

Requested Categories _____

Department/Service – For Hospital and Health Facility Appointments Only. See relevant hospital bylaws.

(1) _____ (2) _____

Specialty Category

Clinical Specialty _____

Subspecialty (1) _____ (2) _____

Staff Category – For Hospital Appointments Only. See relevant hospital bylaws.

(1) _____ (2) _____

Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists and Certified Nurse Midwives or any other discipline identify your Collaborating/Supervising physician and provide a copy of your agreement/statement.

Supervising/Collaborating Physicians – please identify who you are responsible for

(1) _____ (2) _____

(3) _____ (4) _____

Practice Type

Private Practice Employed If Employed, by whom? _____

Contract Category – For MCOs and POs Only. Please see relevant MCO and/or PO bylaws.

Primary Care Specialty Both Consulting Allied Health

Primary Hospital Affiliation – _____

Home/Personal Data _____

Home Address _____
Street

City _____ State _____ Zip Code _____

Home Phone # (____) _____ Is this number listed in the phone book? Yes No

Home Fax # (____) _____ Cellular # (____) _____

E-mail address _____

Foreign Language/ASL Fluency _____

Name of Spouse/Significant Other (optional) _____

Primary Office

Primary Office Address _____
 Street

City _____ State _____ Zip Code _____

Primary Office Phone # (____) _____ Primary Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Are Patients able to access you or someone covering for you 24/7? yes () no ()

Work E-mail _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Tax ID# _____ Website Address _____

Office Manager/Contact Person Name _____ Phone # (____) _____

Primary Office Hours	Your On-Site Hours	Languages Spoken On-Site	By Whom
Monday _____ AM to _____ PM	Monday _____ AM to _____ PM		
Tuesday _____ AM to _____ PM	Tuesday _____ AM to _____ PM		
Wednesday _____ AM to _____ PM	Wednesday _____ AM to _____ PM		
Thursday _____ AM to _____ PM	Thursday _____ AM to _____ PM		
Friday _____ AM to _____ PM	Friday _____ AM to _____ PM		
Saturday _____ AM to _____ PM	Saturday _____ AM to _____ PM		
Sunday _____ AM to _____ PM	Sunday _____ AM to _____ PM		

Are you accepting new patients at this office? __ Y __ N Is this office wheelchair or handicap accessible? __ Y __ N

Is your primary office also your billing office? __ Y __ N

If no, what is your billing office address? _____
 Street

City _____ State _____ Zip Code _____

Billing Office Phone # (____) _____ Billing Office Fax # (____) _____

E-mail Address _____

Does office bill electronically? __ Yes __ No If yes, what software is used? _____

Second & Third Office (if applicable) If you have more office locations, please copy this page complete in its entirety and attach to the application.

Second Office Address _____
 Street

City _____ State _____ Zip Code _____

Second Office Phone # (____) _____ Second Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Work E-mail _____ Tax ID# _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Office Manager/Contact Person Name _____ Phone#(____) _____

Second Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	____ AM to ____ PM	Monday	____ AM to ____ PM		
Tuesday	____ AM to ____ PM	Tuesday	____ AM to ____ PM		
Wednesday	____ AM to ____ PM	Wednesday	____ AM to ____ PM		
Thursday	____ AM to ____ PM	Thursday	____ AM to ____ PM		
Friday	____ AM to ____ PM	Friday	____ AM to ____ PM		
Saturday	____ AM to ____ PM	Saturday	____ AM to ____ PM		
Sunday	____ AM to ____ PM	Sunday	____ AM to ____ PM		

Are you new patients at this office site? Y N Is this office wheelchair or handicap accessible? Y N

Third Office Address _____
 Street

City _____ State _____ Zip Code _____

Third Office Phone # (____) _____ Third Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Work E-mail _____ Tax ID# _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Office Manager/Contact Person Name _____ Phone#(____) _____

Third Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	____ AM to ____ PM	Monday	____ AM to ____ PM		
Tuesday	____ AM to ____ PM	Tuesday	____ AM to ____ PM		
Wednesday	____ AM to ____ PM	Wednesday	____ AM to ____ PM		
Thursday	____ AM to ____ PM	Thursday	____ AM to ____ PM		
Friday	____ AM to ____ PM	Friday	____ AM to ____ PM		
Saturday	____ AM to ____ PM	Saturday	____ AM to ____ PM		
Sunday	____ AM to ____ PM	Sunday	____ AM to ____ PM		

Are you new patients at this office site? Y N Is this office wheelchair or handicap accessible? Y N

Education/Training

Please provide all of the information requested, below and attach copies of diplomas, certification and other proofs of attendance. If any gaps in chronology of your academic and/or professional history exist, provide a brief summary of details, as well as an explanation for any "No" responses. Please also attach a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

College Undergraduate Education

School _____

Address _____
 Street _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Dates Attended ___/___/___ to ___/___/___ Degree _____

School _____

Address _____
 Street _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Dates Attended ___/___/___ to ___/___/___ Degree _____

Medical/Dental/Professional Education

School _____

Address _____
 Street _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Dates Attended ___/___/___ to ___/___/___ Degree _____

Honors or Recognition _____

School _____

Address _____
 Street _____

City _____ State _____ Zip Code _____

Phone () _____ Fax () _____

Dates Attended ___/___/___ to ___/___/___ Degree _____

Honors or Recognition _____

Internship

Hospital _____

Address _____
 Street _____

City _____ State _____ Zip Code _____

Phone () _____ Phone# () _____ Fax # () _____

Phone () _____ Fax () _____

Dates of Service ___/___/___ to ___/___/___ Specialty _____

Internship Completed? ___ Yes ___ No* Name of Director/Department Chair _____

* Full explanation required on a separate sheet of paper

Education/Training (continued)

Residency

Hospital _____

Address _____

Street _____

City _____ State _____ Zip Code _____ Phone# _____ Fax # _____

Dates of Service ___/___/___ to ___/___/___ Specialty _____

Residency? __ Yes __ No* Name of Director/Department Chair _____

* Full explanation required on a separate sheet of paper

Hospital _____

Address _____

Street _____

City _____ State _____ Zip Code _____ Phone# _____ Fax # _____

Dates of Service ___/___/___ to ___/___/___ Specialty _____

Residency? __ Yes __ No* Name of Director/Department Chair _____

* Full explanation required on a separate sheet of paper

Formal Post Graduate/Fellowship Education

Hospital _____

Address _____

Street _____

City _____ State _____ Zip Code _____ Phone# _____ Fax # _____

Dates of Service ___/___/___ to ___/___/___ Specialty _____

Fellowship? __ Yes __ No* Name of Director/Department Chair _____

* Full explanation required on a separate sheet of paper

Other Training

Institution _____

Address _____

Street _____

City _____ State _____ Zip Code _____ Phone# _____ Fax # _____

Dates of Service ___/___/___ to ___/___/___ Specialty _____

Completed? __ Yes __ No* Name of Director/Department Chair _____

• Full explanation required on a separate sheet of paper

Any additional Training must be documented on a separate sheet of paper

Hospital Affiliations/Work Experience/Professional History _____

List in chronological order, beginning with the most recent, all institutional affiliations or places of employment. This includes all hospitals, teaching institutions, managed care organizations, private practices, corporations, military assignments and government agencies and all other licensed health care organizations. **Exclude residency and fellowship training.** If more space is needed, please use another sheet. Please also **attach** a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

Institution _____

Address _____
Street _____

City _____ State _____ Zip Code _____ (____) _____ (____) _____
Phone # _____ Fax # _____

Department or Service _____ Dates of Service ____/____/____ to ____/____/____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____
Street _____

City _____ State _____ Zip Code _____ (____) _____ (____) _____
Phone # _____ Fax # _____

Department or Service _____ Dates of Service ____/____/____ to ____/____/____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____
Street _____

City _____ State _____ Zip Code _____ (____) _____ (____) _____
Phone # _____ Fax # _____

Department or Service _____ Dates of Service ____/____/____ to ____/____/____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____
Street _____

City _____ State _____ Zip Code _____ (____) _____ (____) _____
Phone # _____ Fax # _____

Department or Service _____ Dates of Service ____/____/____ to ____/____/____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Last Name, First Initial

Hospital Affiliations/Work Experience/Professional History (cont'd) _____

Institution _____

Address _____

Street

City

State

Zip Code

() Phone #

() Fax #

Department or Service _____ Dates of Service ___/___/___ to ___/___/___

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

() Phone #

() Fax #

Department or Service _____ Dates of Service ___/___/___ to ___/___/___

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

() Phone #

() Fax #

Department or Service _____ Dates of Service ___/___/___ to ___/___/___

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Board Certification/Recertification _____

Attach copies of Board specialty and subspecialty certifications and recertifications, or a copy of qualifying letter(s).

Certifying Board _____ Date of Original Certification ___/___/___

Certifying Board _____ Date of Original Certification ___/___/___

Certifying Board _____ Date of Original Certification ___/___/___

Emergency Care Training, Infection Control Certification, Special Credentials and CME Courses

Submit with your Uniform Application Form a list of all major training (excluding residency and fellowship) and continuing education courses you have completed within the past two years. Attach copies of each certificate you hold for emergency care training (i.e. CPR, ACLS, ATLS, PALS). Please indicate any special credentials you possess related to OB ultrasound and neuropsychology testing for HMO's. If you have trained in additional procedures, submit certificates of training or other documentation.

Identification Numbers

Please list identification numbers assigned to you by the for the following entities:

Blue Cross Blue Shield - Rochester# _____ Preferred Care # _____

Medicare UPIN # _____ Medicaid/MMIS # _____

Workers' Compensation # _____

Other # _____

Other # _____

Professional Associations

List memberships in professional societies, colleges, academies, etc.:

<u>Organization</u>	<u>Initial Date of Membership</u>	<u>Status</u>
_____	/ /	Active / Inactive
_____	/ /	Active / Inactive
_____	/ /	Active / Inactive
_____	/ /	Active / Inactive
_____	/ /	Active / Inactive
_____	/ /	Active / Inactive

Professional Licensing Information

Attach copies of each item listed below, including state licenses, DEA, ECFMG/USMLE and infection control certificates:

<u>State</u>	<u>License Type</u> (i.e. Limited)	<u>License #</u>	<u>Date Received</u>	<u>Expiration Date</u>	<u>Status</u>
<u>New York</u>	_____	_____	/ /	/ /	Current/ Pending
_____	_____	_____	/ /	/ /	Active / Inactive
_____	_____	_____	/ /	/ /	Active / Inactive
_____	_____	_____	/ /	/ /	Active / Inactive
_____	_____	_____	/ /	/ /	Active / Inactive

* For those licenses which are no longer active, please provide an explanation regarding the reason for disassociation.

Federal Narcotics Registration /DEA # _____ Expiration Date ___/___/___

Federal Narcotics Registration /DEA # _____ Expiration Date ___/___/___

Federal Narcotics Registration /DEA # _____ Expiration Date ___/___/___

ECFMG # _____ USMLE # (formerly NBME) _____

Professional References

List four professional references who have had direct clinical observation of your work for at least one year. Please identify those individuals you have listed that are/were your partners. For MCOs and POs, be sure to refer to each organization's criteria as requirements may vary.

Name _____
First _____ Middle Initial _____ Last _____ Degree _____
Title/Position _____
Address _____
Street _____
City _____ State _____ Zip Code _____
Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Name _____
First _____ Middle Initial _____ Last _____ Degree _____
Title/Position _____
Address _____
Street _____
City _____ State _____ Zip Code _____
Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Name _____
First _____ Middle Initial _____ Last _____ Degree _____
Title/Position _____
Address _____
Street _____
City _____ State _____ Zip Code _____
Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Name _____
First _____ Middle Initial _____ Last _____ Degree _____
Title/Position _____
Address _____
Street _____
City _____ State _____ Zip Code _____
Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Corrective or Disciplinary Action

If the answer to any of the questions above is "Yes," provide a full explanation on a separate sheet. The explanation must include all relevant details, including the name and address of the attorney defending you, the name and address of any insurance company/companies providing professional liability coverage when the action occurred, the clinical background of the action, and the sum and substance of the findings in such actions or proceedings.

1. Yes No Have you ever been reported to the National Practitioner Data Bank, Healthcare Integrity and/or Protection Data Bank?
2. Yes No Has your employment, medical staff appointment, panel participation, affiliation or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused or limited in any hospital, health care facility or managed care organization, IPA or PPO including to avoid disciplinary action for reasons related to professional competence or conduct?
3. Yes No Has your license to practice your profession in any jurisdiction ever been limited, restricted, suspended, revoked, denied or subject to probationary conditions?
4. Yes No Have you ever voluntarily or involuntarily relinquished your license to practice your profession in any state?
5. Yes No Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (including Medicare, Medicaid or a managed care organization)?
6. Yes No Has your narcotics registration certificate ever been voluntarily or involuntarily limited, restricted, denied renewal, suspended or revoked?
7. Yes No Have you ever been denied membership, membership renewal or been subject to any professional review, censure or reprimand in any medical organization or professional society -- local, state or national?
8. Yes No Have you ever been subject to disciplinary action by a state agency or professional body (i.e. Medical Society, IPRO, OPMC)?
9. Yes No Do you have any pending misconduct changes against you in this state or any other state?
10. Yes No Has your specialty board certification or qualification ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?
11. Yes No Have you ever been convicted of, or are you currently under investigation for, a misdemeanor or felony in any jurisdiction?
12. Yes No Are you presently subject to any suspension, revocation, discontinuance, limitation, restriction or monitoring proceedings?
13. Yes No Have you ever been cited for violation of patient rights as set forth by the Federal Law and/or NYS Department of Health or any other state department of health?

Attestation

1. True False I attest that the information provided in this application is complete, true and accurate.
2. True False I agree to update this Uniform Application Form while it is being processed, should there be any change in the information provided.
3. True False I understand that any misrepresentation, misstatement or omission from this application could result in the immediate rejection of this application or subsequent revocation of any privileges/membership granted and subject to reporting according to NYS regulations.
4. True False I am currently able to perform the clinical privileges that I have requested from each specific hospital, health care facility and/or managed care organization to which I direct this Uniform Application Form.
5. True False I am not currently using any illegal drug, nor have I during the past two years.

Signature

1. **Before signing this Uniform Application Form**, please make enough copies for each hospital, managed care organization or other health care entity with which you seek affiliation. Each entity requires an **original signature**. Therefore, it is ***vital*** that you make your copies prior to signing this form. Forms without original signatures will not be processed.
2. **You are responsible for mailing** a copy of the Uniform Application Form to each entity with which you seek affiliation.
- 3.
4. **Be sure to attach all requested documents** to each copy of the Uniform Application Form before mailing.
5. **Please retain the unsigned original application once it is completed** in the event you would like to apply to another entity at a future date.

I hereby waive any confidentiality provision concerning the information provided in this application, pursuant to New York State Public Health Law section 2805-k.

Signature

____/____/____
Date

***A checklist is provided on the next page for your assistance
when preparing this application.***

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Checklist

Please provide an explanation on a separate sheet for any missing items and attach copies of all requested items. Your Application will not be considered complete and cannot be processed without all of the following documentation:

- Completed Uniform Application Form.
- Signed and dated Release Statement for each entity to which you are applying for privileges, employment, panel participation or membership.
- Copy of current board certifications/qualifying letters.
- Current Curriculum Vitae.
- Copies of professional diplomas.
- Applicable training certificates.
- CME documentation.
- Copy of current NYS license registration certificate.
- Other current state licenses and registration certificates.
- Copy of current DEA registration certificate.
- ECFMG/USMLE certificate.
- Copy of current infection control training certificate.
- Current malpractice insurance face sheet(s).
- Explanations for Yes/No answers on a separate sheet.
- Current Health Assessment Form, completed, dated and signed by your personal physician.
- Original signature and date on each copy of the Uniform Application Form for each of your affiliations.
- Original, unsigned copy for your files and future use.