California Participating Physician
Reapplication

This application is submitted to: _____ , herein, this Healthcare Organization [1]

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application:

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

II. IDENTIFYING INFORMATION

Last Name:		**First:**	**Middle:**
Is there any other name under which you have been known? Name (s)			
Home Mailing Address:		**City:**	
		State:	**ZIP:**
Home Telephone Number:		**E-Mail Address:**	
Home Fax Number:		**Pager Number:**	
Birth Date:	**Birth Place (City/State/Country):**	**Citizenship (If not a United States citizen, please include copy of Alien Registration Card).**	
Social Security No.:		**Gender :** ☐ **Male** ☐ **Female**	
Specialty:		**Race/Ethnicity [2] (voluntary):**	
Subspecialties:			

III. PRACTICE INFORMATION

Practice Name (if applicable):	**Department Name (If Hospital Based):**	
Primary Office Street Address:	**City:**	
	State:	**ZIP:**
Telephone Number:	**Fax Number:**	
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	

1 As used in the Information release/Acknowledgment Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above
2 This information will be used for consumer purposes only.

Physician Name: _____

Secondary Office Street Address:	**City:**	
	State:	**ZIP:**
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	
Teriary Office Street Address:	**City:**	
	State:	**ZIP:**
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	

Other Medical Interests in Practice, Research, etc.:

VII. RESIDENCIES/FELLOWSHIPS (COMPLETED WITHIN THE LAST 2 YEARS) ☐ Check here if N/A

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

Institution:		**Program Director:** **Telephone No.** **Fax No.**	
Mailing Address:	**City:**	**State:** **County:**	**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 a separate sheet.)**			
Institution:		**Program Director** **Telephone No.** **Fax No.**	
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**
Type of Training:	**Specialty: Adult Reconstruction**	**From:** **(mm/yy)**	**To:** **(mm/yy)**
Did you successfully complete the program? ☐ **Yes** ☐ **No** **(If "No", please explain on a separate sheet.)**			
Institution:		**Program Director:** **Telephone No.** **Fax No.**	
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**
Type of Training:	**Specialty:**	**From:** **(mm/yy)**	**To:** **(mm/yy)**
Did you successfully complete the program? ☐ **Yes** ☐ **No** **(If "No", please explain on a separate sheet.)**			

IV. MEDICAL LICENSE/REGISTRATION (Remember to attach copies of documents)

California State Medical License Number:	**Issue Date:**	**Expiration Date:**
Drug Enforcement Administration (DEA) Registration Number:		**Expiration Date:**
Controlled Dangerous Substances Certificates (CDS) (if applicable):		**Expiration Date:**
Medicare UPIN/National Physician Identifier (NPI):	**MediCal/Medicaid Number:**	

V. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	**Policy Number:**	**Original Effective Date:**	
Mailing Address:	**City:**	**State:**	**ZIP:**
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.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

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

X. ALL OTHER STATE MEDICAL LICENSES. List All Medical License Now or Previously Held.

(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	**License Number:**	**Expiration Date:**
State:	**License Number:**	**Expiration Date:**
State:	**License Number:**	**Expiration Date:**

VII. BOARD CERTIFICATION

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 equivalent requirements approved by the Medical Board of California**
- **a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty**

Name of Issuing Board:	**Specialty:**	**Date Certified/Recertified:**	**Expiration Date (if any):**

Physician Name: _____

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 eligibility for certification on separate sheet.		

X. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)

(Attach additional sheets if necessary. Reference This Section Number and Title)

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

IX. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list current affiliation{s} This includes 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:**	

If you do not have hospital privileges, please explain on Addendum A.

B. **PREVIOUS AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)**

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

Physician Name: ______________________________

X. PEER REFERENCES

List three professional references, preferably from your specialty area, not including 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.

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

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

XI. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and title)

Chronologically list all work history activities since completion of postgraduate training (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 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)**

Physician Name: _____

XII. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to question A through K is "yes," or if your answer to L is "no," please provide full details on a separate sheet.

A.	**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 ☐**
B.	**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 ☐**
C.	**Have you ever been denied, for possible incompetence or improper professional conduct, or breach of contract, 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) or have your clinical privileges, membership, contractual participation or employment at any such organization ever been suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending?**	**Yes ☐ No ☐**
D.	**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 or contract, or in return for such an investigation not being conducted, or is any such action pending?**	**Yes ☐ No ☐**
E.	**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 ☐**
F.	**Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subject to probationary conditions, or not renewed, or is any such action pending?**	**Yes ☐ No ☐**
G.	**Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?**	**Yes ☐ No ☐**
H.	**Have you ever been convicted of any crime (other than a minor traffic violation)?**	**Yes ☐ No ☐**
I.	**Do you presently use any drugs illegally?**	**Yes ☐ No ☐**
J.	**Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?**	**Yes ☐ No ☐**
K.	**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 ☐**
L.	**. Are you able to perform all the services required by your agreement with, or the professional staff bylaws, or the Healthcare Organization 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?**	**Yes ☐ No ☐**

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omission or misrepresentations 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)

Physician Name: _____.

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and 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 Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations{IPAs}, -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 claim history}, licensing authorities, and businesses and individuals acting as their agents collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, 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 of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, 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 Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professional Code Section 809 et seq, if applicable.

I the undersigned 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 Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization 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 Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension reduction, limitation, nonrenewal or voluntary relinquishment by registration of my medical staff membership or clinical privileges at any 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, ant filed and served malpractice suite or arbitration action; or (vi) my conviction of any criminal law (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 hereby affirm that the information submitted in this application and any addenda thereto (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 material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 7 and 8.

Print Name Here:_____

Signature_____**Date**_____

(Stamped Signature Is Not Acceptable)

3
The intent of this release is to apply at a minimum, protection comparable to those available in California to any action, regardless of where such action is brought.

Physician Name: _____

Addenda Submitting (Please check the following):

☐ **Addendum A - Health Plan and IPA/Medical Group**
☐ **Addendum B - Professional Liability Action Explanatio**

This Application and Addenda A and B were created and are endorsed by:

- American Medical Group Association - (310/430-1191x223)
- California Association of Health Plans - (916/552-2910)
- California Healthcare Association - (916/552-7574)
- California Medical Association - (415/882-3368)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Application nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the healthcare organization from which it was provided.

Physician Name: _____.