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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TXseal | | Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev.01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed. | | | | | | | | | | | | | |
| Texas Standardized Credentialing Application | | | | | | | | | | | | ***(Please type or print)*** | | | |
| Section I-Individual Information | | | | | | | | | | | | | | | |
| Type of professional | | | | | | | | | | | | | | | |
| **Physician** | | | | | | | | | | | | | | | |
| Last Name | | | | | | first | | | | middle | | | | (jr., sr., etc.) | |
| **Hamidi** | | | | | | **vala** | | | |  | | | |  | |
| Maiden name | | | | | | years associated (Yyyy-yyyy) | | | | other name | | | | years associated (yyyy-yyyy) | |
|  | | | | | |  | | | |  | | | |  | |
| home mailing address | | | | | | | | | | | | | | | |
| **202 8th Street** | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | postal code | | |
| **Brooklyn** | | | | | | | **New York USA** | | | | | | **11215** | | |
| home phone number | | | | | | | social security number | | | | | | Female | | Male |
| **Cell: (425) 922-9307** | | | | | | | **538-53-3053** | | | | | |
| **correspondence** address | | | | | | | | | | | | | | | |
| **7703 Floyd Curl Drive, Dept. of Medicine/ MC** | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | postal code | | |
| **San Antonio** | | | | | | | **Texas USA** | | | | | | **78229** | | |
| phone number | | | | | | Fax number | | | | | e-mail | | | | |
|  | | | | | |  | | | | | [**Vala14H@gmail.com**](mailto:Vala14H@gmail.com) | | | | |
| date of birth (mm/dd/yyyy) | | | | | | | place of birth | | | | | | citizenship | | |
| **09/21/1983** | | | | | | | **IRAN** | | | | | | **IRAN** | | |
| if not american citizen, visa number & status | | | | | | | | | | | | | are you eligible to work in the united states? | | |
|  | | | | | | | | | | | | | Yes | No | |
| U.s. military service/public health | | | | | | | dates of service (mm/dd/yyyy) to | | | | | | last location | | |
| Yes | No | | | | | | (mm/dd/yyyy) | |  | | | |  | | |
| branch of service | | | | | | | are you currently on active or reserve military duty? | | | | | | | | |
|  | | | | | | | Yes | No | | | | | | | |
| Education | | | | | | | | | | | | | | | |
| **professional degree** (medical, dental, chiropractic, etc.) | | | | | | | | | | | | | | | |
| Issuing Institution: | | | |  | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | |
| **Fasa University of Medical Sciences** | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | postal code | | |
| **Fasa** | | | | | | | **Fars/ Iran** | | | | | |  | | |
| degree | | | | | | | | | | attendance dates (mm/yyyy to mm/yyyy) | | | | | |
| **Doctor of Medicine** | | | | | | | | | |  | | | | | |
| Please check this box and complete and submit Attachment A if you received other professional degrees. | | | | | | | | | | | | | | | |
| post graduate education | | | | | | | | | | specialty | | | | | |
| Internship | | | Residency | | Fellowship | | Teaching Appointment | | |  | | | | | |
| Institution | | | | | | | | | | | | | | | |
| **New York Methodist Hospital** | | | | | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | |
| **506 6th street** | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | postal code | | |
| **Brooklyn** | | | | | | | **New York / United States** | | | | | | **11215** | | |
| Program successfully completed | | | | | | | | | | attendence dates (mm/yyyy to mm/yyyy) | | | | | |
| **07/11 to 06/14** | | | | | |
| program director | | | | | | | | | | current program director (if known) | | | | | |
| **Harvey Dosik** | | | | | | | | | |  | | | | | |
| post graduate education | | | | | | | | | | specialty | | | | | |
| Internship | | | Residency | | Fellowship | | Teaching Appointment | | |  | | | | | |
| Institution | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | postal code | | |
|  | | | | | | |  | | | | | |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Education - *continued* | | | | | | | | | | | | | | | | | | | | | | | |
| **Post graduate education** | | | | | | | | | | | | | | attendence dates (mm/yyyy to mm/yyyy) | | | | | | | | | |
| Program successfully completed | | | | | | | | | | | | | |  | | | | | | | | | |
| program director | | | | | | | | | | | | | | current program director (if known) | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | |
| *Please check this box and complete and submit Attachment B if you received additional postgraduate training.* | | | | | | | | | | | | | | | | | | | | | | | |
| **other graduate-level education** | | | | | | | | | | | | | | | | | | | | | | | |
| Issuing Institution: | | | **N/A** | | | | | | | | | | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | state/country | | | | | | | | | | | postal code | | | | |
|  | | | | | | | |  | | | | | | | | | | |  | | | | |
| degree | | | | | | | | | | | | | | attendance dates (mm/yyyy to mm/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 | | | | |
| **Medical License** | | | | | | | | **Will apply** | | | | | | | | | | | **Texas** | | | | |
| 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 | | | | |
| **Medical License** | | | | | | | |  | | | | | | | | | | | **Florida** | | | | |
| 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 | | | | |
|  | | | | | | | |  | | | | | | | | | | |  | | | | |
| 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) | | | | |
|  | | | | | | | | | | |  | | | | |
| DPS Number: | | |  | | | | | original date of issue (mm/dd/yyyy) | | | | | | | | | | | expiration date (mm/dd/yyyy) | | | | |
|  | | | | | | | | | | |  | | | | |
| **Other Cds** (please specify) | | | | | | | | number | | | | | | | | | | | state of registration | | | | |
|  | | | | | | | |  | | | | | | | | | | |  | | | | |
| original date of issue (mm/dd/yyyy) | | | | | | | | expiration date (mm/dd/yyyy) | | | | | | | | | | | do you currently practice in this state? | | | | |
|  | | | | | | | |  | | | | | | | | | | | Yes | | No | | |
| upin | | | | | | | | | | | | | | national provider identifier (when available) | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | |
| are you a participating medicare provider? | | | | | | | | | | | | | | are you a participating medicaid provider? | | | | | | | | | |
| Yes | | No | Medicare Provider Number: | | | | | **Applying** | | | | | | Yes | | No | | Medicaid provider number | | | | **Applying** | |
| educational council for foreign medical graduates (ecfmg) | | | | | | | | | | | | | | | | | | | ecfmg issue date (mm/dd/yyyy) | | | | |
| N/A | | Yes | | No | ECFMG Number: | | | | **-** | | | | | | | | | |  | | | | |
| Professional/Specialty Information | | | | | | | | | | | | | | | | | | | | | | | |
| primary specialty | | | | | | | | board certified? | | | | | | | | | |  | | | | | |
|  | | | | | | | | Yes | | | No | | Name of Certifying Board: | | | | |
| initial certification date (mm/yyyy) | | | | | | | | recertification date(s), if applicable (mm/yyYY) | | | | | | | | | | | expiration date, if applicable (mm/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 | | | | | | August 2014 | | | | | | | | | | | | | | | | | (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 | | | | | | | | board certified? | | | | | | | | | | | | | | | |
|  | | | | | | | | Yes | | | No | | | Name of Certifying Board: | | | | | |  | | | |
| initial certification date (mm/yyyy) | | | | | | | | recertification date(s), if applicable (mm/yYYy) | | | | | | | | | | | expiration date, if applicable (mm/yyyy) | | | | |
|  | | | | | | | |  | | | | | | | | | | |  | | | | |

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| Professional/Specialty Information *- continued* | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | board certified? | | | | | | | | | | |
| **N/A** | | | | | | | Yes | | | No | | Name of Certifying Board: | | | |  | |
| initial certification date (mm/yyyy) | | | | | | | recertification date(s), if applicable (mm/yYYy) | | | | | | | | expiration date, if applicable (mm/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 past work history. You may submit a Curriculum Vitae as*  *a supplement. Please explain all gaps in employment that lasted more than six months.* | | | | | | | | | | | | | | | | | |
| current practice/employer name | | | | | | | | | | | | | | | start date/end date (mm/yyyy to mm/yyyy) | | |
| **University of Texas Health Science Center** | | | | | | | | | | | | | | |  | | |
| address | | | | | | | | | | | | | | | | | |
| **7703 Floyd Curl Drive, Dept. of Medicine/ MC** | | | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | | | postal code | | |
| **San Antonio** | | | | | | | **Texas USA** | | | | | | | | **78229** | | |
| previous practice/employer name | | | | | | | | | | | | | | | start date/end date (mm/yyyy to mm/yyyy) | | |
| **New York Methodist Hospital** | | | | | | | | | | | | | | |  | | |
| address | | | | | | | | | | | | | | | | | |
| **506 6th street** | | | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | | | postal code | | |
| **Brooklyn** | | | | | | | **New York/ United states** | | | | | | | | **11215** | | |
| Reason for discontinuance | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| previous practice/employer name | | | | | | | | | | | | | | | start date/end date (mm/yyyy to mm/yyyy) | | |
|  | | | | | | | | | | | | | | |  | | |
| address | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | | | postal code | | |
|  | | | | | | |  | | | | | | | |  | | |
| Reason for discontinuance | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| previous practice/employer name | | | | | | | | | | | | | | | start date/end date (mm/yyyy to mm/yyyy) | | |
|  | | | | | | | | | | | | | | |  | | |
| address | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| city | | | | | | | state/country | | | | | | | | postal code | | |
|  | | | | | | |  | | | | | | | |  | | |
| Reason for discontinuance | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| please provide an explanation for any gaps greater than six months (mm/yyyy to mm/yyyy) in work history. | | | | | | | | | | | | | | | | | |
| Gap Dates: | |  | | | Explanation: | | | |  | | | | | | | | |
| Gap Dates: | |  | | | Explanation: | | | |  | | | | | | | | |

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| Work History *- continued* | | | | | | | | | | | |
| Gap Dates: | |  | | Explanation: | | |  | | | | |
| Gap Dates: | |  | | Explanation: | | |  | | | | |
| *Please check this box and complete and submit Attachment C if you have additional work history.* | | | | | | | | | | | |
| Hospital Affiliations *– Please include all hospitals where you are currently have or have previously had privileges.* | | | | | | | | | | | |
| do you have hospital privileges? | | | | | | if you do not have admitting privileges, what admitting arrangements do you have? | | | | | |
| Yes | No | | | | |  | | | | | |
| primary hospital where you have admitting privileges | | | | | | | | | | start date (mm/yyyy) | |
| **University Health Systems** | | | | | | | | | | **Applying** | |
| address | | | | | | | | | | | |
| **4502 Medical Drive** | | | | | | | | | | | |
| city | | | | | state/country | | | | | postal code | |
| **San Antonio** | | | | | **Texas USA** | | | | | **78229** | |
| phone number | | | Fax number | | | | | e-mail | | | |
| **210-358-4000** | | | **210-358-4775** | | | | |  | | | |
| full unrestricted privileges? | | | types of privileges (provisional, limited, conditional, etc.) | | | | | | | are privileges temporary? | |
| Yes | No | | **Provisional** | | | | | | | 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) | |
|  | | | | | | | | | |  | |
| address | | | | | | | | | | | |
|  | | | | | | | | | | | |
| city | | | | | state/country | | | | | postal code | |
|  | | | | |  | | | | |  | |
| phone number | | | Fax number | | | | | e-mail | | | |
|  | | |  | | | | |  | | | |
| full unrestricted privileges? | | | types of privileges (provisional, limited, conditional, etc.) | | | | | | | are privileges temporary? | |
| Yes | No | |  | | | | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | | | | | |
|  | | | | | | | | | | | |
| *Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.* | | | | | | | | | | | |
| previous hospital where you have had privileges | | | | | | | | | | Affiliation Dates (mm/yyyy to mm/yyyy)) | |
|  | | | | | | | | | |  | |
| address | | | | | | | | | | | |
|  | | | | | | | | | | | |
| city | | | | | state/country | | | | | postal code | |
|  | | | | |  | | | | |  | |
| phone number | | | Fax number | | | | | e-mail | | | |
|  | | |  | | | | |  | | | |
| full unrestricted privileges? | | | types of privileges (provisional, limited, conditional, etc.) | | | | | | | are privileges temporary? | |
| Yes | No | |  | | | | | | | Yes | No |
| Reason for discontinuance | | | | | | | | | | | |
|  | | | | | | | | | | | |
| *Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.* | | | | | | | | | | | |
| 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.* | | | | | | | | | | | |
| 1 Name/title | | | | | | | | | phone number | | |
| **Edmund Giegerich, MD Chief Endocrinology and Vice Chairman Medicine** | | | | | | | | | **(917)- 922-3991** | | |
| address | | | | | | | | | | | |
| **506 6th street** | | | | | | | | | | | |
| city | | | | | state/country | | | | | postal code | |
| **Brooklyn** | | | | | **New York, USA** | | | | | **11215** | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| References *- continued* | | | | | | | | | | | | |
| 2 Name/title | | | | | | | | | | phone number | | |
| **Stephen Peterson, MD Chairman of Medicine** | | | | | | | | | | **718-780-5248** | | |
| address | | | | | | | | | | | | |
| **506 6th street** | | | | | | | | | | | | |
| city | | | | | | state/country | | | | | postal code | |
| **Brooklyn** | | | | | | **New York, USA** | | | | | **11215** | |
| 3 Name/title | | | | | | | | | | phone number | | |
|  | | | | | | | | | |  | | |
| address | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| city | | | | | | state/country | | | | | postal code | |
|  | | | | | |  | | | | |  | |
| Professional Liability Insurance Coverage | | | | | | | | | | | | |
| self-insured? | | | | name of current malpractice insurance carrier or self-insured entity | | | | | | | | |
| Yes | | No | | **University of Texas Systems** | | | | | | | | |
| address | | | | | | | | | | | | |
| **Office of the General Counsel, 201 West Seventh Street** | | | | | | | | | | | | |
| city | | | | | | state/country | | | | | postal code | |
| **Austin** | | | | | | **Texas USA** | | | | | **78701-2982** | |
| phone number | | | | | policy number | | effective date (mm/dd/yyyy) | | | | | expiration date (mm/dd/yyyy) |
| **512-499-4462** | | | | | **N/A** | |  | | | | | **08/31/2014** |
| amount of coverage per | | | | | amount of coverage aggregate | | type of coverage | | | | | length of time with carrier |
| occurance | | | **$500,000.00** | | **$1,500,000.00** | | Individual | | Shared | | |  |
| name of previous malpractice insurance carrier if with current carrier less than 5 years | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| address | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| city | | | | | | state/country | | | | | postal code | |
|  | | | | | |  | | | | |  | |
| phone number | | | | | policy number | | effective date (mm/dd/yyyy) | | | | | expiration date (mm/dd/yyyy) |
|  | | | | |  | |  | | | | |  |
| amount of coverage per | | | | | amount of coverage aggregate | | type of coverage | | | | | length of time with carrier |
| occurance | | |  | |  | | Individual | | Shared | | |  |
| Call Coverage | | | | | | | | | | | | |
| See attached list of hospital staff within my department I utilize for call coverage. | | | | | | | | | | | | |
| please list names of colleague(s) providing regular coverage and his or her specialties. | | | | | | | | | | | | |
| Name: |  | | | | | | Specialty: |  | | | | |
| Name: |  | | | | | | Specialty: |  | | | | |
| Name: |  | | | | | | Specialty: |  | | | | |
| Name: |  | | | | | | Specialty: |  | | | | |
| Name: |  | | | | | | Specialty: |  | | | | |
| please list full names of all partners in your practice  check this box and attach list for large group. | | | | | | | | | | | | |
| Name: |  | | | | | | Name: |  | | | | |
| Name: |  | | | | | | Name: |  | | | | |
| Name: |  | | | | | | Name: |  | | | | |
| Name: |  | | | | | | Name: |  | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | |
| 1of1 | | |  | | |
| 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 | | | | | | | | | | | | | | | | |
| **UTHSCSA** | | | | | | | | | | | | | | | **UTHSCSA MSP Medicine** | | | | | | | | | | | | | | | | |
| practice location address | | | | | | | | **7703 Floyd Curl Drive** | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary** | | | | | | | |
| city | | | | | | | | | state/country | | | | | | | | | | | | | | postal code | | | | | | | | |
| **San Antonio** | | | | | | | | | **Texas USA** | | | | | | | | | | | | | | **78229** | | | | | | | | |
| phone number | | | | | | | | Fax number | | | | | | | | e-mail | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |
| back office phone number | | | | | | | | | site-specific medicaid number | | | | | | | | | | | | | | tax id number | | | | | | | | |
|  | | | | | | | | | **085144601** | | | | | | | | | | | | | | **74-1586031** | | | | | | | | |
| group number corresponding to tax id number | | | | | | | | | group name corresponding to tax id number | | | | | | | | | | | | | | | | | | | | | | |
| **00T156** | | | | | | | | | **UTHSCSA MSP Medicine** | | | | | | | | | | | | | | | | | | | | | | |
| are you currently practicing at this location? | | | | | | | | | if no, expected start date? (mm/dd/yyyy) | | | | | | | | | | | | | | do you want this location listed in the | | | | | | | | |
| Yes | No | | | | | | | |  | | | | | | | | | | | | | | directory? | | | | | | Yes | | No |
| office manager or staff contact | | | | | | | | | | | | | | | | phone number | | | | | | | | | | fax number | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| credentialing contact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Crystal L Jeffers-Credentialing Coordinator | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7703 Floyd Curl Drive Dept. of Medicine/Administration MC 7870 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | | state/country | | | | | | | | | | | | | | postal code | | | | | | | | |
| **San Antonio** | | | | | | | | | Texas USA | | | | | | | | | | | | | | **78229** | | | | | | | | |
| phone number | | | | | | | | Fax number | | | | | | | | e-mail | | | | | | | | | | | | | | | |
| **210-567-1418** | | | | | | | | **210-567-4652** | | | | | | | | [**Jeffers@uthscsa.edu**](mailto:Jeffers@uthscsa.edu) | | | | | | | | | | | | | | | |
| billing company’s name (if applicable) | | | | | | | | | | | | | | | | | | | | | | billing representative | | | | | | | | | |
| **MSRDP** | | | | | | | | | | | | | | | | | | | | | | **N/A** | | | | | | | | | |
| address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **P. O. Box 528** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | | state/country | | | | | | | | | | | | | | postal code | | | | | | | | |
| **San Antonio** | | | | | | | | | **Texas USA** | | | | | | | | | | | | | | **78292-0528** | | | | | | | | |
| phone number | | | | | | | | Fax number | | | | | | | | e-mail | | | | | | | | | | | | | | | |
| **210-450-6330** | | | | | | | | **210-450-4450** | | | | | | | | **N/A** | | | | | | | | | | | | | | | |
| department name if hospital-based | | | | | | | | | check payable to | | | | | | | | | | | | | can you bill electronically? | | | | | | | | | |
| **N/A** | | | | | | | | | **MSRDP/CTRC** | | | | | | | | | | | | | Yes | | No | | | | | | | |
| hours patients are seen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Monday | | No Office Hours | | | | | | Morning: | | **8:00am** | | | | | | Afternoon: | | | | |  | | | | Evening: | | | | | **5:00pm** | |
| Tuesday | | No Office Hours | | | | | | Morning: | | **8:00am** | | | | | | Afternoon: | | | | |  | | | | Evening: | | | | | **5:00pm** | |
| Wednesday | | No Office Hours | | | | | | Morning: | | **8:00am** | | | | | | Afternoon: | | | | |  | | | | Evening: | | | | | **5:00pm** | |
| Thursday | | No Office Hours | | | | | | Morning: | | **8:00am** | | | | | | Afternoon: | | | | |  | | | | Evening: | | | | | **5:00pm** | |
| Friday | | No Office Hours | | | | | | Morning: | | **8:00am** | | | | | | Afternoon: | | | | |  | | | | Evening: | | | | | **5:00pm** | |
| 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 locations accepts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| all new patients | | | exists 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: | | **18+** | | | 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 number | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | | | | | state & License number | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |

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| Practice Location Information *–* continued | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| non-english languages spoken by health care providers | | | | | | | | | | | | | | | non-english languages spoken by office personnel | | | | | | | | | | | |
| **None** | | | | | | | | | | | | | | | **Spanish** | | | | | | | | | | | |
| are interpreters available? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | If yes, please specify languages: | | | | | | | | **Spanish** | | | | | | | | | | | | | | | |
| does this practice location meet ada accessibility standards? | | | | | | | | | | | | | | | which of the following facilities are handicapped accessible? | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | Building | | Parking | Restroom | | | | | | Other: |  | |
| does this location have other services for the disabled? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Text-Telephony-TTY | | | | American Sign Language – ASL | | | | | | | | | Mental/Physical Impairment Services | | | | | Other: | | | | | **Unknown** | | | |
| is this location accessible by public transportation? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bus | | Regional Train | | | | Other: | | |  | | | | | | | | | | | | | | | | | |
| Does this location provide childcare services? | | | | | | | | | | | | | | | does this location qualify as a minority business enterprise? | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | | Yes | No | | | | | | | | | | |
| who at this location have the following current certifications? (please list only the applicant’s certification expiration dates.) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basic Life Support | | | | | Staff | | | Provider Exp: | | | |  | | | Advanced Life Support in OB | | | | Staff | | | Provider Exp: | | | |  |
| Advanced Trauma Life Support | | | | | Staff | | | Provider Exp: | | | |  | | | Cardio-Pulmonary Resuscitation | | | | Staff | | | Provider Exp: | | | |  |
| Advanced Cardiac Life Support | | | | | Staff | | | Provider Exp: | | | |  | | | Pediatric Advanced Life Support | | | | Staff | | | Provider Exp: | | | |  |
| Neonatal Advanced Life Support | | | | | Staff | | | Provider Exp: | | | |  | | | Other (please specify) | | | | Staff | | | Provider Exp: | | | |  |
| does this location provide any of the following services on site? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE): | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| X-ray; please list all certifications: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other services | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Radiology Services | | | | | | | EKG | | | | | | | Care of Minor Lacerations | | | | | | | Pulmonary Function Tests | | | | | |
| Allergy Injections | | | | | | | Allergy Skin Tests | | | | | | | Routine Office Gynecology | | | | | | | Drawing Blood | | | | | |
| Age Appropriate Immunizations | | | | | | | Flexible Sigmoidoscopy | | | | | | | Tympanometry/Audiometry Tests | | | | | | | Asthma Treatments | | | | | |
| Osteopathic Manipulations | | | | | | | IV Hydration/Treatments | | | | | | | Cardiac Stress Tests | | | | | | | Physical Therapies | | | | | |
| Other: | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| please list any additional office procedures provided (including surgical procedures) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| is anesthesia administered at this practice location? | | | | | | | | | | | | | | | | | | | | | who administers it? | | | | | |
| Yes | No | | Please specify the classes or categories: | | | | | | | | | |  | | | | | | | |  | | | | | |
| Please *check this box and complete and submit Attachment F if you have other practice locations.* | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- |
| **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 filed 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 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 DPS | | | |
|  | | | |
| 10 | Have your Federal IDEA and/or DPS 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, IDEA or DPS authorizing entities, education or training program, Medicare or Medicaid |  |  |
|  | program, or any other private, federal or state health program? |  |  |
|  | | Yes | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Section II – Disclosure Questions - *continued* | | | | |
| 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 or 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 |
|  | *If yes, please check this box and complete and submit Attachment G.* | | | |
|  | | | | |
| 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 professional? |  | |  |
|  | | Yes | | No |
|  | | | | |
| 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 ever 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 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 included, 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 on page 10 to explain yes answers to any question except 16.* | | | | |

|  |  |
| --- | --- |
| Section II – Disclosure Questions - *continued* | |
| *Please use the space below to explain yes answers to any question except 16.* | |
|  | |
| question number | please explain |
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| Section III – 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 and/or clinical privileges | |
| (hereinafter, referred to as “Participation”) at or with | |
| (please indicate managed care company(s) or hospital(S) 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. | |
|  | |
| 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 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. | |
|  | |
| 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 an/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; (iii) my registration 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, or Agent(s), or any other third | |
|  | |
|  | V.H |
|  | applicant’s initials and date (mm/dd/yyyy) |

|  |  |
| --- | --- |
| Section III – Standard Authorization, Attestation and Release – continued | |
| 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 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 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 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 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. | |
|  | Vala hamidi |
|  | signature |
|  | **Vala Hamidi** |
|  | Name (Please print or type) |
|  | **3053** |
|  | last 4 digits of ssn or npi (Please print or type) |
|  |  |
|  | date (mm/dd/yyyy) |
|  |  |
| Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following: | |
| Copy of DEA or state DPS Controlled Substances Registration Certificate | |
| Copy of other Controlled Dangerous Substances Registration Certificate | |
| Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant’s name | |
| Copies of IRS W-9s for verification of each tax identification number used | |
| Copy of workers compensation certificate of coverage, if applicable | |
| Copy of CLIA certifications, if applicable | |
| Copies of radiology certifications, if applicable | |
| Copy of DD214, record of military service, if applicable | |
|  | |
|  | |
| Reproduction of this form without any changes is allowed. | |
|  | |
|  | |
| Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals) | |
| With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you | |
| (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive | |
| copies of information about yourself, including private information. However the state governmental body may withhold | |
| information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are | |
| entitled to request that the state governmental body correct information that it has about you that is incorrect. For information | |
| about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you | |
| have submitted this application. | |
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| Texas Standardized Credentialing Application | | | | Attachment A – Other Professional Degrees | |
| **other professional degree** | | | | | |
| Issuing Institution: | **N/A** | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
|  | | |  | | |
| **other professional degree** | | | | | |
| Issuing Institution: |  | | | | |
| address | | | | | |
|  | | | | | |
| city | | state/country | | | postal code |
|  | |  | | |  |
| degree | | | attendance dates (mm/yyyy to mm/yyyy) | | |
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| Texas Standardized Credentialing Application | | | | | Attachment B – Other Post-Graduate Education | |
| **other post graduate education** | | | | specialty | | |
| Internship | Residency | Fellowship | Teaching Appointment |  | | |
| Institution | | | | | | |
| **N/A** | | | | | | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | | postal code |
|  | | |  | | |  |
| Program successfully completed | | | | attendence dates (mm/yyyy to mm/yyyy) | | |
|  | | |
| program director | | | | current program director (if known) | | |
|  | | | |  | | |
| other post graduate education | | | | specialty | | |
| Internship | Residency | Fellowship | Teaching Appointment |  | | |
| Institution | | | | | | |
|  | | | | | | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | | postal code |
|  | | |  | | |  |
| Program successfully completed | | | | attendence dates (mm/yyyy to mm/yyyy) | | |
|  | | |
| program director | | | | current program director (if known) | | |
|  | | | |  | | |
| other post graduate education | | | | specialty | | |
| Internship | Residency | Fellowship | Teaching Appointment |  | | |
| Institution | | | | | | |
|  | | | | | | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | | postal code |
|  | | |  | | |  |
| Program successfully completed | | | | attendence dates (mm/yyyy to mm/yyyy) | | |
|  | | |
| program director | | | | current program director (if known) | | |
|  | | | |  | | |
| other post graduate education | | | | specialty | | |
| Internship | Residency | Fellowship | Teaching Appointment |  | | |
| Institution | | | | | | |
|  | | | | | | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | | postal code |
|  | | |  | | |  |
| Program successfully completed | | | | attendence dates (mm/yyyy to mm/yyyy) | | |
|  | | |
| program director | | | | current program director (if known) | | |
|  | | | |  | | |
| other post graduate education | | | | specialty | | |
| Internship | Residency | Fellowship | Teaching Appointment |  | | |
| Institution | | | | | | |
|  | | | | | | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | | postal code |
|  | | |  | | |  |
| Program successfully completed | | | | attendence dates (mm/yyyy to mm/yyyy) | | |
|  | | |
| program director | | | | current program director (if known) | | |
|  | | | |  | | |

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| Texas Standardized Credentialing Application | | Attachment C – Other Work History | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
| **N/A** | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
|  | | | |
| previous practice/employer name | | | start date/end date (mm/yyyy to mm/yyyy) |
|  | | |  |
| address | | | |
|  | | | |
| city | state/country | | postal code |
|  |  | |  |
| Reason for discontinuance | | | |
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| --- | --- | --- | --- | --- | --- | --- | --- |
| Texas Standardized Credentialing Application | | | | | Attachment D – Other Current Hospital Affiliations | | |
| other hospital where you have privileges | | | | | | start date (mm/yyyy) | |
| **N/A** | | | | | |  | |
| address | | | | | | | |
|  | | | | | | | |
| city | | | state/country | | | postal code | |
|  | | |  | | |  | |
| phone number | | Fax number | | e-mail | | | |
|  | |  | |  | | | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | | are privileges temporary? | |
| Yes | No |  | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | |
|  | | | | | | | |
| other hospital where you have privileges | | | | | | start date (mm/yyyy) | |
|  | | | | | |  | |
| address | | | | | | | |
|  | | | | | | | |
| city | | | state/country | | | postal code | |
|  | | |  | | |  | |
| phone number | | Fax number | | e-mail | | | |
|  | |  | |  | | | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | | are privileges temporary? | |
| Yes | No |  | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | |
|  | | | | | | | |
| other hospital where you have privileges | | | | | | start date (mm/yyyy) | |
|  | | | | | |  | |
| address | | | | | | | |
|  | | | | | | | |
| city | | | state/country | | | postal code | |
|  | | |  | | |  | |
| phone number | | Fax number | | e-mail | | | |
|  | |  | |  | | | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | | are privileges temporary? | |
| Yes | No |  | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | |
|  | | | | | | | |
| other hospital where you have privileges | | | | | | start date (mm/yyyy) | |
|  | | | | | |  | |
| address | | | | | | | |
|  | | | | | | | |
| city | | | state/country | | | postal code | |
|  | | |  | | |  | |
| phone number | | Fax number | | e-mail | | | |
|  | |  | |  | | | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | | are privileges temporary? | |
| Yes | No |  | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | |
|  | | | | | | | |
| other hospital where you have privileges | | | | | | start date (mm/yyyy) | |
|  | | | | | |  | |
| address | | | | | | | |
|  | | | | | | | |
| city | | | state/country | | | postal code | |
|  | | |  | | |  | |
| phone number | | Fax number | | e-mail | | | |
|  | |  | |  | | | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | | are privileges temporary? | |
| Yes | No |  | | | | Yes | No |
| of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital? | | | | | | | |
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| Texas Standardized Credentialing Application | | | | Attachment E – Other Previous Hospital Affiliations | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
|  | | | | |  | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
|  | | | | | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
|  | | | | |  | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
|  | | | | | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
|  | | | | |  | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
| **\** | | | | | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
| **\** | | | | | **-** | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
|  | | | | | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
|  | | | | | **-** | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
|  | | | | | | |
| previous hospital where you have had privileges | | | | | affiliation dates (mm/yyyy to mm/yyyy) | |
|  | | | | | **-** | |
| address | | | | | | |
|  | | | | | | |
| city | | | state/country | | postal code | |
|  | | |  | |  | |
| full unrestricted privileges? | | types of privileges (provisional, limited, conditional, etc.) | | | are privileges temporary? | |
| Yes | No |  | | | Yes | No |
| reason for discontinuance | | | | | | |
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| Texas Standardized Credentialing Application | | | | | | | | | | | | | | | | | Attachment F – Other Practice Locations | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | |
| **N/A** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| practice location address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | | state/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? | | | | | | | | | if no, expected start date? (mm/dd/yyyy) | | | | | | | | | | | | | | do you want this location listed in the | | | | | | | | |
| Yes | No | | | | | | | |  | | | | | | | | | | | | | | directory? | | | | | | Yes | | No |
| office manager or staff contact | | | | | | | | | | | | | | | | phone number | | | | | | | | | | fax number | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |
| credentialing contact | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | | state/country | | | | | | | | | | | | | | postal code | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
| phone number | | | | | | | | Fax number | | | | | | | | e-mail | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |
| billing company’s name (if applicable) | | | | | | | | | | | | | | | | | | | | | | billing representative | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| city | | | | | | | | | state/country | | | | | | | | | | | | | | 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 locations accepts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| all new patients | | | exists 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 number | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | | | | | state & License number | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Practice Location Information *-* continued | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
| **N/A** | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| Name | | | | | | | | | professional designation | | | | | | | | | | state & License number | | | | | | |
|  | | | | | | | | |  | | | | | | | | | |  | | | | | | |
| non-english languages spoken by health care providers | | | | | | | | | | | | | | non-english languages spoken by office personnel | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | |
| are interpreters available? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | No | | If yes, please specify languages: | | | | | | |  | | | | | | | | | | | | | | | |
| does this practice location meet ada accessibility standards? | | | | | | | | | | | | | | which of the following facilities are handicapped accessible? | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | Building | | Parking | Restroom | | | | | | Other: |  | |
| does this location have other services for the disabled? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Text-Telephony-TTY | | | | American Sign Language – ASL | | | | | | | | Mental/Physical Impairment Services | | | | | Other: | | | | |  | | | |
| is this location accessible by public transportation? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bus | | Regional Train | | | | Other: | | |  | | | | | | | | | | | | | | | | |
| Does this location provide childcare services? | | | | | | | | | | | | | | does this location qualify as a minority business enterprise? | | | | | | | | | | | |
| Yes | No | | | | | | | | | | | | | Yes | No | | | | | | | | | | |
| who at this location have the following current certifications? (please list only the applicant’s certification expiration dates.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Basic Life Support | | | | | Staff | | | Provider Exp: | | |  | | | Advanced Life Support in OB | | | | Staff | | | Provider Exp: | | | |  |
| Advanced Trauma Life Support | | | | | Staff | | | Provider Exp: | | |  | | | Cardio-Pulmonary Resuscitation | | | | Staff | | | Provider Exp: | | | |  |
| Advanced Cardiac Life Support | | | | | Staff | | | Provider Exp: | | |  | | | Pediatric Advanced Life Support | | | | Staff | | | Provider Exp: | | | |  |
| Neonatal Advanced Life Support | | | | | Staff | | | Provider Exp: | | |  | | | Other (please specify) | | | | Staff | | | Provider Exp: | | | |  |
| does this location provide any of the following services on site? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE): | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| X-ray; please list all certifications: | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| other services | | | | | | | | | | | | | | | | | | | | | | | | | |
| Radiology Services | | | | | | | EKG | | | | | | Care of Minor Lacerations | | | | | | | Pulmonary Function Tests | | | | | |
| Allergy Injections | | | | | | | Allergy Skin Tests | | | | | | Routine Office Gynecology | | | | | | | Drawing Blood | | | | | |
| Age Appropriate Immunizations | | | | | | | Flexible Sigmoidoscopy | | | | | | Tympanometry/Audiometry Tests | | | | | | | Asthma Treatments | | | | | |
| Osteopathic Manipulations | | | | | | | IV Hydration/Treatments | | | | | | Cardiac Stress Tests | | | | | | | Physical Therapies | | | | | |
| Other: | |  | | | | | | | | | | | | | | | | | | | | | | | |
| please list any additional office procedures provided (including surgical procedures) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| is anesthesia administered at this practice location? | | | | | | | | | | | | | | | | | | | | who administers it? | | | | | |
| Yes | No | | Please specify the classes or categories: | | | | | | | | |  | | | | | | | |  | | | | | |
| Please *check this box and complete and submit Attachment F if you have other practice locations.* | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Texas Standardized Credentialing Application | | | | Attachment G – Malpractice Claims History | | | | | |
| **incident** date (mm/dd/yyyy) | | Date Claim was filed (mm/dd/yyyy) | | | Claim/case status | | | | |
| **N/A** | |  | | |  | | | | |
| professional liability carrier involved | | | | | | | | | |
|  | | | | | | | | | |
| address | | | | | | | | | |
|  | | | | | | | | | |
| city | | | state/country | | | | postal code | | |
|  | | |  | | | |  | | |
| phone number | | | policy number | | amount of award or settlement & amount paid | | | | |
|  | | |  | | **$** |  | | **$** |  |
| method of resolution | | |  | |  | | | | |
| Dismissed | | | Settled (with prejudice) | | Settled (without prejudice) | | | | |
|  | | |  | |  | | | | |
| Judgment | | | Judgment for Plaintiff(s) | | Mediation or Arbitration | | | | |
| description of allegations | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| were you primary defendant or co-defendant? | | | Number of other co-defendants | | your involvement (attending, consulting, etc.) | | | | |
|  | | |  | |  | | | | |
| description of alleged injury to the patient | | | | | | | | | |
|  | | | | | | | | | |
| to the best of your knowledge, is this case included in the national practitioner data bank (NPDB)? | | | | | | | | | |
| Yes | No | | | | | | | | |
| **incident** date (mm/dd/yyyy) | | Date Claim was filed (mm/dd/yyyy) | | | Claim/case status | | | | |
|  | |  | | |  | | | | |
| professional liability carrier involved | | | | | | | | | |
|  | | | | | | | | | |
| address | | | | | | | | | |
|  | | | | | | | | | |
| city | | | state/country | | | | postal code | | |
|  | | |  | | | |  | | |
| phone number | | | policy number | | amount of award or settlement & amount paid | | | | |
|  | | |  | | $ |  | | $ |  |
| method of resolution | | |  | |  | | | | |
| Dismissed | | | Settled (with prejudice) | | Settled (without prejudice) | | | | |
|  | | |  | |  | | | | |
| Judgment | | | Judgment for Plaintiff(s) | | Mediation or Arbitration | | | | |
| description of allegations | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| were you primary defendant or co-defendant? | | | Number of other co-defendants | | your involvement (attending, consulting, etc.) | | | | |
|  | | |  | |  | | | | |
| description of alleged injury to the patient | | | | | | | | | |
|  | | | | | | | | | |
| to the best of your knowledge, is this case included in the national practitioner data bank (NPDB)? | | | | | | | | | |
| Yes | No | | | | | | | | |