CredentialMyDoc Credentialing Application

Section I-Individual Information

TYPE OF PROFESSIONAL: PhD, LP

LAST NAME: Ranadheer
FIRST: Durgi
MIDDLE:
(JR., SR., ETC.): Suffix

MAIDEN NAME:
YEARS ASSOCIATED (YYYY-YYYY): MM/DD/YYYY
MM/DD/YYYY

OTHER NAME:
YEARS ASSOCIATED (YYYY-YYYY)
MM/DD/YYYY
MM/DD/YYYY

HOME MAILING ADDRESS: Hyderabad | LB Nagar

CITY: Hyderabad
STATE/COUNTRY: Telangana
POSTAL CODE: 54@564

HOME PHONE NUMBER: 286218

SOCIAL SECURITY NUMBER: 222

GENDER: Male

CORRESPONDENCE ADDRESS:

CITY:
STATE/COUNTRY: Select State
POSTAL CODE:

PHONE NUMBER:

FAX NUMBER:

E-MAIL: dranadheer@gmail.com

DATE OF BIRTH (MM/DD/YYYY): 12/02/2026

PLACE OF BIRTH: Nizamabad
Telangana

CITIZENSHIP:

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS:

ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? (•) Yes ( ) No

CAQH ID:
USERNAME:
PASSWORD:

U.S.MILITARY SERVICE/PUBLIC HEALTH (•) Yes ( ) No

DATES OF SERVICE (MM/DD/YYYY) TO (MM/D /YYYY)
12/05/2017
12/02/2020

LAST LOCATION: New Jersey

BRANCH OF SERVICE: Mexico

ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ( ) Yes (•) No

Education

[ ] Does Not Apply

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)
Issuing Institution:

ADDRESS:

CITY

STATE/COUNTRY Select State

POSTAL CODE

DEGREE Select Degree

ATTENDANCE DATES(MM/YYYY TO MM/YYYY)
MM/DD/YYYY MM/DD/YYYY

POST-GRADUATE EDUCATION
◉ Internship ○ Residency ○ Fellowship ○ Teaching Appointment

SPECIALTY
Select SPECIALTY

INSTITUTION

ADDRESS Address Address

CITY

STATE/COUNTRY Select State

POSTAL CODE

☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
MM/DD/YYYY MM/DD/YYYY

PROGRAM DIRECTOR

CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION
○ Internship ○ Residency ○ Fellowship ○ Teaching Appointment

SPECIALTY
Select SPECIALTY

INSTITUTION

ADDRESS

CITY

STATE/COUNTRY Select State

POSTAL CODE

POST-GRADUATE EDUCATION
☐ Program successfully completed

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
MM/DD/YYYY MM/DD/YYYY

PROGRAM DIRECTOR

CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER GRADUATE-LEVEL EDUCATION
Issuing Institution:

ADDRESS

CITY

STATE/COUNTRY Select State

POSTAL CODE

DEGREE Select Degree

ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
MM/DD/YYYY MM/DD/YYYY

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
4-Wheeler	00004	Telangana
ORIGINAL DATE OF ISSUE (MM/DD/YYYY) 12/07/2022	EXPIRATION DATE (MM/DD/YYYY) 12/03/2025	DO YOU CURRENTLY PRACTICE IN THIS STATE? ○ Yes ○ No I have not obtained Licensure yet ☐
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION

		Select State
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ○ Yes ○ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION Select State
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ○ Yes ○ No
○ DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY) MM/DD/YYYY
○ CDS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY) MM/DD/YYYY	EXPIRATION DATE (MM/DD/YYYY) MM/DD/YYYY
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION Select State
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY) MM/DD/YYYY	DO YOU CURRENTLY PRACTICE IN THIS STATE? ○ Yes ○ No
UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)	
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ○ Yes ○ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ○ Yes ○ No Medicaid Provider Number:	
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ○ N/A ○ Yes ○ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY) MM/DD/YYYY	

Professional/Specialty Information

☐ Does Not Apply

PRIMARY SPECIALTY ABO+G	**BOARD CERTIFIED?** ○ Yes ◉ No Name of Certifying Board: Select CERTIFICATION

INITIAL CERTIFICATION DATE (MM/YYYY) 12/07/2022	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY) MM/DD/YYYY	EXPIRATION DATE, IF APPLICABLE (MM/YYYY) MM/DD/YYYY

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ **I have taken exam, results pending for Board**

☐ **I have taken Part I and am eligible for Part II of the Exam.**

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

☐ **I am not planning to take Boards**

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO: ○ **Yes** ○ **No**

PPO: ○ **Yes** ○ **No**

POS: ○ **Yes** ○ **No**

SECONDARY SPECIALTY Select SPECIALTY	**BOARD CERTIFIED?** ○ Yes ○ No Name of Certifying Board: SELECT CERTIFICATION

INITIAL CERTIFICATION DATE (MM/YYYY) MM/DD/YYYY	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY) MM/DD/YYYY	EXPIRATION DATE, IF APPLICABLE (MM/YYYY) MM/DD/YYYY

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ **I have taken exam, results pending for Board**

☐ **I have taken Part I and am eligible for Part II of the Exam.**

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

☐ **I am not planning to take Boards**

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ○ **Yes** ○ **No**
PPO: ○ **Yes** ○ **No**
POS: ○ **Yes** ○ **No**

ADDITIONAL SPECIALTY
Select SPECIALTY

BOARD CERTIFIED? ○ Yes ○ No
Name of Certifying Board:
SELECT CERTIFICATION

INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.
☐ **I have taken exam, results pending for Board**
☐ **I have taken Part I and am eligible for Part II of the Exam.**
☐ **I am intending to sit for the Boards on (date)**
☐ **I am not planning to take Boards**

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ○ **Yes** ○ **No**
PPO: ○ **Yes** ○ **No**
POS: ○ **Yes** ○ **No**

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History.- Please provide a chronological work history. You may submit a Cu rriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months

☐ Does Not Apply

CURRENT PRACTICE/EMPLOYER NAME Rana Durgi

START DATE/END DATE (MM/YYYY TO MM/YYYY)
12/23/2022
11/22/2025

ADDRESS Three Cube Towers Hietc city

CITY
Hyderabad

STATE/COUNTRY
Telangana

POSTAL CODE
500505

PREVIOUS PRACTICE/EMPLOYER NAME

START DATE/END DATE (MM/YYYY TO MM/YYYY)
MM/DD/YYYY
MM/DD/YYYY

ADDRESS Address 1 Address 2

CITY
City

STATE/COUNTRY
India

POSTAL CODE
Zip

REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME

START DATE/END DATE (MM/YYYY TO MM/YYYY)
MM/DD/YYYY
MM/DD/YYYY

ADDRESS Address 1 Address 2

CITY

City

STATE/COUNTRY

India

POSTAL CODE

Zip

REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME

START DATE/END DATE (MM/YYYY TO MM/YYYY)

MM/DD/YYYY

MM/DD/YYYY

ADDRESS Address 1 Address 2

CITY

City

STATE/COUNTRY

Select State

POSTAL CODE

Zip

REASON FOR DISCONTINUANCE

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YY YY TO MM/YYYY) IN WORK HISTORY.

Gap Dates: MM/DD/YYYY MM/DD/YYYY

Explanation:

Gap Dates: MM/DD/YYYY MM/DD/YYYY

Explanation:

Gap Dates: MM/DD/YYYY MM/DD/YYYY

Explanation:

Gap Dates: MM/DD/YYYY MM/DD/YYYY

Explanation:

Hospital Affiliations-Please include all hospitals where you currently have or have previously had privileges.

Does Not Apply

DO YOU HAVE HOSPITAL PRIVILEGES? Yes No

IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?

PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES

Rainbow Hospital

START DATE (MM/YYYY)

12/04/2019

ADDRESS Banjara Hills Hyderabad

CITY

Hyderbad

STATE/COUNTRY

India

POSTAL CODE

501511

PHONE NUMBER

9963883545

FAX

E-MAIL

FULL UNRESTRICTED PRIVILEGES? Yes No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) Select Status

ARE PRIVILEGES TEMPORARY? Yes No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES

START DATE (MM/YYYY)

MM/DD/YYYY

ADDRESS

CITY
City

STATE/COUNTRY
India

POSTAL CODE
Zip

PHONE NUMBER

FAX

E-MAIL

FULL UNRESTRICTED PRIVILEGES? Yes No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) Select Status

ARE PRIVILEGES TEMPORARY? Yes No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES

AFFILIATION DATES (MM/YYYY TO MM/YYYY) MM/DD/YYYY
MM/DD/YYYY

ADDRESS

CITY
City

STATE/COUNTRY
India

POSTAL CODE
Zip

FULL UNRESTRICTED PRIVILEGES? Yes No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) Select Status

WERE PRIVILEGES TEMPORARY? Yes No

REASON FOR DISCONTINUANCE

References-Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.

Does Not Apply

1 NAME/TITLE Vikram
Vankylanj3@gmail.com

PHONE NUMBER 564561

FAX NUMBER

ADDRESS Hyde Roas

CITY
Sec

STATE/COUNTRY
India

POSTAL CODE
0025886485

2 NAME/TITLE Raki Raki4@gmail.com

PHONE NUMBER 564564

FAX NUMBER

ADDRESS

CITY

STATE/COUNTRY
Select State

POSTAL CODE

3 NAME/TITLE Ram | Ram@778gmail.com | PHONE NUMBER 46456565646 | FAX NUMBER

ADDRESS

CITY

STATE/COUNTRY Select State

POSTAL CODE

Professional Liability Insurance Coverage ☐ Does Not Apply

SELF-INSURED? ○ Yes ○ No | NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY dsvc

ADDRESS ac | vedsc

CITY Secund

STATE/COUNTRY India

POSTAL CODE 8484846456

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY) / EXPIRATION DATE (MM/DD/YYYY)
545664	56	09/07/2022 / 12/10/2029

AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE	LENGTH OF TIME WITH CARRIER
100K	10M	◉ Individual ○ Shared	

PREVIOUS MALPRACTICE INSURANCE ☐ Does Not Apply

NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS 894

ADDRESS Malakpet | Ammerpet

CITY Ranagareddy

STATE/COUNTRY India

POSTAL CODE 8945949

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY) / EXPIRATION DATE (MM/DD/YYYY)
	459	12/06/2013 / 12/03/2020

AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE	LENGTH OF TIME WITH CARRIER
10K	10M	○ Individual ○ Shared	

Practice Location Information - Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.

PRACTICE LOCATION

of

TYPE OF SERVICE PROVIDED ☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY | GROUP/CORPORATE NAME AS IT APPEARS

	ON IRS W-9

PRACTICE LOCATION ADDRESS: ☐ Primary

CITY

STATE/COUNTRY Select country

POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL
BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER	
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ○ Yes ○ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY) MM/DD/YYYY	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ○ Yes ○ No
OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT lastname firstname Suffix

ADDRESS Address Address

CITY City

STATE/COUNTRY Select State

POSTAL CODE Zip

PHONE NUMBER	FAX NUMBER	E-MAIL
BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE	

ADDRESS

CITY

STATE/COUNTRY Select State

POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL
DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ○ Yes ○ No

HOURS PATIENTS ARE SEEN

Monday
☐ No Office Hours
Morning
Afternoon:
Evening:

Tuesday
☐ No Office Hours
Morning
Afternoon:
Evening:

Wednesday
☐ No Office Hours
Morning

Afternoon:
Evening:
Thursday
☐ No Office Hours
Morning
Afternoon:
Evening:
Friday
☐ No Office Hours
Morning
Afternoon:
Evening:
Saturday
☐ No Office Hours
Morning
Afternoon:
Evening:
Sunday
☐ No Office Hours
Morning
Afternoon:
Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?

☐ Answering Service
☐ Voice mail with instructions to call answering service
☐ Voice mail with other instructions
☐ None

THIS PRACTICE LOCATION ACCEPTS

☐ all new patients
☐ existing patients with change of payor
☐ new patients with referral
☐ new Medicare patients
☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS

○ Male only
○ Female only
Age:
○ Other

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?

○ Yes
○ No
If yes, provide the following information for each staff member:

NAME
PROFESSIONAL DESIGNATION

STATE & LICENSE NO.

NAME
PROFESSIONAL DESIGNATION

STATE & LICENSE NO.

Section II-Disclosure Questions - Please provide an explanation for any question answered yes-except 16-on page 10.

Licensure

1	Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted,voluntarily surrendered while under investigation, or have you ever been subject to a consent order,probation or any conditions or limitations by any state licensing board?	○ Yes ◉ No
2	Have you ever received a reprimand or been fined by any state licensing board?	○ Yes ◉ No
Hospital Privileges and Other Affiliations		
3	Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution 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 records 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 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 progr am? If you are currently in a training program, have you been placed on probation, discipline d, 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 certificat ion(s) while under investigation?	○ Yes ◉ No
DEA or CDS		
10	Have your Federal DEA and/or CDS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily 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?	○ Yes ◉ No
Other Sanctions or Investigations		
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 been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	○ Yes ◉ No
15	Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital,facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	○ Yes ◉ No
Malpractice Claims History		
16	Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated , mediated or litigated?	○ Yes ◉ No
Criminal		
17	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical	○ Yes ◉ No

	professional	
18	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?	○ Yes ◉ No
19	Have you been court-martialed for actions related to your duties as a medical professional?	○ Yes ◉ No
Ability to Perform Job		
20	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to pr actice medicine. It is not limited to the day of, or within a matter of days or weeks before the d ate 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. Â§ 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 Con trolled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	○ Yes ◉ No
21	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
Ability to Perform Job		
22	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	○ Yes ◉ No
23	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	○ Yes ◉ No

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III â€“ 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 andâ„or clinical privileges (hereinafter, referred to as â€œParticipationâ€) at or with	☐ Dont Not Apply

I understand and agree that, as part of the credentialing application process for participation andâ„or clinical privileges (hereinafter, referred to as â€œParticipationâ€) at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE â€œENTITYâ€)

and any of the Entityâ€™s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training andâ„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.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

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 Entityâ€™s affiliated entities and their representatives, employees, and/or designated agents; and the Entityâ€™s designated professional credentials verification organization (collectively referred to as â€œAgentsâ€), 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.

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 partyâ€™s agents to release â€œDisciplinary Information,â€ 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, â€œDisciplinary Informationâ€ 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 additionto, 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), andâ„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 andâ„or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer andâ„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 Entityâ€™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.

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 andâ„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 any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; andâ„or immediate suspension or termination of Participation. This action may be disclosed to the Entity andâ„or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

SIGNATURE

Durgi Ranadheer	**NAME**
222	**Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)**

	DATE (MMâ„DDâ„ YYYY)