GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

Please contact the Hospital, Health Plan or other Healthcare Organization, hereinafter "Healthcare Entity(ies)", to which you are applying for instructions on how to proceed. The Healthcare Entity may not have adopted this form for use and/or may require a pre-application prior to submitting this form.

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

Part One is standardized for Healthcare Entity(ies), and contains identical questions that Healthcare Entities need to ask as a part of their credentialing processes. Part One is available on the Georgia Uniform Healthcare Practitioner Credentialing Application Form (UHPCAF) web site at www.georgiacredentialing.org.

Part Two for health plans is standardized and contains additional identical questions that health plans need to ask as part of their credentialing processes and, is also available at www.georgiacredentialing.org.

Part Two for hospitals contains additional, customized or more specific questions as part of their credentialing and privileging processes.

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 ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

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 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 an entire section does not apply to you, then please check the box provided at the top of the section. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Professional Training"), it is not necessary to mark "N/A" in each unneeded answer blank.
- Unless *specifically permitted* by a particular question, please understand that a reference to "See CV or resume" for an answer is not appropriate.
- **If more space than is provided on this Application 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 has been completed in its entirety but *before* you sign and date it or fill in the information on page **ii**, make a copy of the Application to retain in your files and/or computer for future use.
  In so doing, at the time of a submission to another Healthcare Entity, all you will need to do is to check to ensure that all the information remains complete, current and accurate before completing page **ii** and signing and forwarding the Application as needed.
- Any gaps of time greater than thirty (30) days from completion of professional school / training to the present date must be accounted for before your Application will be considered complete.
- Please sign and date the Application.
- Please sign and date Schedule A and Schedule B (as appropriate).
- Identify the Healthcare Entity to which you are submitting this Application and for what practice area(s) you are applying in the spaces provided on page **ii**.
- Mail the Application, Schedules, any Explanation Form(s) prepared in order to answer any question(s) completely, as well as a copy of all applicable enclosures listed on page **ii** to the Healthcare Entity.

GENERAL INSTRUCTIONS - continued

A current copy of the following documents must be submitted with your Application:

- One recent passport size photograph of yourself
- State Professional License(s)
- Federal Narcotics License (DEA Registration) if applicable
- Curriculum Vitae or resume with complete professional history in chronological order (month & year)
- Diplomas and/or certificates of completion from professional school
- Specialty/Subspecialty Certification or letter from certifying body stating your status (if applicable)
- Declaration Page (Face Sheet) of Professional Liability Policy or Certificate of Insurance
- Permanent Resident Card or Visa Status (if applicable)
- Military Discharge Record (Form DD-214) (if applicable)

Name of Healthcare Entity to which you are submitting this Application:
For what type of relationship (i.e., staff membership, network participation, etc.):

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

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

If more space than is provided on this 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:
Title (PhD, CRNA, PA, etc.):		
Is there any other name under which you have been known or have used (e.g. maiden name)? ☐ Yes ☐ No Name(s) and Date(s) Used:		
Home Street Address:		
City:	State:	Zip:
Home Telephone Number:	E-Mail Address:	Citizenship (if not USA, provide type and status of visa and enclose a copy)
Date of Birth:	Place of Birth:	Gender: ☐ Male ☐ Female
Social Security Number:	UPIN:	National Provider Identifier (NPI) (Type 1 Only):
Medicare Provider Number:	Georgia Medicaid Provider Number(s):	Other State Medicaid Provider Number:

Georgia License Number:	Expiration Date mm/yy:	DEA Registration #:	Expiration Date mm/yy:	Controlled Substance Registration #	Expiration Date (if applicable):

Marital Status (optional): ☐ Single ☐ Married ☐ Divorced ☐ Widow	Name of Spouse (if applicable) (optional):	Medical Specialty for Which Applying Primary: Secondary:

II. PRACTICE INFORMATION

A. NAME OF PRIMARY CLINICAL PRACTICE:	Type of Practice Setting: ☐ Solo ☐ Group/Single	Specialty: ☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other
Primary Clinical Practice Street Address:	Start Date at Location (mm/yy):	

City:	County:	State:	Zip:
Primary Office Telephone Number:	Primary Office Fax Number:	Patient Appointment Telephone Number:	
Mailing Address (if different from above):			
Name of Office Manager /Administrative Contact:	Office Manager's Telephone Number:	Office Manager's Fax Number:	
Answering Service Number:	Pager/Beeper Number :	Office E-Mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number:	Credentialing Contact's Fax Number:		
Federal Tax ID Number for this Practice Address:	Name Affiliated with Tax ID Number:		

II. PRACTICE INFORMATION - continued

Does Not Apply ☐

NAME OF SECONDARY CLINICAL PRACTICE:	Type of Practice Setting: ☐ Solo ☐ Group/Single	Specialty: ☐ Group/Multi-Specialty ☐ Hospital Based ☐ Other
Secondary Clinical Practice Street Address:	Start Date at Location (mm/yy):	

City:	County:	State:	Zip:
Answering Service Number:	Pager/Beeper Number:	Office E-Mail Address:	
Federal Tax ID Number for this Practice Address:	Name Affiliated with Tax ID Number:		

B. OTHER OFFICES: ***Please list any other current office locations with the above information on Explanation Form(s).***

C. BILLING ADDRESS: If different than primary clinical site address, please provide complete billing address:

Name of Office Manager/Administrative Contact:	Office Phone Number:	Office Fax Number:

D. INTENTION: If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice.

E. CORRESPONDENCE: To what address would you like all correspondence forwarded?
☐ Primary Office ☒ Secondary Office ☐ Billing Office ☐ Home ☐ Other (Please specify)

F. LANGUAGES:
1. Please list any language other than English (including sign language) in which you are fluent:
2. Please list any language other than English (including sign language) in which a member of your staff is fluent and identify staff member:

III. CERTIFICATION

Does Not Apply ☐

Are you certified by any board in your profession? ☐ YES ☐ NO ***List all current and past board certifications.***

Name of Issuing Board	Specialty	Date Certified (mm/yy):	Date Recertified (mm/yy):	Date Recertified (mm/yy):	Expiration Date (if any) (mm/yy):
		/	/	/	/
		/	/	/	/
		/	/	/	/

Please answer the following questions. Attach Explanation Form(s), if necessary.

A.	Have you ever been examined by any certifying body, but failed to pass? If yes, please provide name 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 for the certification examination? If yes, when? Date: /	☐ YES ☐ NO
	3. If you have applied for the certification examination, have you been accepted to take the certification examination?	☐ YES ☐ NO
	4. If you have been accepted, when do you intend to take the certification examination?	Date: /
	5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s)	
C.	If you are not currently certified, is there an expiration date for admissibility? If yes, when? Date: /	☐ YES ☐ NO
D.	Have you ever had certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, 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.	Have you ever voluntarily relinquished a certification, including any voluntary non-renewal of a time limited certification? If yes, please attach Explanation Form(s).	☐ YES ☐ NO

IV. EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

A. UNDERGRADUATE or TECHNICAL SCHOOL

Complete School Name:	Degree(s) Received:	Graduation Date (mm/yy): /
City:	State/Country:	Course of Study or Major:

B. POST GRADUATE DEGREES

Does Not Apply ☐

Complete School Name:	Degree(s) Received:	Graduation Date (mm/yy): /
City:	State/Country:	Course of Study or Major:

C. PROFESSIONAL TRAINING

Medical / Professional School Name and Street Address:

City:	State/Country:	Zip:

From (mm/yy): /	To (mm/yy): /	Date of Completion (mm/yy): /	Degree(s) Received:

Did you complete the program? ☐ Yes ☐ No (If you did not complete the program, please attach Explanation Form(s)

Medical / Professional School Name and Street Address:

City:	State/Country:	Zip:

From (mm/yy): /	To (mm/yy): /	Date of Completion (mm/yy): /	Degree(s) Received:

Did you complete the program? ☐ Yes ☐ No (If you did not complete the program, please attach Explanation Form(s)

D. FACULTY POSITIONS *List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments.*

Does Not Apply ☐

Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy): /	To (mm/yy): /		
Program Specialty & Institution:	Academic Rank or Title:		
Institution Name & Address:	City:	State/Country:	Zip:
From (mm/yy): /	To (mm/yy): /		

E. MILITARY/PUBLIC HEALTH SERVICE

Does Not Apply ☐

Location of Last Duty Station:

Rank at Discharge:	Branch:	Active Duty Dates: From (mm/yy) /	Active Duty Dates: To (mm/yy) /

Honorable Discharge: ☐ Yes ☐ No If no, attach Explanation Form(s).

Are you currently in the Reserves or National Guard? ☐ Yes ☐ No

Have you ever been court-martialed? ☐ Yes ☐ No If yes, attach Explanation Form(s).

Attach a copy of DD-214 Form.

F. SPONSORSHIP INFORMATION

Does Not Apply ☐

Please name your primary sponsoring physician:

Address:

Phone Number:	Fax Number:

V. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Does Not Apply ☐

Please include all ever held. If more room is needed please list on an attached Explanation Form.

Type and Status:	Number:	State/Country:	Expiration Date (mm/yy): /
Year Obtained:	Year Relinquished:	Reason:	
Type and Status:	Number:	State/Country:	Expiration Date (mm/yy): /
Year Obtained:	Year Relinquished:	Reason:	

VI. CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Please list in reverse chronological order with the current affiliation(s) first: *(A) current hospital affiliations, (B) hospital applications in process, (C) previous hospital affiliations and (D) other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities).* ***Do not list residencies, internships or fellowships. Please list all employment in Section VII.***

A. CURRENT HOSPITAL AFFILIATIONS

Does Not Apply ☐

Primary Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy): /	
Facility Name:		Complete Address:
Department/Status (e.g. active, courtesy, provisional, etc.):	Appointment Date (mm/yy): /	

B. OTHER FACILITY AFFILIATIONS *Please list all current affiliations with other facilities.*

Does Not Apply ☐

Facility Name:		Complete Address:
From (mm/yy): /	To (mm/yy): /	
Reason for Leaving:		

VII. PROFESSIONAL PRACTICE / WORK HISTORY

A curriculum vitae or resume is not sufficient for a complete answer to these questions.

Does Not Apply ☐

Please list in reverse chronological order all work and professional and practice history activities not detailed under Section II, IV or VI. Include any previous office addresses and any military experience. **Explain below any gaps greater than thirty (30) days.**

Name of Current Practice / Employer:		
Contact Name:		Complete Address:
Telephone Number: ( ) -		
From (mm/yy): /	To (mm/yy): /	
Name of Previous Practice / Employer:		
Contact Name:		Complete Address:
Telephone Number: ( ) -		
From (mm/yy): /	To (mm/yy): /	
Name of Previous Practice / Employer:		
Contact Name:		Complete Address:
Telephone Number: ( ) -		
From (mm/yy): /	To (mm/yy): /	

VIII. PROFESSIONAL PRACTICE / WORK HISTORY - continued

If your training, practice, military or work experience has been interrupted for more than thirty (30) days by, for example, illness, injury or family medical leave, then please explain below any such gap since completing medical school.	Does Not Apply ☐

Explanation of Interruption:	From (mm/yy):	To (mm/yy):
	/	/
	/	/
	/	/

IX. PROFESSIONAL REFERENCES

Please list three (3) references, from licensed professional peers who through recent observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. At least one reference must be a practitioner in your same professional discipline. **(Please refer to Part Two of this Application for any additional specific reference requirements.)**

Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	
Name of Reference:		Complete Address:
Specialty:		
Dates of Association: / - /		
Telephone Number: ( ) -	Fax Number: ( ) -	

X. 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 <u>within the last ten years</u>, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not on an Explanation Form of the Application.

NOTE: IF YOU ARE COVERED BY A MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM THAT IS A CLAIMS MADE POLICY, YOU ARE REQUIRED TO SHOW EVIDENCE OF PURCHASE OF CURRENT REPORTING ENDORSEMENT COVERAGE (TAIL COVERAGE) OR PRIOR OCCURRENCE/ACTS COVERAGE TO COVER PREVIOUS YEARS OF PRACTICE.

X. PROFESSIONAL LIABILITY INSURANCE - continued

Please list all previous professional liability carriers within the past ten (10) years (including any carriers during medical training if within the ten year period). Does Not Apply ☐

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

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

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.**

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

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. Please make additional copies as necessary.)***

1.	Have there *ever been* any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you? ☐ Yes ☐ No
2.	Are any professional liability (i.e. malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending*? ☐ Yes ☐ No
3.	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

XI. 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? ***If the answer to this question is* "YES," *please give full explanation of the specific details on an Explanation Form and attach to the Application.*** (**Note**: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or 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 such on **an attached Explanation Form.**	☐ Yes ☐ No

XII. ATTESTATION QUESTIONS

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

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on an Explanation Form and attach to the Application.

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, have you ever 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, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity?	☐ Yes ☐ No
C.	Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending?	☐ Yes ☐ No
D.	Have you ever 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.	Have you ever 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.	Have you ever 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 ever made an adverse quality determination concerning your treatment rendered to any patient?	☐ Yes ☐ No
H.	Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?	☐ Yes ☐ No
I.	Are any criminal charges currently pending against you?	☐ Yes ☐ No
J.	Have you ever been arrested for or charged with a crime involving children?	☐ Yes ☐ No
K.	Have you ever been arrested for or charged with a sexual offense?	☐ Yes ☐ No
L.	Have you ever 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

XIII. ATTESTATION AND SIGNATURE

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

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application 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, 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 on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided in this Application should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Signature:	
Printed Name:	**Date:**

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL CREDENTIALING APPLICATION FORM

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 ALLIED HEALTHCARE PROFESSIONAL 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:

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 Application, I have the burden of producing adequate information for proper evaluation of this Application.

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. 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 (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 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 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. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

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.

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL 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 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 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 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. This Authorization and Release shall apply in connection with the evaluation and processing of this Application 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 to the following Healthcare Entity(ies):

_____

_____

_____

Schedule B

Claim of

GEORGIA UNIFORM ALLIED HEALTHCARE PROFESSIONAL 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; for recredentialing, just complete forms for the last ten (10) years. 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:**	