



## Uniform Credentialing Application

63 O.S. 2011, Section 1-106.2

**This form must be completed in full and typed or printed legibly (i.e. do not state “see CV”), unless the credentialing entity to which you are applying advises you otherwise. 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.**

## Uniform Credentialing Application

### 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.**



## Uniform Credentialing Application

### SECTION 3: CURRENT PROFESSIONAL PRACTICE

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

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

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

List any restrictions on your practice (i.e. patient age and gender): \_\_\_\_\_

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## 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 - -			

### Foreign Medical Graduates:

ECFMG # \_\_\_\_\_

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**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

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Specialty	Institution	State	Zip Code	Your Program Director ( )
Address		City		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

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Specialty	Institution	State	Zip Code	Your Program Director ( )
Address		City		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

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Specialty	Institution	State	Zip Code	Your Program Director ( )
Address		City		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

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Specialty	Institution	State	Zip Code	Your Program Director ( )
Address		City		Phone Number

Dates Attended (mo/day/year) From: \_\_\_ - \_\_\_ - \_\_\_ to \_\_\_ - \_\_\_ - \_\_\_

## Uniform Credentialing Application

### 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
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(2)		( )		City	State	Zip Code	Phone Number
	Position/Rank	From: ____ - ____ - ____	to ____ - ____ - ____	Inclusive Dates (mo/day/year)			
(3)		( )		City	State	Zip Code	Phone Number
	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
		Zip Code	Telephone Number
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	
(2)		___ Primary	___ Secondary
	Facility Name		
		( )	
	Complete Mailing Address	City	State
		Zip Code	Telephone Number
	From: ____ - ____ - ____	to ____ - ____ - ____	Staff Category
	Reason for Discontinuance	Department or Service	

**This section continues on next page.**

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### -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

## Uniform Credentialing Application

### 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.**

## Uniform Credentialing Application

### -Section 10 Continued-

#### SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification	Name of Board
<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
Date Initially Certified	Date Most Recently Recertified      Date Certification Expires

Subspecialty or Added Qualification	Name of Board
<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> - <input type="text"/>
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 <input type="text"/> - <input type="text"/> - <input type="text"/>	Date Qualification Expires <input type="text"/> - <input type="text"/> - <input type="text"/>

Classifications:

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you certified in CPR?	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Basic Life Support (BLS)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Advanced Cardiac Life Support (ACLS)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Health Care Provider (CoreC)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Advanced Trauma Life Support (ATLS)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Neonatal Advanced Life Support (NALS)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Pediatric Advanced Life Support (PALS)	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No Other _____	Expires <input type="text"/> - <input type="text"/> - <input type="text"/>

## Uniform Credentialing Application

### SECTION 11: OFFICE INFORMATION Primary 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 (\_\_\_\_) \_\_\_\_\_

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.

## Uniform Credentialing Application

### 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?

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

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

If yes, please list: \_\_\_\_\_  
 Yes  No Other: \_\_\_\_\_

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.

**Uniform Credentialing Application**

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**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.

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