

## Instructions for Completing The Maine Uniform Professional Staff Application

Contact each organization to which you are applying to determine if they accept the uniform application and what other information they may require.

Type or legibly complete the application with blue or black ink.

When submitting your application to a credentialing entity (hospital or managed care organization, etc)

- Determine that the information contained in the original application is up to date and correct.
- Update as needed, using blue or black ink. Strike out any incorrect information and insert modification, initialing and dating any change.
- ***Keep the original , unsigned application form for your files and future use.***
- Copy the original application and any addenda the credentialing entity has requested.
- Sign and date the copy of the application on pages 5 and 9.

Complete a unique **Credentials Verification and Release Form** for each organization to which you are applying. This may be a standard release or one specifically designed and supplied by the organization.

By following the instructions above, your signature will be an original and the date will be current. The information on the application must be complete and accurate. An incomplete application will delay processing.

- Submit the completed application as well as any requested addenda.
- Attach copies of the documents as requested on the application checklist each time the application is submitted.
- For your convenience and to ensure information accuracy, keep the application current at all times.
- If you have any questions, please call the healthcare organization to which you are applying.

**This application form is available as a download at [www.meamss.org](http://www.meamss.org)**

# **Application Checklist for The Maine Professional Staff Application**

Before submitting your application, please take a minute to review this checklist to ensure the application is complete

Signature on pages 5 and 9 must be original and must have a current date.

Essential facts about any pending or closed malpractice suit(s) must be included. Use the Malpractice Claims/Suit History on page 9. If none, so indicate on the supplement form, sign and date.

Most healthcare organizations in Maine require the following documents be attached to your application, if not previously provided.

- Copy of Current Curriculum Vitae**
- Copies of All current healthcare licenses**
- Face sheet of current malpractice policy showing policy limits and expiration date**
- Copy of DEA registration, if applicable**
- Copies of Board Certificates**
- Certified copy of change of name document, if applicable**
- Copy of any current Life Support Certificates (i.e., BCLS, ACLS, ATLS, PALS or NPR)**
- NPI confirmation document**
- Original passport sized photograph. This photo may be sent to references or current hospital(s) for identification**
- For NPs under delegation and PAs - Copy of the Registration of Physician Extender and current Plan of Supervision. Plan of supervision must be specific to the healthcare facility to which you are applying.**

**Check with each facility and managed care organization to which you are applying to determine if any additional documents are required.**

# Maine Professional Staff Application

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\_\_\_\_\_  
Today's Date

## GENERAL INFORMATION

\_\_\_\_\_  
Last Name                                      First Name                                      Middle Initial Degree                                      Social Security Number

Gender\* (optional)     Female                                       Male

\_\_\_\_\_  
Other Surname Used

\* Data will be used for consumer information purposes only

Date of Birth \_\_\_\_\_ Place of Birth: City/ State or Country \_\_\_\_\_

If not a US citizen, are you eligible to work lawfully in the United States?                                       Yes  No

<b>Home Address</b>	Street or PO Box	
	City/State/Zip	Home Phone <input type="checkbox"/> Unlisted, do not publish
<b>Primary Office Address, in Maine</b>	Office or Group Name	
	Street or PO Box	Phone
	City/State/Zip	Fax
	Office Manager:	Phone or e-mail
	Credentialing Contact:	Phone or e-mail
<b>Mailing Address, if different</b>	Street or PO Box	
	City/State/Zip	
<b>Other Office</b>	Office or Group Name	
	Street or PO Box	Phone
	City/State/Zip	Fax

If additional space is needed, please use a separate sheet of paper.

<b>E-mail Address</b>	If you would like to receive business communications via e-mail, please PRINT a legible e-mail address.
	_____

## SPECIALTY/BOARD CERTIFICATION

Specialty Board	Initial Certification Date	Date of Last Recertification	Expiration date Mo/Yr

**If you are not currently Board certified, are you pursuing certification?**    Yes    No

Name of Specialty Certification: \_\_\_\_\_ Expected date of completion: \_\_\_\_\_

## UNDERGRADUATE EDUCATION

Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr

## PROFESSIONAL OR GRADUATE EDUCATION

Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr
Phone	Fax	
Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr
Phone	Fax	
Institution	Degree Awarded	Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Graduation date: Mo/Yr
Phone	Fax	

## HOSPITAL AFFILIATIONS

List chronologically (most recent first) all current and previous hospitals where you hold or have held professional staff membership and/or clinical privileges, beginning with your PRIMARY hospital. Additional space on next page. If you still need additional space, please use a separate sheet of paper.

Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: From - To (Mo/Yr)
Phone	Fax	Name of Dept Chief
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: From - To (Mo/Yr)
Phone	Fax	Name of Dept Chief
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: From - To (Mo/Yr)
Phone	Fax	Name of Dept Chief
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: From - To (Mo/Yr)
Phone	Fax	Name of Dept Chief
Institution	Department/Service	Position/Staff Category
Address	City/State/Zip	Dates: From - To (Mo/Yr)
Phone	Fax	Name of Dept Chief

## WORK HISTORY

**List chronologically (since completing training) all professional activities, paid or volunteer, self-employment, service as an independent contractor, military service, healthcare entities other than the hospitals listed on page 3. If you need additional space, please use a separate sheet of paper.**

ANY GAP OF GREATER THAN 60 DAYS IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE

Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax
Organization	Title/Position	Dates: From - To (Mo/Yr)
Address	City /State/Zip	Phone Fax

## REFERENCES

**Please provide three (3) professional references. These individuals must have personal knowledge through direct observation of your current clinical abilities, ethical character, and ability to work cooperatively with others. References must include at least one (1) physician and one (1) practitioner in your field. Acceptable references include referring physicians, physicians that provide oversight, supervising personnel, school district administrators if applicable, program directors if recently graduated or completed a clinical rotation. References should not be provided by relatives, or current classmates.**

Name	Phone	Fax
------	-------	-----

Address	City/State/Zip
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In what capacity has this individual observed your clinical abilities:

Name	Phone	Fax
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Address	City/State/Zip
---------	----------------

In what capacity has this individual observed your clinical abilities:

Name	Phone	Fax
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Address	City/State/Zip
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In what capacity has this individual observed your clinical abilities:

### SUPERVISING PHYSICIAN

If your practice is under delegation or physician supervision, please provide name and address of primary supervising physician and attach a current [signed and dated within one (1) year] plan of supervision.

Name	Phone	Fax
Address	City/State/Zip	

### HEALTH INFORMATION

**Your application will be processed in the usual manner regardless of how you answer questions 1 and 2. If you have answered "NO" to question 1 or 2, please explain completely on a separate sheet of paper. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.**

1. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without reasonable accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you able to perform these functions without significant risk of injury to yourself or others?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently engaged in the illegal use of drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**LICENSING-LIST ALL CURRENT AND PAST LICENSES**

STATE	TYPE	LICENSE NO.	DATE ISSUED	EXPIRATION DATE	STATUS
MAINE					

**If the answer is "YES" to any of the following questions, please provide details on a separate sheet of paper.**

1. Have you ever had your license to practice medicine in any state or other jurisdiction involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions, or otherwise disciplined?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are there any proceedings which could result in such action <b>currently</b> pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever voluntarily withdrawn an application, resigned your license or permitted it to lapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**DEA REGISTRATION**

Federal DEA Registration No. \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

If applicable, please list additional:

Federal DEA Registration No. \_\_\_\_\_ Date Issued \_\_\_\_\_ Expiration Date \_\_\_\_\_

**If the answer is "YES" to any of the following questions, please provide details on a separate sheet of paper.**

1. Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your registration ever been modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are there any proceedings which could result in such action <b>currently</b> pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever voluntarily withdrawn your narcotics application, resigned your registration or permitted it to lapse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ID NUMBERS**

NPI# \_\_\_\_\_

Medicare # \_\_\_\_\_  Not applicable

CAQH ID # \_\_\_\_\_  Not applicable

Medicaid # \_\_\_\_\_  Not applicable

## PROFESSIONAL LIABILITY

**If the answer is "YES" to any of the following questions, please explain on a separate sheet of paper.**

1. Have you ever provided professional services without liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been denied professional liability insurance or has your policy ever been canceled or denied renewal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have any restrictions ever been placed on your liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever had an insurance carrier add a surcharge to your malpractice policy or increase your deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If the answer is "YES" to any of the following questions, please complete a Malpractice Claims/Suit History (Page 11) for each event.**

5. Have you <i>ever</i> received a notice of claim <sup>1</sup> or been a defendant in a medical malpractice suit rising out of or in connection with your individual professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you aware of any such notice of claims against another person or entity rising out of or in connection with your individual professional services in the last five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you or your malpractice carrier or any other person or entity made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf or on behalf of any other person or entity rising out of or in connection with your individual professional services in the past five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

1 Notice of claim is defined as a written communication from a claimant or plaintiff setting forth an allegation of professional malpractice, threatening or initiating legal action, and demanding money damages.

## INSURANCE CARRIERS

**List chronologically (CURRENT Carrier first) ALL insurance companies, hospitals, clinics or employers who have provided professional liability coverage. Additional spaces on next page. If you still need additional space, please use a separate sheet of paper. If there is any gap in the chronology, please explain.**

<b>Current insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		
<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		

# INSURANCE CARRIERS

Continued

ANY GAP IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE

<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		
<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		
<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		
<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		
<b>Prior insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		

# MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COPY THIS FORM FOR EACH ADDITIONAL CLAIM/SUIT

**NO CLAIMS:**  Please sign and date at bottom

Date of Alleged Incident: \_\_\_\_\_ Date Lawsuit Filed: \_\_\_\_\_

Name of Court and Case Number: \_\_\_\_\_

Please Explain Nature of Allegations of Wrongdoing/Negligence:

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Status of Case: (with reference to you specifically)

- Notice of Claim Filed: As of \_\_\_\_\_ Date
- Pending Before Malpractice Panel: As of \_\_\_\_\_ Date
- Pending in Court: As of \_\_\_\_\_ Date
- Closed Without Payment: Date \_\_\_\_\_
- Pre-Trial Settlement (\$ \_\_\_\_\_)- As of \_\_\_\_\_ Date
- Verdict for Defendant: As of \_\_\_\_\_ Date
- Verdict for Plaintiff (\$ \_\_\_\_\_)- As of \_\_\_\_\_ Date

What was/is your status:

- Sole Defendant
- Co-Defendant with \_\_\_\_\_
- Other: \_\_\_\_\_

I understand information submitted herein becomes part of my Application for staff appointment/credentialing and may also be used in future recredentialing.

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**Signature**

Date

## ADDITIONAL INFORMATION

**If the answer is "YES" to any of the following questions, please explain on a separate sheet of paper and include a copy of any order or settlement where applicable. All questions must be answered.**

1. Have you ever had your clinical privileges or employment at any hospital or any other health care facility limited, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings <b>currently</b> pending ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever had a request for any specific clinical privilege(s) denied as a result of disciplinary action or granted only with stated limitations (aside from ordinary initial probationary requirements of proctorship) or are there such proceedings <b>currently</b> pending ? For purposes of this question, voluntary withdrawal does not constitute denial.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had hospital (or similar health care institution) privileges that had previously been granted to you suspended, restricted or withdrawn involuntarily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever voluntarily surrendered or modified your privileges or resigned from medical staff membership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had your professional staff membership or status on the staff of any hospital or other health care facility limited, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings <b>currently</b> pending ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been denied membership on any hospital professional staff or been denied advancements in staff status?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is there currently pending against you any litigation, investigatory or disciplinary proceeding with respect to privileges, licensure, DEA or other criminal or administrative matter (including QIO sanctions) or civil matter initiated by the government?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned, by any health care organization, including but not limited to, hospitals, or other health care facilities, based on professional competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned by HMOs, PPOs, physician hospital organization (PHO), independent practitioner association (IPA) professional associations or societies, professional standards review organization (PSRO) or peer review organization (QIO), based on professional competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been excluded, suspended or otherwise sanctioned by Medicare or Medicaid or are there such proceedings <b>currently</b> pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been disciplined by a professional society or resigned while allegations were pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever been convicted in a criminal proceeding or been subject to an adverse government agency administrative decision (including QIO sanctions), been subject to an adverse decision in any civil litigation brought by a government agency, entered a plea of nolo contendere, or been subject to an adverse settlement in any such proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever been convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violation) or are there such proceedings <b>currently</b> pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No