



Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

Dear Health Care Professional:

In 1998, the Oklahoma Legislature passed a law dealing with credentials verification. That law directed the Board of Health to promulgate rules and the Oklahoma State Department of Health to develop a uniform credentialing application. The application will be used to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

The Department developed the Uniform Credentialing Application. Although many of the items apply primarily to physicians, this form is designed for use by all health care professionals.

Please note these specific instructions:

- 1. DO NOT submit this form to the Oklahoma State Department of Health.**
- 2. Contact the facility or organization to which you plan to apply before submitting this form to find out what addendum, supplemental form, additional information, or additional items will be required.**
- 3. All items must be completed.**
- 4. If an item is not applicable, please so state.**
- 5. Please print legibly or type.**
- 6. Be sure to sign and date the application.**
- 7. If additional space is needed, please attach additional sheets.**

The application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. The form is available on the Department's website at <http://hrds.health.ok.gov>. For questions about the form you may contact the Department at (405) 271-6868. The form may also be available online at the different facilities and organizations to which you will be making application.

Protective Health Services
Oklahoma State Department of Health



Health Resources
Development Service
Oklahoma State
Department of Health

Managed Care Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone 405.271.6868
Fax 405.271.7360

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This form must be completed in full and typed or printed legibly (i.e. do not state “see CV”). Write “N/A” in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to: _____

Date: _____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.

SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix
Professional Degree _____ Gender: ___ Male ___ Female

Other Name By Which You Have Been Known _____
Dates This Name Was Used: From: ___ - ___ - ___ to ___ - ___ - ___

Other Name By Which You Have Been Known _____
Dates This Name Was Used: From: ___ - ___ - ___ to ___ - ___ - ___

Social Security Number ___ - ___ - ___ NPID (formerly UPIN) _____

Date of Birth: ___ - ___ - ___ Place of Birth _____ Citizenship _____

Visa Type Visa Number (provide copy) Expiration Date

Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: _____
Street Address

Suite Number City State Zip Code
() () ()

Phone Number Fax Number Emergency or Pager Number
()

Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: _____

This Section continues on next page.

-Section 2 Continued-

Office Street Address: _____
Street Address

Suite Number	City	State	Zip Code
()		()	()
Phone Number		Fax Number	Emergency or Pager Number
()			
Answering Service Number		E-Mail Address	

Office Mailing Address: _____
Street Address

Suite Number	City	State	Zip Code
()		()	()
Phone Number		Fax Number	Emergency or Pager Number
()			
Answering Service Number		E-Mail Address	

Office Billing Address (If Different From Claims Payment Address): _____
Street Address

Suite Number	City	State	Zip Code
()		()	()
Phone Number		Fax Number	Emergency or Pager Number
()			
Answering Service Number		E-Mail Address	

Claims Payment Address (If Different From Office Billing Address): _____
Street Address

Suite Number	City	State	Zip Code
()		()	()
Phone Number		Fax Number	Emergency or Pager Number
()			
Answering Service Number		E-Mail Address	

Make Checks Payable To: _____

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice)	Subspecialty	% Of Time
--	--------------	-----------

Secondary Specialty	Subspecialty	% Of Time
---------------------	--------------	-----------

Do you wish to be listed as:
 Primary Care Provider Specialist Hospitalist On-Call Other (specify) _____

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

Yes No Are you accepting new patients?

Yes No Are you willing, in the future to accept new patients?

Yes No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

Yes No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

Yes No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

()	()	()
-----	-----	-----

Phone Number	Fax Number	Answering Service Number
--------------	------------	--------------------------

Name: _____

Street Address	Suite Number
----------------	--------------

City	State	Zip Code
------	-------	----------

()	()	()
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Phone Number	Fax Number	Answering Service Number
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List any restrictions on your practice (i.e. patient age and gender): _____

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: () _____			
	Dates Attended (mo/day/year) From: ____ - ____ - _____ to ____ - ____ - _____			
	Graduation Date ____ - ____ - _____			
(2)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: () _____			
	Dates Attended (mo/day/year) From: ____ - ____ - _____ to ____ - ____ - _____			
	Graduation Date ____ - ____ - _____			
(3)	Institution		Degree Awarded	
	Mailing Address	City	State	Zip Code
	Telephone Number: () _____			
	Dates Attended (mo/day/year) From: ____ - ____ - _____ to ____ - ____ - _____			
	Graduation Date ____ - ____ - _____			

SECTION 5: TRAINING

Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed: Yes No

Specialty	Institution	Your Program Director	
		()	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(2) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director	
		()	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(3) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director	
		()	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

(4) Type of Program:
 Internship Residency Fellowship Preceptorship Other (specify) _____

Was program successfully completed? Yes No

Specialty	Institution	Your Program Director	
		()	
Address	City	State	Zip Code Phone Number
Dates Attended (mo/day/year) From: ____ - ____ - ____ to ____ - ____ - ____			

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1)		()		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(2)		()		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(3)		()		City	State	Zip Code	Phone Number
	Institution and Address						
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, all hospital/health system affiliations where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your “current primary and secondary admitting facility” (where you currently spend the greatest portion of your time).

(1)		___ Primary	___ Secondary
	Facility Name		
		()	
	Complete Mailing Address	City	State
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	
(2)		___ Primary	___ Secondary
	Facility Name		
		()	
	Complete Mailing Address	City	State
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	

This section continues on next page.

-Section 7 Continued-

(3) _____ Primary ___ Secondary
 Facility Name

_____ ()
 Complete Mailing Address City State Zip Code Telephone Number

From: _____ - _____ - _____ to _____ - _____ - _____
 Dates of Appointment (mo/day/year) Staff Category

_____ Department or Service
 Reason for Discontinuance

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) _____
 Name and Nature of Affiliation

_____ ()
 Mailing Address City State Zip Code Telephone Number

From: _____ - _____ - _____ to _____ - _____ - _____
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) _____
 Name and Nature of Affiliation

_____ ()
 Mailing Address City State Zip Code Telephone Number

From: _____ - _____ - _____ to _____ - _____ - _____
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) _____
 Name and Nature of Affiliation

_____ ()
 Mailing Address City State Zip Code Telephone Number

From: _____ - _____ - _____ to _____ - _____ - _____
 Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: _____ - _____ - _____ to _____ - _____ - _____

_____ Branch of Service
 Location

From: _____ - _____ - _____ to _____ - _____ - _____

_____ Branch of Service
 Location

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

<u>Oklahoma</u>					
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
USMLE/ECFMG Number			Certification Date		
_____			____-____-____		

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
 (DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

	<u>DEA</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
<u>Oklahoma</u>	<u>BNDD</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	

BOARD CERTIFICATION

Are you Board Certified? Yes No _____
 Name of Board

_____ _____ _____
 Date Initially Certified Date Most Recently Recertified Date Certification Expires

Yes No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____	____ - ____ - ____	____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

Subspecialty or Added Qualification	Name of Board	
____ - ____ - ____	____ - ____ - ____	____ - ____ - ____
Date Initially Certified	Date Most Recently Recertified	Date Certification Expires

BOARD QUALIFICATIONS

___ Yes ___ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

___ Yes ___ No Are you planning to take the exam?

___ Yes ___ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral ____ - ____ - ____

Written ____ - ____ - ____

Other ____ - ____ - ____

Subspecialty or Added Qualification	Name of Board
Date Qualified ____ - ____ - ____	Date Qualification Expires ____ - ____ - ____

Classifications:

___ Yes ___ No Are you certified in CPR? Expires ____ - ____ - ____

___ Yes ___ No Basic Life Support (BLS) Expires ____ - ____ - ____

___ Yes ___ No Advanced Cardiac Life Support (ACLS) Expires ____ - ____ - ____

___ Yes ___ No Health Care Provider (CoreC) Expires ____ - ____ - ____

___ Yes ___ No Advanced Trauma Life Support (ATLS) Expires ____ - ____ - ____

___ Yes ___ No Neonatal Advanced Life Support (NALS) Expires ____ - ____ - ____

___ Yes ___ No Pediatric Advanced Life Support (PALS) Expires ____ - ____ - ____

___ Yes ___ No Other _____ Expires ____ - ____ - ____

SECTION 11: OFFICE INFORMATION

Primary Office

Group Name	Name As It Appears On Your W-9 (if applicable)	Business Owned By
Type of Practice:		
<input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Single-Specialty Group <input type="checkbox"/> Multi-Specialty Group Other (specify) _____		

Office Manager	Nurse Coordinator
----------------	-------------------

Group Medicare Number	Group Medicaid Number	IRS Tax ID Number
Does this office have lab service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reference Lab? <input type="checkbox"/> Yes <input type="checkbox"/> No	On Site? <input type="checkbox"/> Yes <input type="checkbox"/> No
CLIA ID # _____	CLIA Waiver # _____	

Does your office have the following:

Yes No Radiology

Yes No EKG

Yes No Audiology

Yes No Treadmill

Yes No Sigmoidoscopy

Yes No Wheelchair/handicapped access?

Yes No Other services for the disabled?

If yes, please list: _____

Yes No Other: _____

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

Yes No Does this office meet all state and local fire, safety and sanitation requirements?

Yes No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____

Yes No Do you or your business own, operate, manage or participate in any medical enterprise or business?
 If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION

Secondary Office

Group Name _____ Name As It Appears On Your W-9 (if applicable) _____ Business Owned By _____
 Type of Practice:
 Solo Partnership Single-Specialty Group Multi-Specialty Group Other (specify) _____

Office Manager _____ Nurse Coordinator _____

Group Medicare Number _____ Group Medicaid Number _____ IRS Tax ID Number _____
 Does this office have lab service? Yes No Reference Lab? Yes No On Site? Yes No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:
 Yes No Radiology
 Yes No EKG
 Yes No Audiology
 Yes No Treadmill
 Yes No Sigmoidoscopy
 Yes No Wheelchair/handicapped access?
 Yes No Other services for the disabled?
 If yes, please list: _____
 Yes No Other: _____

List all independent licensed non-physicians working in this office.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fluent Languages:
 You _____
 Your Staff _____
 Other Resources _____

Yes No Does this office meet all state and local fire, safety and sanitation requirements?
 Yes No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____
Name _____	Specialty _____	Telephone (____) _____

Yes No Do you or your business own, operate, manage or participate in any medical enterprise or business?
 If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

<u>Attached</u>	<u>Item</u>
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:

Practitioners are reminded that each organization will require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.
