

# OREGON PRACTITIONER RECREDENTIALING APPLICATION



- APPLICATION
- PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)
- GLOSSARY OF TERMS AND ACRONYMS

**PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.**

REVIEWED, AMENDED & APPROVED  
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)  
7/16/09

# OREGON PRACTITIONER RECREDENTIALING APPLICATION

**Prior to completing this recredentialing application, please read and observe the following:**

## I. INSTRUCTIONS

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 8, Attestation Questions and page 9, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable).**
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Identify the health care related organization(s) to which this application is being submitted in the space provided below.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you, please check the provided box at the top of the section.**
- **Mail application to the requesting organization(s).**

**Current copies of the following documents must be submitted with this application:**

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate

**A curriculum vitae is optional and not an acceptable substitute.**

**I am applying to (please list: Hospital Staff, HMO, IPA): \_\_\_\_\_**

**for: \_\_\_\_\_ (i.e., staff membership, network participation, if applicable).**

**\*Note: Please return completed application to the health care related organization to which you are applying not to the State of Oregon.**

# OREGON PRACTITIONER RECREDENTIALING APPLICATION

<b>II. PRACTITIONER INFORMATION</b>		<i>Please provide the practitioner's full legal name.</i>	
Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):
Is there any other name under which you have been known or have used since starting professional training?    Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name(s) and Year(s) Used:			
Home Street Address:		Home Telephone Number ( ) -	Mobile/Alternate Number ( ) -
E-mail Address:			
City:	State:	Zip:	
Country:	Birth Date: Month / Day / Year	Birth Place:	
Citizenship:	Social Security Number:	Gender:    Male <input type="checkbox"/> Female <input type="checkbox"/>	
Immigrant Visa Number (if applicable):	Status:	Type:	
Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):		Month / Year Issued:	

<b>III. SPECIALTY INFORMATION</b>		<i>This information may be included in directory listings.</i>	
Principal clinical specialty (For most current specialties list, see: <a href="http://www.wpc-edi.com/codes">http://www.wpc-edi.com/codes</a> ):	Do you want to be designated as a primary care practitioner (PCP)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Additional clinical practice specialties:			
Category of professional activity, check all boxes that apply:			
<u>Clinical Practice:</u> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Locum / Temporary <input type="checkbox"/> Other (explain)		<u>Other Professional Activities:</u> <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Retired <input type="checkbox"/> Other (explain)	

<b>IV. BOARD CERTIFICATION / RECERTIFICATION</b>			Does Not Apply <input type="checkbox"/>
<i>This section does not apply to licensure.</i>			
<i>List all current and past certifications. Please attach additional sheets, if necessary.</i>			
Name and Address of Issuing Board	Specialty	Date Certified/Recertified Month / Year	Expiration Date (if any) Month / Year
<b>If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.</b>			

<b>V. OTHER CERTIFICATIONS</b> <i>Please attach copy of certificate(s), if applicable.</i>			Does Not Apply <input type="checkbox"/>
Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.			
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
<b><i>For additional certifications, please attach a separate sheet.</i></b>			

<b>VI. PRACTICE INFORMATION</b>			
Name of Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Primary Clinical Practice Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	Zip:
Primary Office Telephone Number: ( ) - Ext	Primary Office Fax Number: ( ) -	Patient Appointment Telephone Number: ( ) - Ext	
Mailing Address (if different from above):			Attn:
Office Manager:	Office Manager's Telephone Number: ( ) - Ext	Office Manager's Fax Number: ( ) -	
Exchange / Answering Service Number: ( ) - Ext	Pager Number: ( ) -	Office E-mail Address:	
Recredentialing Contact and Address (if different from above):			
Recredentialing Contact's Telephone Number: ( ) - Ext	Recredentialing Contact's Fax Number: ( ) -	Recredentialing Contact's E-mail Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:	Name Affiliated with Tax ID Number:		
Name of Secondary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Secondary Clinical Practice Street Address:			Effective Date at Location, Month / Year:
City:	County:	State:	Zip:
Secondary Office Telephone Number: ( ) - Ext	Secondary Office Fax Number: ( ) -	Patient Appointment Telephone Number: ( ) - Ext	
Mailing Address (if different from above):			Attn:
Office Manager:	Office Manager's Telephone Number: ( ) - Ext	Office Manager's Fax Number: ( ) -	
Exchange / Answering Service Number: ( ) - Ext	Pager Number: ( ) -	Office E-mail Address:	
Recredentialing Contact and Address (if different from above):			
Recredentialing Contact's Telephone Number: ( ) - Ext	Recredentialing Contact's Fax Number: ( ) -	Recredentialing Contact's E-mail Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:	Name Affiliated with Tax ID Number:		
<b><i>Please list other office locations with above information on a separate sheet.</i></b>			

<b>VII. PRACTICE CALL COVERAGE</b>		<i>Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.</i>
NAME:	SPECIALTY:	
1.		
2.		
3.		
4.		
5.		

<b>VIII. ADDITIONAL EDUCATION</b>		<i>If you have completed additional residencies, internships or advanced specialized education within the past three (3) years, please provide the following information. Please attach additional sheets, if necessary.</i>		Does Not Apply <input type="checkbox"/>
Complete Name and Street Address of Program:				
City:		State:		Zip:
Specialty:		Phone Number: ( ) - :		Fax Number, if available ( ) -
From Month / Year:		To Month / Year:		Month / Year of Completion:
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)				
Complete Name and Street Address of Program:				
City:		State:		Zip:
Specialty:		Phone Number: ( ) -		Fax Number, if available ( ) -
From Month / Year:		To Month / Year:		Month / Year of Completion:
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)				

<b>IX. CONTINUING MEDICAL EDUCATION</b>			<i>Please list activities for which you have received CME credit(s) during the past three (3) years. Please attach a separate sheet, if needed.</i>	Does Not Apply <input type="checkbox"/>
Name:	Month / Year Attended:	Hours:		
Name:	Month / Year Attended:	Hours:		
Name:	Month / Year Attended:	Hours:		
Name:	Month / Year Attended:	Hours:		
Name:	Month / Year Attended:	Hours:		
Name:	Month / Year Attended:	Hours:		

<b>X. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES &amp; ID NUMBERS</b>			<i>Please attach additional sheets, if necessary.</i>
Oregon License or Registration Number:	Type:	Month / Day / Year of Expiration Date:	
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Month / Day / Year of Expiration Date:	
Controlled Substance Registration (CSR) Number (if applicable):		Month / Day / Year Issued:	
UPIN:	Medicare Number:	DMAP Number:	
Individual NPI Number:			

<b>XI. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS &amp; CERTIFICATES</b>		Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary</i>		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		

<b>XII. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS</b>
<b>Please list for the past three (3) years all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include all (A) affiliations in the past three (3) years, and/or (B) applications in process (i.e., hospitals, surgery centers or any other health care related facility). If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XIII, Professional Practice/Work History.</b>

<b>A. AFFILIATIONS IN THE PAST THREE (3) YEARS</b>			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status: (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Appointment		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		

If you do not have hospital admitting privileges, check here:

Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

<b>B. APPLICATIONS IN PROCESS</b>			Does Not Apply <input type="checkbox"/>
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Year of Submission:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Year of Submission:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Year of Submission:		

### XIII. PROFESSIONAL PRACTICE / WORK HISTORY

*A curriculum vitae is not sufficient.*

**A.** Please chronologically list and account for work, professional and practice history activities for the past three (3) years to present, including military service. **Please explain in section B any gaps greater than two (2) months. Please attach additional sheets, if necessary.**

Name of Current Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's E-mail Address, if available:		Professional Liability Carrier:

<b>B. Please explain any gaps greater than two (2) months in the past three (3) years. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.</b>		Does Not Apply <input type="checkbox"/>
Activities and/or Names:	From Month / Year:	To Month / Year:

<b>XIV. PEER REFERENCES</b>		
<b>Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.</b>		
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: ( ) - Ext	Fax Number: ( ) -	E-mail Address, if available:
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: ( ) - Ext	Fax Number: ( ) -	E-mail Address, if available:
Name of Reference:		Complete Address, include Department if applicable:
Specialty:		
Professional Relationship:		
Telephone Number: ( ) - Ext	Fax Number: ( ) -	E-mail Address, if available:

## XV. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		

**Please list all previous professional liability carriers within the past three (3) years.**  
**Please attach additional sheets, if necessary.** Does Not Apply

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		

## XVI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

**Modification to the wording or format of these Attestation Questions will invalidate the application.**

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	<b>In the last three (3) years</b> has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction <b>ever been</b> denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you <b>ever been</b> fined or received a letter of reprimand or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B.	<b>In the last three (3) years</b> have you <b>ever been</b> suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	<b>In the last three (3) years</b> have you <b>ever been</b> denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization <b>ever been</b> placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	<b>In the last three (3) years</b> have you <b>ever</b> surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E.	<b>In the last three (3) years</b> has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* <b>ever been</b> withdrawn on your request prior to the organization’s final action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F.	<b>In the last three (3) years</b> has your membership or fellowship in any local, county, state, regional, national, or international professional organization <b>ever been</b> revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G.	<b>In the past three (3) years</b> , have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H.	<b>In the last three (3) years</b> have you <b>ever</b> had board certification revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I.	<b>In the last three (3) years</b> have you <b>ever been</b> the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J.	<b>In the last three (3) years</b> have you ever been charged with a criminal violation (felony or misdemeanor)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K.	Do you presently use any illegal drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L.	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.		
M.	Are you <b>unable</b> to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
N.	<b>In the last three (3) years</b> have any professional liability claims or lawsuits <b>ever been</b> closed and/or filed against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	If yes, please complete <b>Attachment A, Professional Liability Action Detail</b> , for <b>each</b> past or current claim and/or lawsuit.		
O.	<b>In the last three (3) years</b> has your professional liability insurance <b>ever been</b> terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you <b>ever been</b> denied professional liability insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**\*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system**

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OREGON PRACTITIONER RECREDENTIALING APPLICATION**  
**AUTHORIZATION AND RELEASE OF INFORMATION FORM**

**Modified Releases Will Not Be Accepted**

**By submitting this application, I understand and agree to the following:**

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system] indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and recredentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest Extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

<b>Printed Name:</b>	
<b>Signature:</b>	<b>Date:</b>

**I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):**


**Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.**

# ATTACHMENT A

## PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Please list any past or current professional liability claim or lawsuit, which has been filed against you **in the past three (3) years. Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's Name (print or type):

Month / Day / Year of the incident: and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month / Day / Year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Month / Day / Year of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

**I verify the information contained in this form is correct and complete to the best of my knowledge.**

Signature:

Date:

**Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.**

## GLOSSARY OF TERMS AND ACRONYMS

**AAHC:** Accreditation Association for Ambulatory Health Care - An organization that offers voluntary accreditation for ambulatory care organizations.

**AANA:** American Association of Nurse Anesthetists

**ACUMENTRA:** Oregon Medical Professional Review Organization - A private, non-profit organization that contracts to undertake appropriateness of care, utilization management and quality improvement projects for CMS, other public agencies and insurance companies.

**ACCREDITATION:** A comprehensive, standardized evaluation process that involves assessing the degree to which an organization/individual complies with a defined set of standards.

**ACGME:** Accreditation Council for Graduate Medical Education - This organization is responsible for the Accreditation of post-M.D. medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

**ACLS:** Advanced Cardiac Life Support

**ADMITTING PRIVILEGES:** The right granted to a doctor to admit patients to a particular hospital.

**AGENT:** An insurance company representative licensed by the state, who solicits, markets, negotiates, binds and administers contracts of insurance.

**AGPA:** American Group Practice Association

**AHA:** American Hospital Association

**AHP:** Allied Health Personnel - Specially trained and licensed, or registered when required by Oregon law, health workers who perform tasks, which might otherwise be performed by physicians or nurses.

**AMA:** American Medical Association

**ANA:** American Nurses Association

**ANCILLARY SERVICES:** Supplemental health care services provided to a person while being treated. Included are laboratory, radiology, physical therapy, etc.

**ATLS:** Advanced Trauma Life Support

**ATTESTATION:** A signed statement indicating that a practitioner personally confirmed the validity, correctness, and completeness of his or her credentialing/recredentialing application.

**BHC:** Behavioral Health Care - A broad array of mental health, chemical dependency, forensic, mental retardation or developmental disabilities and cognitive rehabilitation services provided in settings such as acute, long term and ambulatory care.

**BLS:** Basic Life Support

**CALL COVERAGE:** Practitioners who provide care for your patients when you are unavailable.

**CLAIM PENDING:** A current request by the insured for indemnification by the insurance company for a loss that is a covered peril.

**CLAIMS-MADE COVERAGE:** A policy providing liability coverage only if a written claim is made during the policy period or any applicable extended reporting period. For example, a claim made in the current year could be charged against the current policy even if the injury or loss occurred many years in the past. If the policy has a retroactive date, an occurrence prior to that date is not covered. (contrast with Occurrence Coverage).

**CME:** Continuing Medical Education

**CMS:** Centers for Medicare and Medicaid Services - The federal agency that administers funds and oversees provision of medical care to Medicare and Medicaid patients.

**COA:** Certificate of Authority - A certificate issued by a state government, licensing the operation of a health maintenance organization.

**CON:** Certificate of Need - A certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment or offer a new or different health service.

**CONTINUITY OF CARE:** The provision of care by the same set of practitioners over time or, if the same practitioners are not available, a mechanism to promptly provide appropriate clinical information to the practitioners who continue to provide the same type and level of care.

**COORDINATION OF CARE:** The mechanisms ensuring that patients and practitioners have access to, and take into account, all required information on patient condition and treatment to ensure that the patient receives appropriate health care services.

**COVERAGE:** The services for which an insurance policy does and does not pay.

**CPR:** Cardio-Pulmonary Resuscitation

**CREDENTIALING/RE-CREDENTIALING:** The process of determining eligibility, for organizations such as hospitals or PHOs, for medical staff membership and privileges to be granted to physicians. Credentials and performance are periodically reviewed, which could result in physician privileges being denied, modified or withdrawn.

**CSO:** Clinical Service Organization - A medical center integrating the activities of the medical school, faculty practice plan and hospital to negotiate with managed care plans.

**CSR:** Controlled Substance Registration

**CVO:** Credential Verification Organization - A group that provides a centralized, uniform process for state medical boards, private and governmental entities to obtain a verified, primary source record of a physician's core medical credentials by gathering, verifying and permanently storing a physician's credentials in a centralized repository.

**DCO:** Direct Contracting Organization - Individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary.

**DEA:** Drug Enforcement Agency - The federal agency that issues licenses to prescribe and dispense scheduled drugs.

**DMAP:** Division of Medical Assistance Programs - A state agency that acts as the administrator for the Medicaid component of the Oregon Health Plan.

**ECFMG:** Educational Commission for Foreign Medical Graduates - A certification process that assesses the readiness of graduates of foreign medical schools to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

**EPO:** Exclusive Provider Organization - A managed care organization that designates specific physicians and other providers who can provide health care services.

**EXCLUSIONS:** The specific conditions or circumstances listed in an insurance policy for which the policy will not provide benefit payments.

**HCFA:** See CMS.

**HMO:** Health Maintenance Organization - An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Health care services are rendered by practitioners affiliated with the health care system. In these types of managed care organizations, in order to receive reimbursement, members must obtain all services from an affiliated practitioner or provider and must comply with a pre-defined authorization system.

**HSA:** Health Systems Agency - A health-planning agency created under the National Health Planning and Resource Development Act of 1974.

**ID:** Identification

**INCIDENT REPORT:** The documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established health department licenses, policies, procedures and/or practices.

**INDEMNIFICATION:** Insurance benefits paid to or on behalf of an insured for the provision of goods and services covered by the policy.

**INSURANCE:** Protection by written contract against financial hazards (in whole or in part) of the happenings of specified fortuitous events.

**INSURED:** A person or organization, covered by an insurance policy, including the “named insured” and any other parties for whom protection is provided under the policy.

**INSURER:** The party to the insurance contract who promises to pay losses or benefits or a corporation engaged primarily in the business of furnishing insurance.

**INTERNSHIP:** Receiving supervised practical experience in the health care field, usually as an advanced or graduate student, also referred to as post-graduate year 1 (PGY1)

**IPA:** Independent Practice Association - A federation of independently-practicing physicians and/or other practitioners organized to contract with health plans and other third party payers as to the conditions under which medical services will be covered for insured patients with the understanding that said conditions shall be considered and independently agreed to by each practitioner or legally-integrated group of practitioners belonging to the IPA.

**IPN:** Integrated Provider Network - A group comprised of primary and secondary hospitals, physicians and other health care practitioners within a city or other geographic area.

**ISN:** Integrated Service Network - A group comprised of a combination of physicians and other health care providers who deliver health care in an integrated way.

**LAPSED POLICY:** A policy terminated for non-payment of premiums.

**LOCUM TENENS:** The act of a practitioner temporarily taking the place of another practitioner.

**MALPRACTICE:** Professional misconduct or lack of ordinary skill in the performance of a professional act, which renders the responsible practitioner liable to suit for damages.

**MCO:** Managed Care Organization - Any type of organizational entity providing managed care such as an HMO, PPO, and EPO, etc.

**MEDICAID:** A joint federal and state-funded health care program for low-income families and individuals or disabled persons.

**MEDICARE:** Federal health insurance administered by HCFA. It is the nation's largest health insurance program, which provides health insurance to people age 65 and over, those who have permanent kidney failure and certain people with disabilities.

**NA (N/A):** Not Applicable

**NCHSR:** National Center for Health Services Research

**NCQA:** National Committee for Quality Assurance - An independent non-profit organization that has worked with consumers, health care purchasers, state regulators and the managed care industry in developing standards that evaluate the structure and function of medical and quality management systems in managed care organizations.

**NEGLIGENCE:** The failure to use the reasonable care that a prudent person would have used under the same or similar circumstances.

**NIMH:** National Institute of Mental Health

**NPI:** National Provider Identification number, a unique health identification number for health care providers, became an HIPAA (Health Insurance Portability and Accountability Act of 1996) standard by May 23, 2007 for most covered health care entities and May 23, 2008 for small health plans.

**NON-PARTICIPATING PROVIDER:** Physicians/providers and facilities that are not under contract as health providers for a HMO/PPO.

**NOTICE OF CANCELLATION:** A written notice by an insurance company of their intent to cancel the policy.

**NRP:** Neonatal Resuscitation Program

**OCCURRENCE COVERAGE:** A policy form providing liability coverage only for injury or damage that occurs during the policy period, regardless of when the claim is actually made. For example, a claim made in the current policy year could be charged against a prior policy period, or may not be covered, if it arises from an occurrence prior to the effective date. (contrast with Claims-Made Coverage)

**OHMO:** Office of Health Maintenance Organizations - A component of the U.S. Department of Health and Human Services that is charged with the responsibility for directing the federal HMO program.

**OMB:** Oregon Medical Board - A state agency responsible for administering the Medical Practice Act and establishing the rules and regulations pertaining to the practice of medicine in Oregon. The board determines requirements for Oregon licensure as a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Physician Assistant (PA), and Acupuncturist (LAc).

**PALS:** Pediatric Advanced Life Support

**PARTICIPATING PROVIDER:** A physician or other health care practitioner who has contracted with a health plan to provide medical services to members.

**PCG:** Physician Care Groups - A classification system used to determine payment for physician services.

**PCN:** Primary Care Network - A group of primary care providers linked for purposes of administering health coverage.

**PCP:** Primary Care Provider - A physician or other health care practitioner who is responsible for monitoring an individual's overall health care needs.

**PEER:** Individual(s) in the same professional discipline as the applicant with personal knowledge of the applicant.

**PERIL:** The cause of a loss insured against in a policy.

**PGY 1:** Post-graduate Year 1 (see Internship)

**PHO:** Physician/Hospital Organization - A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests.

**POLICY:** The term used for the legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

**POS:** Point of Service - A type of managed care coverage that allows members to choose to receive services either from participating HMO physicians and other health care practitioners and providers, or from those not in the HMO's network. Patients pay less for in-network care and for out-of-network care; members usually pay deductibles and a percentage of the cost of care.

**PPO:** Preferred Provider Organization - A network of doctors and hospitals that provide care to an enrolled population at a pre-arranged discounted rate.

**PRACTITIONER:** A physician or other licensed or registered health care professional qualified to render medical services.

**PREMIUM:** The amount paid for any insurance policy.

**PRO:** Peer Review Organization or Physician Review Organization

**PROFESSIONAL LIABILITY CLAIM:** Written demand for money or services.

**PROFESSIONAL LIABILITY INSURANCE:** Insurance purchased by physicians and other health care providers to help protect themselves from financial risks associated with medical liability claims.

**PROVIDER:** An institution or organization, such as hospitals, home health agencies, and skilled nursing facilities, that provides services to patients.

**PROVIDER TAXONOMY CODES:** A provider classification system, which is a nationally recognized list of provider types and specializations, initially setup by the Centers for Medicare/Medicaid Services (CMS) with the intent to provide a single coding structure to support work on the National Provider System. The current list is now administered and published by the National Uniform Claim Committee (NUCC).

**REHABILITATION SERVICE:** An organization service providing medical, health-related, social and vocational services for disabled persons to help them attain or retain their maximum functional capacity.

**RISK:** The degree of probability of loss or the amount of possible loss to the insuring company.

**SETTLEMENT:** A policy benefit or claim payment. It refers to an agreement between both parties to the policy contract as to the amount and method of payment.

**SNF:** Skilled Nursing Facility - A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

**TAXONOMY CODES:** See Provider Taxonomy Codes.

**TERM:** The period of time a policy is in effect.

**TJC:** The Joint Commission - A private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care and long term care services.

**UPIN:** Unique Provider Identification Number

**USMLE:** United States Medical Licensing Examination - A certifying examination that fulfills requirements for medical licensure, as well as providing a common evaluation system for all applicants for medical licensure. Results of USMLE are reported to medical licensing authorities in the United States for use in granting the initial license to practice medicine.