES ☐ NO

Current Insurance Carrier		Policy No.
Address (street, city, state, zip code)		Telephone Number
Coverage Amount (Claim/Aggregate)	Type of Coverage	Exclusions from Coverage
Initial Date of Coverage	Retroactive Date of Coverage	Expiration Date

Please list all of your professional liability carriers for the **<u>past ten years</u>** (include internship, residency, fellowship programs).

Name of Carrier					Policy No.
Address (street, city, state, zip code)					
Telephone Number		From		To	
Name of Carrier					Policy No.
Address (street, city, state, zip code)					

Telephone Number		From		To	
Name of Carrier			Policy No.		
Address (street, city, state, zip code)					
Telephone Number		From		To	

SECTION 6 – ATTESTATION QUESTIONS

Please answer the questions "yes" or "no". **If your answer to any of the questions 2-17 is "yes", please provide full details and reasons on a separate sheet.**

An affirmative answer to any of these questions does not automatically disqualify you from an appointment at the CMU College of Medicine but may result in further follow-up or investigation for credentialing purposes.

NOTE: All information is for credentialing purposes only. Information will remain confidential and will not be shared.

1)	Are you currently able, with or without reasonable accommodation, to perform delineated clinical activities and other staff duties?	☐ YES ☐ NO
2)	Do you have or have you ever had any license revoked, suspended, denied, restricted, limited or issued/placed in a probationary status or voluntarily relinquished?	☐ YES ☐ NO
3)	Have you ever had a DEA Certificate revoked, suspended, limited, restricted in any way or voluntarily relinquished?	☐ YES ☐ NO
4)	Have you ever voluntarily not renewed your DEA license, Medical or Dentistry License in any state?	☐ YES ☐ NO
5)	Have you ever been terminated, placed on probation or otherwise disciplined from a residency program or medical staff?	☐ YES ☐ NO
6)	Have your privileges at any hospital ever been refused, suspended, diminished, revoked or not renewed?	☐ YES ☐ NO
7)	Have you ever voluntarily withdrawn your privileges or resigned from any hospital or training program?	☐ YES ☐ NO
8)	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?	☐ YES ☐ NO
9)	Have you ever been named in a malpractice case?	☐ YES ☐ NO
10)	Are you now, or have you ever been, involved in Administrative, professional, or judicial proceedings in which malpractice on your part is or was alleged? **If "yes", please provide full details and information on a separate sheet**	☐ YES ☐ NO
11)	Have you ever been subject to disciplinary action for academic or other reason in any of the colleges, universities, graduate or professional schools you have attended?	☐ YES ☐ NO
12)	Have you ever been convicted of a crime other than minor traffic violations?	☐ YES ☐ NO
13)	Have you ever been convicted of a felony?	☐ YES ☐ NO
14)	Are you aware of any criminal charges pending or expected to be brought against you?	☐ YES ☐ NO
15)	Do you have any contagious or communicable diseases that could endanger others?	☐ YES ☐ NO

16)	Have you ever been addicted to or dependent upon intoxicating liquor, narcotics or other illegal drug substances?	☐ YES ☐ NO
	a) Has this addiction ever permanently, presently or chronically impaired or distorted your judgment, behavior, or capacity to recognize reality or ability to cope with the ordinary demands of life?	☐ YES ☐ NO
17)	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student or home mortgage loans).	☐ YES ☐ NO

I certify that the information submitted on this application is complete and correct to the best of my knowledge. I understand that any false, misleading or missing information may be cause for withdrawal of the preliminary appointment.

Signature _____ Date: _____

Printed Name _____