



# **Application for Employment**

**Mississippi**

**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**



Please check one:

- Original Application
- Reappointment

This application is submitted to: \_\_\_\_\_, herein, this M

## Mississippi Participating Physician Application

**For office use only**

- NOT IN SYSTEM    MCR    EAP
- SS Sent to NM    SS Correct in DI
- SOLO    CHIP    STAR Provider
- Group PROVCODE: \_\_\_\_\_
- AAS    NAAS    HERO

### SECTION A.

#### *Practice, Educational, Licensure and Work History Info*

#### I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- Face Sheet of Professional Liability Policy or Certification
- DEA Certificate
- Curriculum Vitae
- Board Certification (if applicable)
- ECFMG (if applicable)

#### II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birthdate:      Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).	
Social Security #:	Gender <sup>2</sup> : <input type="checkbox"/> Male <input type="checkbox"/> Female	
Specialty:	Race/Ethnicity <sup>2</sup> (voluntary):	
Subspecialties: <b>Internal Medicine</b>		

#### III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City:                  State:                  County:                  Zip:	City:                  State:                  County:                  Zip:
Telephone Number:	FAX Number:
Office Manager/Administrator:	Telephone Number:
	Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

<sup>1</sup> As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

<sup>2</sup> This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	FAX Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	FAX Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: <input type="checkbox"/> Yes <input type="checkbox"/> No	24 Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Back office Telephone Number: ( )	
Please identify other networks in which you participate:		
Please identify other networks from which you have been denied admission or de-selected:		
<b>Name of Network</b>	<b>Address</b>	<b>Reason for Denial or Deselection</b>
Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotripsy, mobile testing, MRI, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list:		
Medical Group(s) / IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check all that apply: <input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty <input type="checkbox"/> Group Practice <input type="checkbox"/> Multi Specialty
If Yes, please list specialty(s):		
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list:		
Name:	Type of Provider:	License Number:
Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:	Mississippi Medical License Number:	

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages?  Yes  NO If Yes, specify limitations:

Do you participate in EDI (electronic data interchange)?  Yes  No If so, which Network? Do you use a practice management system/software:  Yes  No If so, which one?

What type of anesthesia do you provide in your group/office?  
 Local  Regional  Conscious Sedation  General  None  Other (please specify): \_\_\_\_\_

Has your office received any of the following accreditation's, certifications, or licensures?  
 American Association for Accreditation of Ambulatory Surgery Facilities (AAASF)  Medicare Certification  
 Mississippi Department of Health Licensure  Other:

**IV. BILLING INFORMATION**

Billing Company:

Street Address: City:  
State: ZIP:

Contact: Telephone Number:

Name Affiliated with Tax ID Number: Federal Tax ID Number:

**V. OFFICE HOURS – Please indicate the hours your office is open:**

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holidays 24 HOUR COVERAGE

**VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)**

Answering Service Company: Telephone Number: Fax Number:  
( ) ( )

Mailing Address: City:  
State: ZIP:

Covering Physician's Name: Telephone Number:  
( )

Covering Physician's Name: Telephone Number:  
( )

Covering Physician's Name: Telephone Number:  
( )

Covering Physician's Name: Telephone Number:  
( )

If you do not have hospital privileges, please provide written plan for continuity of care:

**VII. FOREIGN LANGUAGES SPOKEN**

Fluently by Physician:

Fluently by Staff:

**VIII. LABORATORY SERVICES**

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:

Billing Name:

Type of Service Provided:

Do you have a CLIA Certificate?

 Yes  No

Do you have a CLIA waiver?

 Yes  No

Certificate Number:

Certificate Expiration Date:

**IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)**

Medical School:

Degree Received:

Date of Graduation (mm/yy)

Mailing Address:

City:

State &amp; Country:

ZIP:

Medical/Professional School:

Degree Received:

Date of Graduation (mm/yy)

Mailing Address:

City:

State &amp; Country

ZIP:

**X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)**

Institution:

Program Director:

Mailing Address:

City:

State &amp; Country:

ZIP:

Type of Internship:

Specialty:

From: (mm/yy)

To: (mm/yy)

**XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)**

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution:

Program Director:

Mailing Address:

City:

State &amp; Country:

ZIP:

Type of Training (e.g. residency, etc)

Specialty:

From: (mm/yy)

To: (mm/yy)

Did you successfully complete the program?

 Yes  No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?  
 Yes  No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?  
 Yes  No (If "No", please explain on separate sheet.)

**XII. BOARD CERTIFICATION (Attach copies of documents.)**

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	Specialty:	Certification Number:	Date Certified/ Rectified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above?  
 Yes  No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? If Yes, Provide details.  
 Yes  No

**XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)**

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

**XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)**

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:	
Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain on separate sheet			
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):		Date Issued:	Valid Through:
Visa Number:		Date Issued:	Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:	

**XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)**

State	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No

**XVI. PROFESSIONAL ORGANIZATIONS**

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Are you an Officer or Director of any of the professional organizations listed above?  
 If Yes, please list:  Yes  No

**XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)**

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Per Claim Amount: \$	Aggregate Amount: \$	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

**If you have had professional liability carriers in the last five years other than the one listed above, please list them below.**

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

**XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

**A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	
If you do not have hospital privileges, please explain.		

**B. PREVIOUS AFFILIATIONS (Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of other Hospital/institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

**XIX. PEER REFERENCES**

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

**XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)**

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )
		Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

**Section B.**  
***Professional Liability Action Explanation***

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

**I. CASE INFORMATION**

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:  
 Hospital     My office     Other doctor's office     Surgery Center  
 Other, (please specify) \_\_\_\_\_

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.): \_\_\_\_\_

Allegation: \_\_\_\_\_

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action?     Yes     No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)**

Lawsuit/arbitration still ongoing, unresolved.  
 Judgement rendered and payment was made on my behalf.    Amount paid on my behalf: \_\_\_\_\_  
 Judgement rendered and I was found not liable.  
 Lawsuit/arbitration settled and payment made on my behalf.    Amount paid on my behalf: \_\_\_\_\_  
 Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

**Summarize** the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

# SUMMARY

## SECTION C. *Certification*

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Stamped Signature Is not Acceptable)

## Section D. Attestation Questions

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?  
Yes  No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?  
Yes  No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?  
Yes  No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  
Yes  No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?  
Yes  No
6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?  
Yes  No
7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?  
Yes  No
8. Have you ever been convicted of any crime (other than a minor traffic violation)?  
Yes  No
9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)  
Yes  No
10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?  
Yes  No
11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?  
Yes  No
12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?  
Yes  No
13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)  
Yes  No
14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services?  
Yes  No

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Stamped Signature Is Not Acceptable)

**Section E.**  
***Information Release/Acknowledgements***

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”) by and between “this Managed Care Entity” and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. “Healthcare Organizations”), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

*This Application is endorsed by:*  
● *Mississippi Association of Health Plans*  
● *Mississippi State Medical Association*  
● *Mississippi Hospital Association*

<sup>3</sup> The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

## Physician/Outpatient Clinician Application

### Signature Page

#### Authorization and Attestation to Information, Agreement to Terms and Conditions, and Consent for Release of Information

- I do hereby apply for privileges as a participating provider for Corphealth. I understand that it is my responsibility to provide evidence of my competence and qualifications. I hereby give permission to Corphealth and/or its designee(s) to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certificate boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers, and any other entity needed to obtain information necessary to complete the credentialing process, which may include a criminal history background check.
- The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and or professional competence, character, ethics, or any other matter applicable to the credentialing procedure, I release and agree to hold harmless Corphealth and/or its designee(s) and their respective authorized representatives, from any and all liability for any damages, costs and expenses which may result from the gathering of and good faith use of the information gathered during the credentialing process.
- I hereby authorize the education facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, present and past employers to submit information requested by Corphealth and/or its designee(s) and their respective authorized representatives, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless any such entity referenced in the previous sentence, their representatives, employees, and agents from any damages which may result from providing this information as long as such release of information is done in good faith and without malice.
- I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by Corphealth. I further understand that any misrepresentation, misstatement, or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of my network status. I agree to use my best efforts to inform Corphealth in writing, within 15 days, if there is any change in the information contained in this application as a result of developments subsequent to my signing this application.
- If I am accepted for participation and subject to proper confidentiality restrictions required by law, my office medical records for Corphealth members may be subject to inspection by a representative of Corphealth for credentialing, peer, utilization and quality review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.
- I authorize and consent to Corphealth rendering evaluations with respect to my capabilities or to release information requested by other hospitals, medical authorities or health plans. I hereby release from liability Corphealth and its representatives for releasing information described in this paragraph or any evaluation of my capabilities.
- I agree to abide by Corphealth's policy that only co-payments and deductibles (if applicable) are to be collected at the time of service and that I may not balance bill patient.
- I understand and agree with my rights as regards all information obtained by Corphealth during primary verification(e.g.,malpractice insurance carriers, state licensing boards, Criminal History Background Checks, etc) of my credentials: a) the information will be held in confidence, except as otherwise provided by law, b) the information will be available for review and update of credentialing status, c) I will be notified of any information that varies substantially from the information I provided, d) I have the right to correct any erroneous information, and e) I have the right to appeal any negative decision based on quality issues.

I attest that the information provided in or attached to this application is complete, accurate and true to the best of my knowledge and that I have current malpractice protection through a commercial carrier. I acknowledge that this Consent and Release Form will be valid until revoked by me, and that a photocopy or fax of this document with my signature will serve as an original and may be accepted by any person or entity from which information is needed to complete the credentialing process and I specifically waive written notice from any such entity or individual who may provide information based upon this authorized request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

(Applications must be returned within  
30 days of signature date.)

**Note: You will be listed in the network under the same name that appears on your license.**

# CORPHEALTH ADDENDUM TO STATE STANDARDIZED APPLICATIONS

In addition to your state standardized application, please return this addendum and current copies of state license(s), Board Certification(s), Psychiatry Residency certificate (if not board certified), diploma, federal DEA and state CDS, if applicable.

<b>Provider Name:</b> _____		Social Security #: _____	
NOTE -- You will be listed in the network under the name on your license.			
<b><u>FOCUS OF PRACTICE</u></b>			
Accepting New Patients?    ___ Yes    ___ No		Reachable or phone coverage arranged 24 hrs/day?    ___ Yes    ___ No	
<b>AGES:</b> _____ Child    _____ Adolescent    _____ Adult    _____ Geriatric			
<b>MODALITIES:</b> _____ General Mental Health    _____ Chemical Dependency			
<b><u>SPECIALTIES:</u></b> In order to make proper referrals, please check the specialties listed below which represent at least <b>20% or more</b> of your practice. <b>Do not select more than six (6) specialties or you will be classified as a general practitioner.</b>			
<input type="checkbox"/> Chronic Illnesses	<input type="checkbox"/> Mood Disorders/Depression	<input type="checkbox"/> Post Partum	<input type="checkbox"/> Disease Management
<input type="checkbox"/> Brief Psychotherapy	<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Violence/Trauma (Rape, all abuse)	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Child Abuse/Neglect	<input type="checkbox"/> Neuropsychological Testing	<input type="checkbox"/> Gay/Lesbian Issues	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Community Resource Services	<input type="checkbox"/> Sexuality	<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Personality Disorders	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Grief/Death/Dying	<input type="checkbox"/> Anxiety/Phobic Disorders	<input type="checkbox"/> Psychiatric Disability	<input type="checkbox"/> Autism
<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Religious Emphasis	<input type="checkbox"/> Marital Therapy	<input type="checkbox"/> Nursing Home

**Medicare #** \_\_\_\_\_    **Medicaid #** \_\_\_\_\_    **NPI #** \_\_\_\_\_

<b>WORK HISTORY –</b> complete this section if info not on CV or state app		Chronologically, list <b>present employment</b> and <b>previous work history</b> (include month and year) related to clinical practice within the past five (5) years. Please explain any gaps greater than six (6) months. A Curriculum Vita (CV) may be substituted as long as the CV provides all details requested; i.e, month & year for past 5 yr. employment history, including start date with current employment or practice). Begin with the most recent.		
Practice / Employer (list current position first)	Title/Position	Address (Complete)	Month/Year Started	Month/Year Ended
Current Practice:				Present

<b>Physicians Not Board Certified in Psychiatry by ABMS or AOA or Board Certified in Addiction Medicine by ASMS:</b> (Complete this section if information is not included on state app)		
Date Part I of Bd Exam scheduled: _____	Date Part I of Bd Exam passed: _____	Date Part II of Bd exam scheduled: _____
<input type="checkbox"/> <b>Check here if you are <u>NOT</u> planning to take Board Examinations (this could affect eligibility).</b>		

<b>PHYSICIANS WHO DO NOT DO INPATIENT TREATMENT:</b>
<input type="checkbox"/> <b>Check here and agree to the following if you do not do inpatient treatment:</b>
I agree to refer my Corphealth patients who need inpatient treatment to an in-network facility (if one is in my locale) - <b>OR</b> - I agree to contact a Corphealth Case Manager at 1-800-777-6300 for a proper referral.
<b>ANP/CNS ONLY</b> - Please submit the following Information:
Copy of ANP or CNS Certificate for Mental Health – state or national certification is required.
Letter from supervising/collaborating physician or practice agreement, if state required.
Are you requesting prescriptive authority? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, provide documentation for prescriptive authority.
If you are requesting prescriptive authority and the state in which you practice requires federal DEA certification or state CDS registration, you <b>must</b> submit a copy.

**Please note:** If you answered “yes” to any professional questions on the application, you must provide a full explanation of your involvement, date(s) of action or occurrence, status/outcome, amount of any judgment or settlement, and details of any adverse decision(s). Include a copy of any order, settlement, or dismissal for each proceeding. If an action is pending, provide an explanation and current status.