

CREDENTIALING QUESTIONNAIRE AND ATTESTATION

PROFESSIONAL QUESTIONS

Be sure to complete all questions. Your answers will be kept confidential. Please attach a detailed description of all relevant facts, including the reason, date of action, and the final outcome of the action for any questions answered "yes."

1. In the past ten years have you had any negative action taken in connection with your license including but not limited to refusal, suspension, revocation, probation, reprimand, censure or restriction in any way by any state or jurisdiction board?	[] Yes [] No
2. Have you ever been censured by a Medical Society or other Professional Society or other professional board or association?	[] Yes [] No
3. Have you ever had your Drug Enforcement Administration number (DEA#) restricted, suspended, revoked or otherwise limited or DEA license application refused?	[] Yes [] No
4. Have you ever had an agreement with Medicare or Medicaid that was restricted, probational, suspended, excluded or terminated?	[] Yes [] No
5. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid?	[] Yes [] No
6. Have you ever been convicted of a criminal offense other than a minor traffic violation?	[] Yes [] No
7. Has any hospital or facility ever taken any action regarding your privileges including but not limited to suspension, restriction, denial or revocation?	[] Yes [] No
8. Have you ever voluntarily resigned privileges in lieu of disciplinary action?	[] Yes [] No
9. Has there been within the past five years, any malpractice judgments found against you or malpractice settlement made, with or without prejudice?	[] Yes [] No
10. Do you have an impairment which even with reasonable accommodation, would interfere with your ability to provide professional services?	[] Yes [] No
11. Are you now, or have you ever been an active or habitual user of any mind or mood altering substance including but not limited to alcohol, narcotics, barbiturates, hypnotics, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substances, which would interfere with your ability to provide professional services?	[] Yes [] No
12. Has your participation in any insurance carrier sponsored program been suspended or revoked?	[] Yes [] No

MALPRACTICE INSURANCE

Please enclose a copy of your malpractice insurance face sheet.

Carrier:	Expiration Date (mm/dd/yyyy) □□ / □□ / □□□□	Level: Per occurrence \$	In aggregate \$
Do you intend to maintain your current professional liability insurance limits? If so, please enclose a detailed explanation.			
[] Yes [] No			

ATTESTATION

I hereby submit this application for participation in Local 456. I understand that this application will be reviewed based on the information I have provided herein.

I hereby certify that the information contained in this form is complete, accurate and true and the information found to be false could result in denial or subsequent termination of my participation in Local 456.

To assist Local 456 and its Credentials Verification Organization(CVO) in evaluating my application, I authorize any hospital, group practice, other clinical employer, professional society, malpractice carrier or other agency or organization with information regarding my professional credentials to release, furnish copies or give details of my professional credentials, qualifications and professional records related to my privileges, qualifications, type of clinical practice and compliance including my moral and ethical qualifications. I hereby release from liability from any and or individuals and organizations, who in good faith and without malice, provide information to Local 456 for the purpose of evaluating this application, and release Local 456 from liability from its use of the information it gathers in the application process.

A photocopy of this permission will be valid as the original.

Provider Signature	Name (please type or print)	Date