Oregon Common Credentialing Advisory Group Members

January 2017

Debra Bartel, FACMPE - Clinic Administrator, Portland Diabetes & Endocrinology Center PC

Danielle Coates, CPCS - Medical Staff Office Manager, Tuality Healthcare

Erick Doolen - Chief Information Officer/SVP of Operations, Pacific Source Health Plans ***(Co-Chair)***

Larlene Dunsmuir - Family Nurse Practitioner, Oregon Nurses Association/Nurse Practitioners of Oregon

Michael Duran, MD - Psychiatrist, Oregon State Hospital

Tooba Durrani, ND, MSOM, LAc - Oregon Association of Acupuncture and Oriental Medicine (OAAOM)

Denal Everidge - Medical Staff Coordinator, Oregon Health & Sciences University

Kevin Ewanchyna, MD - Chief Medical Officer, Samaritan Health Plans/Intercommunity Health Network CCO ***(Co-Chair)***

Stephen Godowski - Credentialing Coordinator, Therapeutic Associates, Inc. & NW Rehab Alliance

Ruby Jason, MSN, RN, NEA-BC - Executive Director, Oregon Board of Nursing

Joanne Jene, MD - Physician/Anesthesiologist/Retired, Oregon Medical Association/Oregon Society of Anesthesiologists

Shannon Jones - Human Resources Manager, Dentist Relations and Recruitment, Willamette Dental Group

Ann Klinger, CPCS - Credentialing Supervisor, Providence Health Plans

Kecia Norling - Administrator, Northwest Ambulatory Surgery Center

Mary Pohlman, CPCS – Manager, Credentials, Kaiser Permanente

Cristi L. Skye, RN, MSN, CPMSM/CPCS - Medical Staff Liaison, Asante Rogue Regional Medical Center

Shelley Sneed - Executive Director, Board of Optometry

Richard Ulbricht - Credentialing Manager, Portland IPA

Jennifer Waite, CPCS - Credentialing Manager, Central Oregon IPA

Suggestions for the Oregon Practitioner Credentialing Application
ACPCI Considerations and Recommended Actions - October 2016; AND CCAG Input - December 2016

No.	Received	Suggestor	Suggestions	Action	Notes
1	8/15/2016	Sarah Ayers, NaraNW	Page 4 Section VIII Undergraduate Education and Section IX Graduate Education Suggest including box for start date in addition to graduation date in these two sections.	Accepted	-Group noted that this change could be helpful for PAs, NPs, as well as some of the allied health professionals. -Group noted that the form currently asks for start dates in the higher education sections. -Concern raised by one member related to uncertainty around how this change would affect her organization's internal processes. That being said, the change was approved unanimously.
2	8/15/2016	Danielle Coates, Tuality	Page 7 Section XVI Hospital and Other Health Care Facility Affiliations Suggest adding box for "Professional Liability Carrier" to each affiliation, in addition to having that box for Work History section entries. This way providers would really get to thinking about all the policies that should be listed on the malpractice page.	Accepted	-Group notes asking practitioner's to tie their malpractitice carrier to their hospital and health care facility affiliations in addition to their work histories could be useful in helping practitioners know all of the liability carriers they need to list in Section XX Professional Liability Insurance. -Victor raised the concern that practitioners may not know which liability carrier is associated with each of their affiliations. -Change was accepted with one opposition vote from Victor. This opposition will be considered when discussing this change with CCAG.

No.	Received	Suggestor	Suggestions	Action	Notes
3	8/24/2016	Steve Godowski, Therapeutic Associates	"What providers have expressed needing is a way to know which sections are applicable to their specific profession. A sheet that would list the sections most applicable to their profession—this would be helpful to providers that are needing to fill out the form for the first time and need some guidance." Suggest adding a sheet that lists the sections most applicable to different health care professions.	Accepted, as Amended	-Becky noted that this sounds like something separate from the application like a guidelines document. -Valery noted that the "Does Not Apply" checkboxes in sections throughout the application were meant for practitioners that don't need to fill out those sections. -Group votes to update all "Does Not Apply" checkboxes throughout the applications to read: "Does Not Apply to My Practitioner Type". Numerous sections in the application provide a “Does Not Apply” box to address circumstances other than just practitioner type. Changing these boxes as described above also creates challenges to maintain spacing of the applications’ contents. For these reasons, OHA recommends keeping the “Does Not Apply” boxes as they are, and changing bullet #6 in Section I Instructions on Page 1 to read: “If a section does not apply to you or your practitioner type, please check the “Does Not Apply” box at the top of the section.”

No.	Received	Suggestor	Suggestions	Action	Notes
4	8/30/2016	Catherine Jensen, Willamette Ear Nose & Throat	1) Throughout Word version of application you are unable to tab between fields. For example, pressing tab in Last Name just highlights Middle Name and doesn't actually go to the entry field like in the 2012 Word application. Suggest correcting this issue, so tab works like it did in 2012 application (s). This simply requires restricting editing priveleges to "Filling in Forms" in Word, or publishing only PDF versions.	Accepted	-Group votes to offer paper versions of 2016 OPCA and OPRA forms in PDF fillable form file types.
			2) The check boxes do not work. You should be able to click on yes or now and have the field fill. Suggest correcting this issue. This simply requires restricting editing priveleges to "Filling in Forms" in Word, or publishing only PDF versions.	Accepted	-Group votes to offer paper versions of 2016 OPCA and OPRA forms in PDF fillable form file types.
			3) When entering phone numbers on the document you cannot tab from the area code to the next entry point. It takes you to the next set of information to be entered. Suggest correcting this issue. This simply requires restricting editing priveleges to "Filling in Forms" in Word, or publishing only PDF versions.	Accepted	-Group votes to offer paper versions of 2016 OPCA and OPRA forms in PDF fillable form file types.

No.	Received	Suggestor	Suggestions	Action	Notes
5	9/6/2016	Elizabeth McLaughlin, FamilyCare Health	A) Page 2 Section II Practitioner Information and Page 6 Section XIV Health Care Licensure, Registrations, Certificates & ID Numbers Suggest moving NPI and Medicaid and Medicare Numbers to the Page 2 Section II Practitioner Information section.	Not Accepted	-Group agrees there is value in keeping Section XIV as is, so there is one place where all these numbers are collected.
			B) Page 2 Section II Practitioner Information Suggest adding field for Languages Spoken to Page 2 Section II Practitioner Information section.	Not Accepted	-Group noted that accreditation standards should be what we tie the application forms to and in the past we denied this change request in that vain.
			C) Page 3 Section VI Practice Information Suggest adding field for Office Hours to Page 3 Section VI Practice Information section.	Not Accepted	-Group noted that accreditation standards should be what we tie the application forms to and in the past we denied this change request in that vain.
6	9/9/2016	Catherine Drexler, Principal Life Insurance Company	A) Page 1 Documents to attach to application section Suggest adding "Specialty Training Certificate (if applicable)" to the list of current documents submitted with application.	Not Accepted	-Group voiced concern over not understanding the meaning and purpose of this change request, and voted to deny based on not having enough information to understand what the suggestion means.
			B) Page 6 Section XIV Health Care Licensure, Registrations, Certificates & ID Numbers Suggest changing "Individual NPI Number" field text to "Entity Type 1 (Individual) NPI Number". This would clarify that the form doesn't want Entity Type 2 (organization) NPI numbers.	Accepted, as Amended	-Group votes to change the language in this box to read "Individual (Type 1) NPI Number:". -Group votes to append the following two bullet points to the glossary entry for NPI explaining what Type 1 and Type 2 NPI providers are, in order to highlight the differences between them: • Entity Type 1 NPI providers: Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI. • Entity Type 2 NPI providers: Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

No.	Received	Suggestor	Suggestions	Action	Notes
Additional Suggestions/Recommendations Submitted by CCAG Members - December 2016					
CCAG 1	1/5/2017	Ruby Jason, Oregon State Board of Nursing	A) Page 11 Attestation Questions Suggest rewording attestation question G from "Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?" to "Have you **ever** voluntarily or involuntarily left or been discharged from the education program leading to your current licensure or any subsequent training program?" This way the question does not only apply to physicians but to all disciplines of health care practitioners that may be completing the OPCA.	N/A	N/A
			B) Glossary Both the OMB and AANE (American Association of Nurse Anesthestists) are listed in the glossary, but they don't seem to listed anywhere in the applications themselves. Suggest removing both from glossary.	N/A	N/A
CCAG 2	1/5/2017	Deb Bartel, Portland Diabetes & Endocrinology Center PC	Comment on ACPCI recommendation #6-2 regarding clarifying invidiual NPI #: If a provider is in a group do we fill in their individual NPI in the first box and the Group NPI in the second box? The amended language is very unclear to me and I wouldn't know how to fill this in. The form should include the practitioner's individual NPI as well as a space for the Group NPI (I believe the current for does NOT have space for the group NPI).	N/A	N/A

No.	Received	Suggestor	Suggestions	Action	Notes
CCAG 3	1/11/2017	Jen Waite, Central Oregon Independent Physicians Association	A) Comment on ACPCI recommendation #1 regarding adding "State date" field to the undergraduate and graduate education sections: I agree with the addition of including a start date. From an aesthetical perspective, I would recommend listing the start date box above the month/year of graduation box. As it is currently proposed, I can imagine applicants listing their start and end dates in the opposite boxes.	N/A	N/A
			B) Comment on ACPCI recommendation #2 regarding asking for "Professional Liability Carrier" in the "Hospital and Other Health Care Facility Affiliations" section: I agree with Victor's opposition. In many cases, the hospital's malpractice insurance policy covers the practitioner while providing services within that facility and the practitioner has no idea who the carrier is or what the policy details are, unless the practitioner is a true "hospital-employed" practitioner.	N/A	N/A

OREGON PRACTITIONER CREDENTIALING APPLICATION

- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**

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)
OCTOBER 26, 2016

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing 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 Credentialing 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 11, Attestation Questions and page 12, 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.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit 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 CREDENTIALING APPLICATION

II. PRACTITIONER INFORMATION

Please provide the practitioner's full legal name.

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 ☐ No ☐
Name(s) and Year(s) Used:

Home Street Address:	Home Telephone Number ( ) -	Mobile/Alternate Number ( ) -
	Email Address:	

City:	State:	ZIP:
Country:	Birth Date: Month / Day / Year	Birth Place:
Citizenship:	Social Security Number:	Gender: Male ☐ Female ☐

Immigrant Visa Number (if applicable):	Visa Expiration Date	Status:	Type:

Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):	Month / Year Issued:

III. SPECIALTY INFORMATION

This information may be included in directory listings.

Principal clinical specialty **(For most current specialties list, see: http://www.wpc-edi.com/codes):**	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐

Additional clinical practice specialties:

Category of professional activity, check all boxes that apply:

Clinical Practice:		Other Professional Activities:	
☐ Full Time	☐ Part Time	☐ Administration	☐ Teaching
☐ Locum / Temporary	☐ Telemedicine	☐ Research	☐ Retired
☐ Other (explain)		☐ Other (explain)	

IV. BOARD CERTIFICATION / RECERTIFICATION

This section does not apply to licensure.

Does Not Apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name and Address of Issuing Board	Specialty	Date Certified/Recertified Month / Year	Expiration Date (if any) Month / Year

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.

V. OTHER CERTIFICATIONS

Please attach copy of certificate(s), if applicable.

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:

For additional certifications, please attach a separate sheet.

VI. PRACTICE AND EMPLOYMENT INFORMATION

Name of Primary 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/Billing 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 Email Address:
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( ) - Ext	Credentialing Contact's Fax Number: ( ) -		Credentialing Contact's Email 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/Billing 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 Email Address:
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( ) - Ext	Credentialing Contact's Fax Number: ( ) -		Credentialing Contact's Email Address:
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	

Please list other office locations with above information on a separate sheet.

VII. PRACTICE CALL COVERAGE

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

	NAME:	SPECIALTY:
1.		
2.		
3.		
4.		
5.		

VIII. UNDERGRADUATE EDUCATION

Please attach additional sheets, if necessary.

Complete School Name and Street Address:	Degree Received:	Month / Year of Graduation: Month / Year of Start:
City:	State:	Course of Study or Major:

IX. GRADUATE EDUCATION

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete School Name and Street Address:	Degree Received:	Month / Year of Graduation: Month / Year of Start:
City:	State:	Course of Study or Major:

X. MEDICAL / PROFESSIONAL EDUCATION

Please attach additional sheets, if necessary.

Complete Medical / Professional School Name and Street Address:

City:	State	ZIP:
Degree Received:	Phone Number: ( ) -	Fax Number, if available ( ) -

From Month / Year:	To Month / Year:	Month / Year of Completion:

Did you complete the program? Yes ☐ No ☐ **(If you did not complete the program, please explain on a separate sheet.)**

Complete Medical / Professional School Name and Street Address:

City:	State:	ZIP:
Degree Received:	Phone Number: ( ) - :	Fax Number, if available ( ) -

From Month / Year:	To Month / Year:	Month / Year of Completion:

Did you complete the program? Yes ☐ No ☐ **(If you did not complete the program, please explain on a separate sheet.)**

XI. POST-GRADUATE YEAR 1 / INTERNSHIP

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
City:	State:	ZIP:
Type of Internship / Specialty:	Phone Number: ( ) -	Fax Number, if available ( ) -
From Month / Year:	To Month / Year:	Month / Year of Completion:
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XII. RESIDENCIES

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
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 ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	
Complete Institution Name and Street Address:		
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 ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XIII. FELLOWSHIPS, PRECEPTORSHIPS, OR OTHER CLINICAL TRAINING PROGRAMS

Please attach additional sheets, if necessary.

Does Not Apply ☐

Complete Institution Name and Street Address:		
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 ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	
Complete Institution Name and Street Address:		
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 ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**	

XIV. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES & ID NUMBERS

Please attach additional sheets, if necessary.

Oregon License or Registration Number:	Type:	Month / Day / Year of Expiration:
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Month / Day / Year of Expiration:
Controlled Substance Registration (CSR) Number (if applicable):		Month / Day / Year of Issue:
Entity Type 1 (Individual) NPI Number:	Medicare Number:	DMAP Number:
Physician Assistant Supervising Physician Full Name and Oregon License Number:		

XV. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES

Please include all ever held.

Does Not Apply ☐

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:		
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:		

Please attach additional sheets, if necessary.

XVI. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., 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 XVII, Professional Practice/Work History.**

A. CURRENT AFFILIATIONS

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Appointment		
Professional Liability Carrier:			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Professional Liability Carrier:			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Professional Liability Carrier:			
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Appointment		
Professional Liability Carrier:			

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. APPLICATIONS IN PROCESS

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Submission:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
Status:	Month / Day / Year of Submission:		

C. PREVIOUS AFFILIATIONS

Please attach additional sheets, if necessary.

Does Not Apply ☐

Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Professional Liability Carrier:	Reason for Leaving:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Professional Liability Carrier:	Reason for Leaving:		
Facility Name:	Phone Number: ( ) -	Fax Number, if available ( ) -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Professional Liability Carrier:	Reason for Leaving:		

XVII. PROFESSIONAL PRACTICE / WORK HISTORY

Does Not Apply ☐

Curriculum vitae is not sufficient.

A. **Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. <u>Please attach additional sheets, if necessary.</u>**

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

B.	**Please explain any gaps greater than two (2) months. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.**	Does Not Apply ☐

Activities and/or Names:	From Month / Year:	To Month / Year:

XVIII. PEER REFERENCES

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.

Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Email Address, if available:
Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - (Ext	Fax Number: ( ) -	Email Address, if available:
Name of Reference: Specialty: Professional Relationship:		Complete Address, include Department if applicable:
Telephone Number: ( ) - Ext	Fax Number: ( ) -	Email Address, if available:

XIX. CONTINUING MEDICAL EDUCATION

Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.

Does Not Apply ☐

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:**

XX. PROFESSIONAL LIABILITY INSURANCE

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

Please list all previous professional liability carriers within the past five (5) 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 ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: ( ) - Ext	Fax Number, if available: ( ) -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

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

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

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

XXI. 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.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
B.	Have you **ever been** 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 ☐	NO ☐
C.	Have you **ever been** 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 **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation , involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
D.	Have you **ever** 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 ☐	NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization***** **ever been** withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation , not renewed while under investigation , involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
G	Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐	NO ☐
H	Have you **ever** had board certification revoked?	YES ☐	NO ☐
I	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
J.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES ☐	NO ☐
K.	Do you presently use any illegal drugs?	YES ☐	NO ☐
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? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐	NO ☐
M	Are you **unable** 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 ☐	NO ☐
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES ☐	NO ☐
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES ☐	NO ☐

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 CREDENTIALING 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 Credentialing 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.

Printed Name:	
Signature:	**Date:**

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 Credentialing 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. **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 Credentialing Application will invalidate the application.

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 AND APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
October 26, 2016

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.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit 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

II. PRACTITIONER INFORMATION

Please provide the practitioner's full legal name.

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 ☐ No ☐ Name(s) and year(s) used:			
Home street address:		Home telephone number: ( )	Mobile/alternate number: ( )
		Email address:	
City:	State:	ZIP:	
Country:	Birth date (month/day/year): / /	Birth place:	
Citizenship:	Social Security number:	Gender: Male ☐ Female ☐	
Immigrant visa number (if applicable):	Visa expiration date:	Type:	

III. SPECIALTY INFORMATION

This information may be included in directory listings.

Principal clinical specialty ***(For most current specialties list, see: http://www.wpc-edi.com/codes.)*:**	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐
Additional clinical practice specialties:	

Category of professional activity, check all boxes that apply:

Clinical practice:

- ☐ Full time
- ☐ Part time
- ☐ Locum/temporary
- ☐ Telemedicine
- ☐ Other *(explain)*:

Other professional activities:

- ☐ Administration
- ☐ Teaching
- ☐ Research
- ☐ Retired
- ☐ Other *(explain)*:

IV. BOARD CERTIFICATION/RECERTIFICATION

This section does not apply to licensure.

Does not apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name and address of issuing board	Specialty	Date certified/recertified month/year	Expiration date *(if any)* month/year

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.

V. OTHER CERTIFICATIONS *Please attach copy of certificate(s), if applicable.* Does not apply ☐

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:

For additional certifications, please attach a separate sheet.

VI. PRACTICE AND EMPLOYMENT INFORMATION

Name of primary 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/billing 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 email address:
Recredentialing contact and address *(if different from above)*:			
Recredentialing contact's telephone number: ( ) Ext.:	Recredentialing contact's fax number: ( )		Recredentialing contact's email address:
Federal tax ID number or Social Security number, if used for business purposes:		Name affiliated with tax ID number:	

Name of primary 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/billing 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 email address:
Recredentialing contact and address *(if different from above)*:			
Recredentialing contact's telephone number: ( ) Ext.:	Recredentialing contact's fax number: ( )		Recredentialing contact's email address:
Federal tax ID number or Social Security number, if used for business purposes:		Name affiliated with tax ID number:	

Please list other office locations with above information on a separate sheet.

VII. PRACTICE CALL COVERAGE

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

NAME:	SPECIALTY:
1.	
2.	
3.	
4.	
5.	

VIII. ADDITIONAL EDUCATION

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.

Does not apply ☐

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 ☐ No ☐ ***(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 ☐ No ☐ ***(If you did not complete the program, please explain on a separate sheet.)***

IX. CONTINUING MEDICAL EDUCATION

Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.

Does not apply ☐

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:

X. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES AND ID NUMBERS

Please attach additional sheets, if necessary.

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:
Entity Type 1 (Individual) NPI number:	Medicare number:	OMAP number:

Physician Assistant Supervising Physician Full Name and Oregon License Number:

XI. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS AND CERTIFICATES

Please attach additional sheets, if necessary

Does not apply ☐

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:		

XII. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

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.**

A. AFFILIATIONS IN THE PAST THREE (3) YEARS

Facility name:	Phone number: ( )	Fax number, if available: ( )	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/day/year of appointment:		
Professional Liability Carrier:			
Facility name:	Phone number: ( )	Fax number, if available: ( )	Complete address:
Status:	Month/day/year of appointment:		
Professional Liability Carrier:			
Facility name:	Phone number: ( )	Fax number, if available: ( )	Complete address:
Status:	Month/day/year of appointment:		
Professional Liability Carrier:			

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. APPLICATIONS IN PROCESS

Does not apply ☐

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 email 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 email 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 email 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 email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's came:
Telephone number: ( ) Ext.:	Fax number: ( )	Complete address:
From month/year:	To month/year:	
Contact's email 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 email 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 email address, if available:		Professional liability carrier:

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.**	Does not apply ☐

Activities and/or names:	**From month/year:**	**To month/year:**

XIV. PEER REFERENCES

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.

Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: ( ) Ext.:	Fax number: ( )	Email address, if available:
Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: ( ) Ext.:	Fax number: ( )	Email address, if available:
Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: ( ) Ext.:	Fax number: ( )	Email address, if available:

XV. PROFESSIONAL LIABILITY INSURANCE

Current insurance carrier/provider of professional liability coverage:	Policy number:	Type of coverage *(check one)*: Claims-made ☐ Occurrence ☐
Name of local contact:	Mailing address:	
Contact's telephone number: ( ) Ext.:	Fax number, if available: ( )	
Per claim limit of liability:	Aggregate amount:	
Month/day/year effective:	Month/day/year retroactive date, if applicable:	Month/day/year of expiration:

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 ☐ Occurrence ☐
Name of local contact:	Mailing address:	
Contact's telephone number: ( ) Ext.:	Fax number, if available: ( )	
Per claim limit of liability:	Aggregate amount:	
Month/day/year effective:	Month/day/year retroactive date, if applicable:	Month/day/year of expiration:

Insurance carrier/provider of professional liability coverage:	Policy number:	Type of coverage *(check one)*: Claims-made ☐ Occurrence ☐
Name of local contact:	Mailing address:	
Contact's telephone number: ( ) Ext.:	Fax number, if available: ( )	
Per claim limit of liability:	Aggregate amount:	
Month/day/year effective:	Month/day/year retroactive date, if applicable:	Month/day/year of expiration:

Insurance carrier/provider of professional liability coverage:	Policy number:	Type of coverage *(check one)*: Claims-made ☐ Occurrence ☐
Name of local contact:	Mailing address:	
Contact's telephone number: ( ) Ext.:	Fax number, if available: ( )	
Per claim limit of liability:	Aggregate amount:	
Month/day/year effective:	Month/day/year retroactive date, if applicable:	Month/day/year of expiration:

Insurance carrier/provider of professional liability coverage:	Policy number:	Type of coverage *(check one)*: Claims-made ☐ Occurrence ☐
Name of local contact:	Mailing address:	
Contact's telephone number: ( ) Ext	Fax number, if available: ( )	
Per claim limit of liability:	Aggregate amount:	
Month/day/year effective:	Month/day/year retroactive date, if applicable:	Month/day/year of expiration:

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.	**In the last three (3) years** has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐ NO ☐
B.	**In the last three (3) years** have you **ever been** 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 ☐ NO ☐
C.	**In the last three (3) years** have you **ever been** 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 **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES ☐ NO ☐
D.	**In the last three (3) years** have you **ever** 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 ☐ NO ☐
E.	**In the last three (3) years** has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization*** ever been** withdrawn on your request prior to the organization's final action?	YES ☐ NO ☐
F.	**In the last three (3) years** has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation , not renewed while under investigation , involuntarily relinquished, or is any such action pending or under review?	YES ☐ NO ☐
G.	**In the past three (3) years,** have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐ NO ☐
H.	**In the last three (3) years** have you **ever** had board certification revoked?	YES ☐ NO ☐
I.	**In the last three (3) years** have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐ NO ☐
J.	**In the last three (3) years** have you ever been charged with a criminal violation *(felony or misdemeano*r)?	YES ☐ NO ☐
K.	Do you presently use any illegal drugs?	YES ☐ NO ☐
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? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐ NO ☐
M.	Are you **unable** 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 ☐ NO ☐
N.	**In the last five (5) years** have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES ☐ NO ☐
O.	**In the last three (3) years** has your professional liability insurance **ever been** terminated, not renewed, restricted, or *modified (e.g. reduced limits, restricted coverage, surcharged)*, or have you **ever been** denied professional liability insurance?	YES ☐ NO ☐

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.

Printed name: _____

Signature: _____ **Date:** _____

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

_____

_____

_____

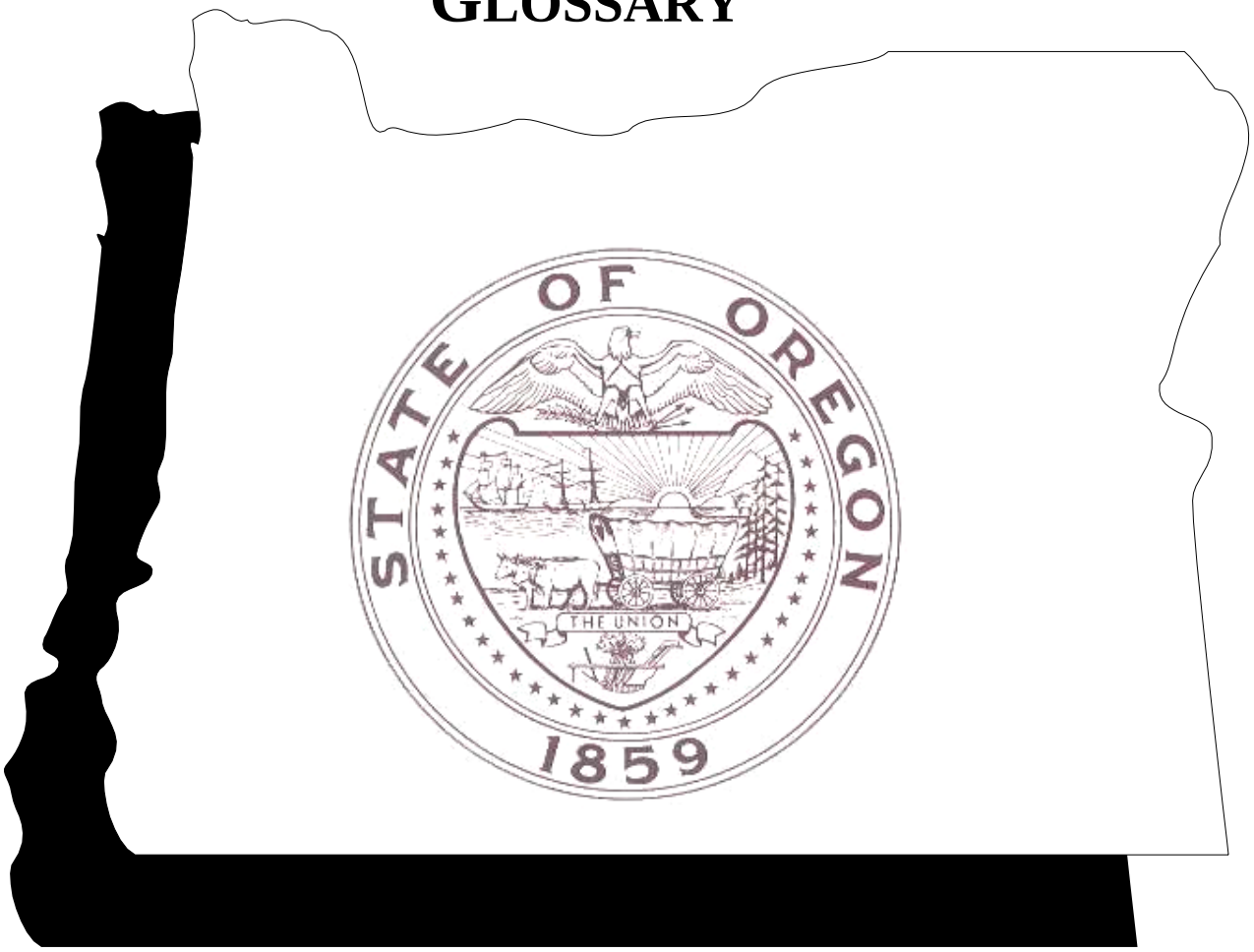
Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.

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 five (5) 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.

OREGON PRACTITIONER CREDENTIALING APPLICATION GLOSSARY



GLOSSARY OF TERMS AND ACRONYMS

AAAHC: 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 the 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/RECREDENTIALING: 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 CMS. 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 manage 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. There are two types of health care providers in terms of NPIs:

- Entity Type 1 NPI providers: Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
- Entity Type 2 NPI providers: Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

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.

TELEMEDICINE: Using telecommunication technology to deliver health services, including but not limited to clinical diagnosis, clinical services, patient consultation and the practice of medicine across state lines.

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.

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.

Common Credentialing Advisory Group (CCAG)
2017 Meeting Schedule

Wednesday, February 1, 2017
2:00-4:00pm
Portland – Lincoln

Wednesday, April 5, 2017
2:00-4:00pm
Portland – Lincoln

Wednesday, June 7, 2017
2:00-4:00pm
Salem – HSB

Wednesday, August 2, 2017
2:00-4:00pm
Portland – Lincoln

Wednesday, October 4, 2017
2:00-4:00pm
Portland – Lincoln

Wednesday, December 6, 2017
2:00-4:00pm
Salem – HSB

*See website for conference room/building locations:
http://www.oregon.gov/oha/OHIT/occp/Pages/CCAG.aspx.