



# **Application for Employment**

**Louisiana**

**Copies of the following must be included in your packet:**

- All State Medical Licensure**
- State Controlled Substance License**
- DEA Certificate**
- ACLS, ATLS, PALS, BLS etc**
- Driver's License**
- Color Photo - Clear and Current**
- Proof of CME - Past 3 Years**
- ECFMG - if applicable**
- Copy of Medical School Diploma**
- CV (current)**
- Board Certificate - if applicable**
- Recent TB Test Results**
- NPI Letter or Email**
- Birth Certificate**



# Contact Information

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Pager & Pin: \_\_\_\_\_

Other Number: \_\_\_\_\_



**Please List at least 5 peer references:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_



# Immunity and Release

I understand and agree that I am in the process of applying as an Independent Contractor to staff contracts held by Emergency Staffing Solutions and that no agreement will be effective until signed by both Emergency Staffing Solutions and me nor will I have any contractual agreement with Emergency Staffing Solutions until that occurs.

I hereby confirm that the information contained in my application is complete and accurate. Material omissions or false statements may be grounds for Emergency Staffing Solutions disregarding this application or terminating my Independent Contractor status. I authorize Emergency Staffing Solutions to contact the references listed in this application and to conduct a customary investigation of my professional background and personal history, including contacting sources not listed by me. A photocopy of this authorization shall be as valid as the original.

I hereby release and hold harmless from and against any and all liability all representatives of Emergency Staffing Solutions and the Hospital(s) for their acts and communications performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I also hereby release from any liability any individuals and organizations who provide information to Emergency Staffing Solutions and the Hospital(s) in good faith and without malice concerning my professional competence, ethics, character and other qualifications for employment, clinical privileges and staff appointments, and I hereby consent for the release of such information.

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**Signature**

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**Printed Name**

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**Date**



# Emergency Department Experience



\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

# Other Hospital/Practice Experience

(continued - if necessary)



\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

# Physician's Authorization

I hereby authorize Emergency Staffing Solutions or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at any facility contracted by Emergency Staffing Solutions of the amount payable to such individual under Part B or Title XVIII of the Social Security Act and to receive on my behalf any payments that may be made pursuant to such assignment. It is understood and agreed that the reasonable charge, which will serve as the basis for payments in accordance with the terms of such assignment, shall be the full charge for the service.

This authorization may be withdrawn at any time upon giving at least 30 days prior written notice to the administrator.

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**Physician's Signature**

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**Printed Name**

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**Date**



## Health Statement

I hereby declare that \_\_\_\_\_ is in good physical health, mentally and emotionally stable, further more, has no health impairments affecting the priveleges requested in his/her application to Emergency Staffing Solutions. This physician has not been hospitalized or institutionalized for any significant health problems during the past five years and is not receiving current therapy for any health problems.

**\*\*to be completed by a physician other than yourself\*\***

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

\_\_\_\_\_  
**Printed Name**

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



# Emergency Medicine Delineation

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform in an emergency situation

3 - I have not performed, and I am not comfortable in performing in an emergency situation

1 2 3	<b>Management of electrolyte disturbances</b>	1 2 3	<b>Treatment of diabetic ketocidosis</b>
1 2 3	<b>Suturing, including facial lacerations</b>	1 2 3	<b>Treatment of snakebite</b>
1 2 3	<b>Treatment of common poisonings</b>	1 2 3	<b>Routine x-rays for fracture</b>
1 2 3	<b>Management of pediatric emergencies</b>	1 2 3	<b>Anesthesia (IV conscious sedation)</b>
1 2 3	<b>Management of severe head injuries</b>	1 2 3	<b>Bladder Cath/Irrigation</b>
1 2 3	<b>Treatment of hypovolemic shock</b>	1 2 3	<b>Cardiac Massage (closed/open)</b>
1 2 3	<b>Anesthesia (IV/regional block)</b>	1 2 3	<b>Central Lines</b>
1 2 3	<b>Arthrocentesis</b>	1 2 3	<b>Foreign Body Removal</b>
1 2 3	<b>Cardiac Electroconversion</b>	1 2 3	<b>Gastric Lavage</b>
1 2 3	<b>Cricothyotomy</b>	1 2 3	<b>Lumbar Puncture</b>
1 2 3	<b>Endotracheal intubation (nasal/oral)</b>	1 2 3	<b>Nasal Packing/Cautery</b>
1 2 3	<b>Fracture/Dislocation (Reduc./Immobil.)</b>	1 2 3	<b>Wound repair/Dressing</b>
1 2 3	<b>Incision/Drainage</b>	1 2 3	<b>Paracentesis</b>
1 2 3	<b>Interosseous IV</b>	1 2 3	<b>Pericardiocentesis</b>
1 2 3	<b>Nail Trephination/Removal</b>	1 2 3	<b>Surgical Debridement</b>
1 2 3	<b>Pacemaker/IV or transcutaneous</b>	1 2 3	<b>Thoracostomy Tube Drainage</b>
1 2 3	<b>Peritoneal Lavage</b>	1 2 3	<b>Treatment of common orthopedic problems</b>
1 2 3	<b>Spinal Immobilization</b>	1 2 3	
1 2 3	<b>Thoracentesis</b>	1 2 3	
1 2 3	<b>Precipitous Vaginal Delivery</b>	1 2 3	
1 2 3	<b>Diagnosis &amp; treatment of common cardiac arrhythmias</b>		
1 2 3	<b>Familiar with Public Health recommendations regarding venereal disease</b>		
1 2 3	<b>Diagnosis/mangement of respiratory failure, including mechanical ventilation</b>		

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



# Hospitalist Delineation

Please circle the appropriate number for each item

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform

3 - I have not performed, and I am not comfortable in performing

- |       |   |       |   |
|-------|---|-------|---|
| 1 2 3 | <b>Arterial catheterization for monitoring</b>          | 1 2 3 | <b>Paracentesis</b>                       |
| 1 2 3 | <b>Arterial puncture for ABG</b>                        | 1 2 3 | <b>Pericardiocentesis - emergent</b>      |
| 1 2 3 | <b>Arthrocentesis</b>                                   | 1 2 3 | <b>Placement transvenous pacer</b>        |
| 1 2 3 | <b>Bone marrow biopsy</b>                               | 1 2 3 | <b>Rhythm strip interpretation</b>        |
| 1 2 3 | <b>Bone marrow aspirate</b>                             | 1 2 3 | <b>Simple Peripheral IV catheter</b>      |
| 1 2 3 | <b>Bronchoscopy, diagnostic</b>                         | 1 2 3 | <b>Swan-Ganz catheter</b>                 |
| 1 2 3 | <b>Cardioversion - emergent</b>                         | 1 2 3 | <b>Thoracentesis</b>                      |
| 1 2 3 | <b>Central venous catheter placement and management</b> | 1 2 3 | <b>Thrombolysis infusion</b>              |
| 1 2 3 | <b>Chest tube</b>                                       | 1 2 3 | <b>Ventilator management</b>              |
| 1 2 3 | <b>Code Team Leader</b>                                 | 1 2 3 | <b>Endotracheal intubation</b>            |
| 1 2 3 | <b>Conscious sedation</b>                               | 1 2 3 | <b>Lumbar puncture</b>                    |
| 1 2 3 | <b>External jugular catheterization</b>                 | 1 2 3 | <b>Neonatal Privileges</b>                |
| 1 2 3 | <b>External/transcutaneous pacemaker</b>                | 1 2 3 | <b>Suprapubic Bladder Catheterization</b> |
| 1 2 3 | <b>Aspiration &amp; Joint injection</b>                 | 1 2 3 | <b>Interosseous IV</b>                    |

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date





# Past and Pending Claims Information

\*Please copy this form for each incident reported



**Physician Name:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Date of Claim:** \_\_\_\_\_

**Patients Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Nature of treatment and diagnosis at time of incident:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allegations made against you:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did the patient expire? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Disability:** \_\_\_\_\_

**Was the case settled? Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Amount of settlement?** \_\_\_\_\_

**Pending:** \_\_\_\_\_ **Settled:** \_\_\_\_\_

**Mediation/Arbitration:** \_\_\_\_\_ **Suit Dropped:** \_\_\_\_\_

**Trial:** \_\_\_\_\_

**Names of other doctors and hospitals, if any, involved in the claim of this suit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Date completed**

\_\_\_\_\_  
**Signature of Applicant**

## Billing Information

In order to expedite the billing process for the facilities you will be working at, please provide the following information:

**Physician Name:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_

**UPIN Number:** \_\_\_\_\_

**Medicare Number:** \_\_\_\_\_

**Medicaid Number:** \_\_\_\_\_

**Drivers License Number:** \_\_\_\_\_

**Drivers License Expiration Date:** \_\_\_\_\_

**Drivers License State:** \_\_\_\_\_



# Authorization for Enumeration for NPI

I, \_\_\_\_\_ (please print name and credentials), with  
\_\_\_\_\_ (name of group), hereby authorize Emergency  
Staffing Solutions (ESS) to cause to be submitted an application enumeration under  
the NPI system (NPPES) on my behalf.

I further authorize ESS to acquire a user name and log-in ID for the NPPES account  
created in my name, to enable updates and correction to the information as required  
by the rules and regulation governing the National Provider Identifier standard. I will  
supply any changes and correction to such information to ESS in a timely fashion, to  
allow them to appropriately perform this function on my behalf.

This authorization shall continue until such time as: 1) I request in writing, ESS to turn  
over the NPPES user name and log-in ID to me for upkeep on my account, or 2) I am  
no longer affiliated with the group, name above, or 3) until the relationship between  
the group and ESS terminates, pursuant to the terms of the Billing Services Agreement  
between the same.

Executed this \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year)

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**Signature**





# LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

## DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**\*\* All sections must be completed in their entirety. "See C.V.", not acceptable\*\***

## GENERAL INFORMATION

LAST NAME		FIRST		MIDDLE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DEGREE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OTHER _____							
Any other name under which you have been known? (AKA) LIST				ECFMG NUMBER		UPIN NUMBER	
HOME STREET ADDRESS				CITY		STATE	ZIP CODE
HOME PHONE NUMBER		PAGER NUMBER/ANSWERING SERVICE		E-MAIL ADDRESS			
SOCIAL SECURITY NUMBER		DATE OF BIRTH	BIRTH PLACE (CITY, STATE)		BIRTH COUNTRY		
NATIONAL PROVIDER IDENTIFIER			MEDICARE PROVIDER NUMBER		MEDICAID PROVIDER NUMBER		

## PRIMARY PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)					OFFICE MANAGER		
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	FAX NUMBER
OFFICE HOURS	MON _____	TUES _____	WED _____	THUR _____	FRI _____	SAT _____	SUN _____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____							
Languages spoken at this location: (other than English) _____							<input type="checkbox"/> Provider <input type="checkbox"/> Other
Accepting Patients?		<input type="checkbox"/> New <input type="checkbox"/> Existing Only		<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify) _____			
Age group(s) treated:		<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65		<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages		<input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____	
Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is this facility handicapped accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency After Hours Number			Arrangements for 24 hour / 7 day a week coverage (Specify)				

Group or Covering Physicians: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### SECOND PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)					OFFICE MANAGER		
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
FAX NUMBER							
OFFICE HOURS	MON ____-____	TUES ____-____	WED ____-____	THUR ____-____	FRI ____-____	SAT ____-____	SUN ____-____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____						<input type="checkbox"/> Provider <input type="checkbox"/> Other	
Accepting Patients? <input type="checkbox"/> New <input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Existing Only <input type="checkbox"/> Other (Specify): _____							
Age group(s) treated: <input type="checkbox"/> 0-6 years <input type="checkbox"/> 7-11 years <input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Over 65 <input type="checkbox"/> All Ages <input type="checkbox"/> Other (Specify): _____							
Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency After Hours Number			Arrangements for 24 hour / 7 day a week coverage (Specify)				
Group or Covering Physicians: _____ _____ _____							

### THIRD PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)					OFFICE MANAGER		
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
FAX NUMBER							
OFFICE HOURS	MON ____-____	TUES ____-____	WED ____-____	THUR ____-____	FRI ____-____	SAT ____-____	SUN ____-____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____						<input type="checkbox"/> Provider <input type="checkbox"/> Other	

### THIRD PRACTICE LOCATION CONTINUED

Accepting Patients?	<input type="checkbox"/> New <input type="checkbox"/> Existing Only	<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____	
Age group(s) treated:	<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65	<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages	<input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____
Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)		
Group or Covering Physicians: _____ _____			

### FOURTH PRACTICE LOCATION

If you have more than four locations, attach additional sheets with the following information

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER				
STREET ADDRESS		CITY		STATE	ZIP CODE		
PHONE NUMBER	FAX NUMBER		OFFICE E-MAIL				
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER			TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION				
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)			CONTACT PERSON		TELEPHONE NUMBER		
CITY	STATE	ZIP CODE	BILLING E-MAIL		FAX NUMBER		
OFFICE HOURS	MON ____-____	TUES ____-____	WED ____-____	THUR ____-____	FRI ____-____	SAT ____-____	SUN ____-____
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____					<input type="checkbox"/> Provider <input type="checkbox"/> Other		
Accepting Patients?	<input type="checkbox"/> New <input type="checkbox"/> Existing Only	<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____					
Age group(s) treated:	<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65	<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages	<input type="checkbox"/> 12-18 years <input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____				
Are PAs and/or nurse/paraprofessional practitioners used? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this facility handicapped Accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)						
Group or Covering Physicians: _____ _____							

### CORRESPONDENCE

Please check location where you would like correspondence sent.			
<input type="checkbox"/> Primary	<input type="checkbox"/> Second	<input type="checkbox"/> Third	<input type="checkbox"/> Fourth
<input type="checkbox"/> All			
<input type="checkbox"/> Other Address _____ _____			
IF DIFFERENT FROM PRACTICE LOCATIONS:			
PHONE NUMBER	FAX NUMBER	E-MAIL	

**SPECIALTY**

TYPE OF PROVIDER:  PRIMARY CARE PHYSICIAN  PHYSICIAN SPECIALIST  BOTH  OTHER SPECIALTY: \_\_\_\_\_

**PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable) BOARD CERTIFIED (ABMS)**

Specialty:  Yes  No

Sub-Specialty:  Yes  No

Sub-Specialty:  Yes  No

**BOARD CERTIFICATION**

**(as recognized by American Board of Medical Specialties)**

**(Please attach a copy of current certification(s).)**

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
SECONDARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
THIRD SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE

**DIRECTORY INFORMATION**

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by health care organization**

Primary Location	Second Location	Third Location	Fourth Location
<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER	FAX NUMBER	E-MAIL
--------------	------------	--------

**PHO / IPA AFFILIATIONS\***

List any other PHO's, IPA's, which you participate in and dates of participation: \_\_\_\_\_


*\* The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

### CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: \_\_\_\_\_

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR

### EDUCATION

**IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.**

**MEDICAL/PROFESSIONAL SCHOOL:**

CITY	STATE	ZIP
DEGREE	YEAR OF GRADUATION	DATES ATTENDED (MO/YR) From                      To
<b>INTERNSHIP: INSTITUTION NAME</b>	TYPE OF TRAINING	
CITY	STATE	
UNIVERSITY AFFILIATION	COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES ATTENDED (MO/YR) From                      To
<b>RESIDENCY: INSTITUTION NAME</b>	TYPE OF RESIDENCY	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
CITY	STATE	DATES ATTENDED (MO/YR) From                      To
UNIVERSITY AFFILIATION	COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>RESIDENCY: INSTITUTION NAME</b>	TYPE OF RESIDENCY	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
CITY	STATE	DATES ATTENDED (MO/YR) From                      To
UNIVERSITY AFFILIATION	COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>FELLOWSHIP: INSTITUTION NAME</b>	SPECIALTY FIELD	DATES ATTENDED (MO/YR) From                      To
CITY	STATE	COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO
	TYPE OF FELLOWSHIP	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
<b>FELLOWSHIP: INSTITUTION NAME</b>	SUBSPECIALTY FIELDS	DATES ATTENDED (MO/YR) From                      To
CITY	STATE	COMPLETED <input type="checkbox"/> YES <input type="checkbox"/> NO
	TYPE OF FELLOWSHIP	<input type="checkbox"/> Clinical <input type="checkbox"/> Research





**PROFESSIONAL LIABILITY INSURANCE COVERAGE**

NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE
Do you participate in the Louisiana Patients' Compensation Fund?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you self-insured in accordance with the Louisiana Medical Malpractice Act?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Please attach a copy of the current Certificates of Insurance.</b>	

**GENERAL QUESTIONS**

**Please check the appropriate response to the following questions:**

**If you answered YES to any of the questions below, please attach a full explanation on a separate page.**

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you presently a named defendant in a pending professional liability lawsuit?  If YES, please enter the number of cases _____ and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action?  If YES, please enter the number of cases _____ and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**REQUIRED ATTACHMENTS**

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current Employer Identification Number (EIN) Letter, W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

**STATEMENT TO APPLICANTS**

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:11.1.A (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:11.1, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

**PROVIDER STATEMENT TO RELEASE INFORMATION**

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

**X**

NAME (Please Print)

SIGNATURE

ORIGINAL SIGNATURE DATE

FIRST REAPPROVAL DATE

SECOND REAPPROVAL DATE

*Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.*