

## Instructions for Completing The Maine Uniform Application for Reappointment

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 7.

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 Reappointment Application

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

Signature on pages 5 and 7 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 7. 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.

- Copies of All current healthcare licenses**
- Face sheet of current malpractice policy showing policy limits and expiration date**
- Copy of current DEA registration, if applicable**
- Copies of current 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 NRP)**
- 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 Application for Reappointment

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\_\_\_\_\_  
Today's date

## GENERAL INFORMATION

\_\_\_\_\_  
Last Name                                      First Name                                      Middle Initial                                      Degree                                      Date of Birth

Other Names Used Professionally \_\_\_\_\_ Social Security Number \_\_\_\_\_

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	NPI <input type="checkbox"/> Personal <input type="checkbox"/> Group
	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 designation:**

Primary (in which you spend 50% or more of your time): \_\_\_\_\_ Secondary: \_\_\_\_\_

Do you have hospital clinical privileges in the specialty noted?  Yes  No

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

If yes:	If no:
Name of Board:	Do you have postgraduate training sufficient to meet the requirements of a specialty board? <input type="checkbox"/> Yes <input type="checkbox"/> No
Expected Date of Completion:	Please explain reason(s) for not pursuing certification on a separate sheet, including unsuccessful attempts.

## FORMAL TRAINING SINCE LAST APPLICATION

Complete this section for any graduate degree programs, formal residencies or fellowships completed since your last application.

**DO NOT USE FOR CME.**

**Please attach a separate CME log detailing continuing education programs attended since your last application.**

Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		
Institution		Dates Attended FROM-TO (Mo/Yr)
Address	City/State/Zip	Specialty
Program Director: Please list current director if different and known.		

## HOSPITAL AFFILIATIONS

List chronologically (most recent first) all current and previous hospitals where you hold or have held medical/professional staff membership and/or clinical privileges SINCE YOUR LAST APPLICATION, 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

## HOSPITAL AFFILIATIONS Continued

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 Professional Staff Only

**List (since your last appointment) any 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.

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:

## LICENSING-List All Current and/or Active Licenses for Past Five (5) Years

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 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

### 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 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 \_\_\_\_\_

# INSURANCE CARRIERS

List chronologically (CURRENT Carrier first) ALL insurance companies, hospitals, clinics or employers who have provided professional liability coverage in the past five (5) years. If you need additional space, please use a separate sheet of paper.

**If there is any gap in 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>Other insurance carrier</b>		Initial policy date	Expiration date
Address		City/State/Zip	
Coverage amounts (incident/aggregate)		Policy Number	
Phone	Fax		

## PROFESSIONAL LIABILITY

If the answer is "YES" to any of the following questions, please explain on a separate sheet of paper, if not previously reported on a prior application.

1. Have you practiced without professional liability coverage in the last five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been denied professional liability insurance or has your policy ever been canceled or denied renewal in the last five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have any restrictions been placed on your liability insurance in the last five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had an insurance carrier add a surcharge to your malpractice policy or increase your deductible in the last five (5) years?	<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 7) for each event, if not previously reported on a prior application.

5. Have you received a notice of claim <sup>1</sup> or been a defendant in a malpractice suit 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
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 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<sup>1</sup> 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.

# 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:

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: As of \_\_\_\_\_ 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 reappointment/recredentialing.

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

\_\_\_\_\_  
Date

**ADDITIONAL INFORMATION**  
**since your last appointment**

**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 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 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 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 voluntarily surrendered or modified your privileges or resigned from medical staff membership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had your medical 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 been denied membership on any hospital medical staff or been denied advancements in medical 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 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 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 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 been disciplined by a professional society or resigned while allegations were pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you 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 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