Last Name	First Name	OFFICE USE ONLY
		Date Received:
Degree	Date you expect to begin practice	

Uniform Application Form

- This application has been developed by the Monroe County Medical Society, in conjunction with area hospitals, managed care organizations and other health care facilities.
- Use of this application enables you to **complete one form and submit copies** to regional hospitals, managed care organizations and other health care entities which utilize the form.
- Please be aware that each hospital, managed care organization or other health care entity may require submission of additional forms specific to the organization.
- This application must be completed entirely, with no gaps in time intervals. **All dates must identify month and year.**
- This application will be accepted only in typewritten or legibly printed form.
- You are responsible for making copies of the completed application, affixing an original signature to each, and sending them as instructed by the organizations with which you wish to affiliate.

Vital Data

Name: _____ _____ _____ _____
Last First Middle Initial Degree

Sex: ❑ M ❑ F Date of Birth: ____/____/____ SS #: _____-____-_____

Place of Birth: _____ _____ _____
City State Country

Citizenship: _____ *If not a citizen of the USA, indicate your visa status:* _____

Alien Registration #: _____

Other names, *i.e. alias, AKA, maiden name, corporate name:* _____

Date of name change: _____/_____/_____

Last Name _____ First Initial _____

Requested Categories

Department/Service – <u>For Hospital and Health Facility Appointments Only.</u> ***See relevant hospital bylaws.***

(1) _____ (2) _____

Specialty Category

Clinical Specialty _____

Subspecialty (1) _____ (2) _____

Staff Category – <u>For Hospital Appointments Only</u>. ***See relevant hospital bylaws.***

(1) _____ (2) _____

Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists and Certified Nurse Midwives or any other discipline identify your Collaborating/Supervising physician and provide a copy of your agreement/statement.

Supervising/Collaborating Physicians – please identify who you are responsible for

(1) _____ (2) _____

(3) _____ (4) _____

Practice Type

❑ Private Practice ❑ Employed If employed, by whom? _____

Contract Category – <u>For MCOs and POs Only</u>. ***Please see relevant MCO and/or PO bylaws.***

❑ Primary Care ❑ Specialty ❑ Both ❑ Consulting ❑ Allied Health

Please list your Primary Hospital Affiliation: _____

If you are pursuing a Primary Care Status, please choose one of the options below:

❑ **I will not follow my patients when admitted to any hospitals I am associated with**

❑ **I will be using the hospitals' Hospitalist service at (list hospitals):**

(1) _____ **(2)** _____

(3) _____ **(4)** _____

❑ **I will follow my patients when admitted to (list hospital(s):**

(1) _____ **(2)** _____

(3) _____ **(4)** _____

Last Name **First Initial**

Home/Personal Data

Home Address _____
Street

_____
City *State* *Zip Code*

Home Phone # (____) _____ Is this number listed in the phone book? ❑ Yes ❑No

Home Fax # (____) _____ Cellular # (____) _____

E-mail Address _____

Foreign Language(s) _____

Name of Spouse/Significant other (optional) _____

Primary Office

Primary Office Address _____
Street

_____
City *State* *Zip Code*

Primary Office Phone # (____) _____ Primary Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Are patients able to access you or is someone covering for you 24/7 ❑ Yes ❑ No

Work E-mail _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Tax ID# _____ Website Address _____

Office Manager/Contact Person Name _____ Phone # (____) _____

Primary Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	____AM to ____PM	Monday	____AM to ____PM		
Tuesday	____AM to ____PM	Tuesday	____AM to ____PM		
Wednesday	____AM to ____PM	Wednesday	____AM to ____PM		
Thursday	____AM to ____PM	Thursday	____AM to ____PM		
Friday	____AM to ____PM	Friday	____AM to ____PM		
Saturday	____AM to ____PM	Saturday	____AM to ____PM		
Sunday	____AM to ____PM	Sunday	____AM to ____PM		

Are you accepting new patients at this office? ❑Yes ❑ No Is this office wheelchair or handicap accessible? ❑Yes ❑ No

Is your primary office also your billing office? ❑ Yes ❑ No

Which address would you like to use for mail? ❑ Office ❑ Home

Last Name **First Initial**

If no, what is your billing office address? _____
Street

_____
City *State* *Zip Code*

Billing Office Phone # (_____) _____ Billing Office Fax # (_____) _____

E-mail Address _____

Does office bill electronically? ❑Yes ❑No If yes, what software is used? _____

Second & Third Office (if applicable) If you have more office locations, please copy this page complete in its entirety and attach to the application.

Second Office Address _____
Street

_____
City *State* *Zip Code*

Second Office Phone # (_____) _____ Second Office Fax # (_____) _____

Direct Phone Line # (_____) _____ Beeper/Pager # (_____) _____

Answering Service Phone # (_____) _____ Cellular Phone # (_____) _____

Work E-mail _____ Tax ID# _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Office Manager/Contact Person Name _____ Phone # (_____) _____

Second Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	_____AM to _____PM	Monday	_____AM to _____PM		
Tuesday	_____AM to _____PM	Tuesday	_____AM to _____PM		
Wednesday	_____AM to _____PM	Wednesday	_____AM to _____PM		
Thursday	_____AM to _____PM	Thursday	_____AM to _____PM		
Friday	_____AM to _____PM	Friday	_____AM to _____PM		
Saturday	_____AM to _____PM	Saturday	_____AM to _____PM		
Sunday	_____AM to _____PM	Sunday	_____AM to _____PM		

Are you accepting new patients at this office? ❑Yes ❑No Is this office wheelchair or handicap accessible? ❑Yes ❑ No

Third Office Address _____
Street

_____
City *State* *Zip Code*

Second Office Phone # (_____) _____ Second Office Fax # (_____) _____

Direct Phone Line # (_____) _____ Beeper/Pager # (_____) _____

Answering Service Phone # (_____) _____ Cellular Phone # (_____) _____

Work E-mail _____ Tax ID# _____

Last Name **First Initial**

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Office Manager/Contact Person Name _____ Phone # (____) _____

Third Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	____AM to ____PM	Monday	____AM to ____PM		
Tuesday	____AM to ____PM	Tuesday	____AM to ____PM		
Wednesday	____AM to ____PM	Wednesday	____AM to ____PM		
Thursday	____AM to ____PM	Thursday	____AM to ____PM		
Friday	____AM to ____PM	Friday	____AM to ____PM		
Saturday	____AM to ____PM	Saturday	____AM to ____PM		
Sunday	____AM to ____PM	Sunday	____AM to ____PM		

Are you accepting new patients at this office? ❑Yes ❑No Is this office wheelchair or handicap accessible? ❑Yes ❑ No

Education/Training

Please provide all of the information requested, below and attach copies of diplomas, certification and other proofs of attendance. If any gaps in chronology of your academic and/or professional history exist, provide a brief summary of details, as well as an explanation for any "No" responses. Please also attach a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

College Undergraduate Education

School _____

Address _____
Street

_____
City State Zip Code

Phone (____) _____ Fax (____) _____

Dates Attended _____ to _____ Degree _____

School _____

Address _____
Street

_____
City State Zip Code

Phone (____) _____ Fax (____) _____

Dates Attended _____ to _____ Degree _____

Medical/Dental/Professional Education

School _____

Address _____
Street

_____
City State Zip Code

Phone (____) _____ Fax (____) _____

Dates Attended _____ to _____ Degree _____

Honors or Recognitions _____ Name of Director/Department Chair _____

_____ _____

Last Name **First Initial**

School _____

Address _____
Street

_____
City State Zip Code

Phone (_____) _____ Fax (_____) _____

Dates Attended _____ to _____ Degree _____

Honors or Recognitions _____ Name of Director/Department Chair _____

Internship

Hospital _____

Address _____
Street

_____
City State Zip Code

Phone (_____) _____ Fax (_____) _____

Dates of Service _____ to _____ Specialty _____

Internship Completed? ❑ Yes ❑ **No*** Name of Director/Department Chair _____

Residency

Hospital _____

Address _____
Street

_____
City State Zip Code

Phone (_____) _____ Fax (_____) _____

Dates of Service _____ to _____ Specialty _____

Residency Completed? ❑ Yes ❑ **No*** Name of Director/Department Chair _____

Hospital _____

Address _____
Street

_____
City State Zip Code

Phone (_____) _____ Fax (_____) _____

Dates of Service _____ to _____ Specialty _____

Residency Completed? ❑ Yes ❑ **No*** Name of Director/Department Chair _____

Formal Post Graduate/Fellowship Education

Hospital _____

Address _____
Street

_____
City State Zip Code

Phone (_____) _____ Fax (_____) _____

Dates of Service _____ to _____ Specialty _____

Fellowship Completed? ❑ **Yes** ❑ No* Name of Director/Department Chair _____

Last Name First Initial

Other Training

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Dates of Service ______ to ______ Specialty ______

Completed? ❑ Yes ❑ **No*** Name of Director/Department Chair ______

***Full explanation required on a separate sheet of paper. Any additional training must be documented on a separate sheet of paper**

Hospital Affiliations/Ambulatory Sites/Surgical Centers/Work Experience/Professional History

List in chronological order, beginning with the most recent, all institutional affiliations or places of employment. This includes all hospitals, teaching institutions, managed care organizations, private practices, corporations, military assignments and government agencies and all other licensed health care organizations. <u>Exclude residency and fellowship training</u>. If more space is needed, please use another sheet. Please also <u>attach</u> a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Last Name ______ First Initial ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Institution ______

Address ______
Street

______
City State Zip Code

Phone ( ) ______ Fax ( ) ______

Department or Service ______ Dates of Service ______ to ______

Department Director/Immediate Supervisor ______

Status ______ Reason for Discontinuation of Service ______

Board Certification/Recertification

Attach copies of Board specialty and subspecialty certifications and recertifications, or a copy of qualifying letter(s).

Certifying Board_____ Date of Original Certification _____ Are you currently certified? Yes ___ No* ___

Certifying Board_____ Date of Original Certification _____ Are you currently certified? Yes ___ No* ___

Certifying Board_____ Date of Original Certification _____ Are you currently certified? Yes ___ No* ___

*** If you were certified and are not current or have never been certified, please provide a full explanation as to why and future plans.**

Emergency Care Training, Infection Control Certification, Special Credentials and CME Courses

Submit with your Uniform Application Form a list of all major training *(excluding residency and fellowship)* and continuing education courses you have completed within the past two years. Attach copies of each certificate you hold for emergency care training *(i.e. CPR, ACLS, ATLS, and PALS)*. Please indicate any special credentials you possess related to OB ultrasound and neuropsychology testing for HMO's. If you have trained in additional procedures, submit certificates of training or other documentation.

Identification Numbers

Please list identification numbers assigned to you by for the following entities:

Medicaid/MMIS # _____ Medicare PTAN # _____

NPI # _____ Taxonomy # _____ Workers' Compensation # _____

Excellus # _____ MVP # _____

CAQH #: _____ Other #: _____

Professional Associations

List memberships in professional societies, colleges, academies, etc.:

Organization	Initial Date of Membership	Status
		❑ Active ❑ Inactive
		❑ Active ❑ Inactive
		❑ Active ❑ Inactive

Professional Licensing Information

Attach copies of each item listed below; including state licenses, DEA, ECFMG/USMLE and infection control certificates:

State	License Type *(i.e. Limited)*	License #	Date Received	Expiration Date	Status
					❑ Current ❑ Pending
					❑ Active ❑ Inactive*
					❑ Active ❑ Inactive*

*** For those licenses which are no longer active, please provide an explanation regarding the reason for disassociation on a separate sheet of paper.**

Federal/State Narcotics Registration /DEA # ______________________ Expiration Date__________

Federal/State Narcotics Registration /DEA # ______________________ Expiration Date__________

Federal/State Narcotics Registration /DEA # ______________________ Expiration Date__________

ECFMG # ____________________ USMLE # (formerly NBME) ____________________

Professional References

List (4) four professional references that have had direct clinical observation of your work for at least one year. **References may not be your partners, practicing associates or fellow training associates.** *For MCOs and POs, be sure to refer to each organization's criteria as requirements may vary.*

Name ______________________________ Degree __________
First ***Middle Initial*** ***Last***

Title/Position ______________________________

Address ______________________________
Street

____
City ***State*** ***Zip Code***

Phone # (_____)__________ Fax #(_____)__________ E-Mail Address__________

Name ______________________________ Degree __________
First ***Middle Initial*** ***Last***

Title/Position ______________________________

Address ______________________________
Street

____
City ***State*** ***Zip Code***

Phone # (_____)__________ Fax #(_____)__________ E-Mail Address__________

Name ______________________________ Degree __________
First ***Middle Initial*** ***Last***

Title/Position ______________________________

Address ______________________________
Street

____
City ***State*** ***Zip Code***

Phone # (_____)__________ Fax #(_____)__________ E-Mail Address__________

Name ______________________________ Degree __________
First ***Middle Initial*** ***Last***

Title/Position ______________________________

Address ______________________________
Street

____
City ***State*** ***Zip Code***

Phone # (_____)__________ Fax #(_____)__________ E-Mail Address__________

Professional Liability Insurance

You must provide an answer for each question in this category and attach a copy of your policy face sheet(s), which name(s) you and show(s) policy limits, coverage, limitations and expiration dates.

Current Carrier _____

Complete Address _____
Street

_____
City *State* *Zip Code*

Phone # _____ **Fax #** _____

Policy #_____

Type of Insurance _____ ❑ Claims Made ❑ Occurrence

Retroactive Date_____

List insurance carriers which provided you with coverage during the last ten years, including those carriers that may have covered you while serving as a locum tenens:

Carrier Name _____

Complete Address _____
Street

_____
City *State* *Zip Code*

Dates of Coverage _____ to _____

Carrier Name _____

Complete Address _____
Street

_____
City *State* *Zip Code*

Dates of Coverage _____ to _____

Carrier Name _____

Complete Address _____
Street

_____
City *State* *Zip Code*

Dates of Coverage _____ to _____

Last Name	First Initial

You must provide an answer for each of the following questions and provide a full explanation to any "Yes" responses on a separate sheet of paper. Also list the name of the carrier and the date of the company's action.

1. ❑ Yes ❑ No Has your professional liability insurance coverage ever been surcharged, suspended or terminated by action of any insurance company?
2. ❑ Yes ❑ No has your professional liability insurance coverage ever been denied or not renewed by action of any insurance company?
3. ❑ Yes ❑ No Has your present professional liability insurance carrier excluded any specific procedures from your coverage**? If yes**, **list the procedure(s), the date(s) the exclusion(s) commenced**
4. ❑ Yes ❑ No Have any professional liability suits been filed against you which are currently pending in this or any other state?
5. ❑ Yes ❑ No Have any professional liability judgments and/or settlements ever been made against you or on your behalf?

If the answer to question four or five is "Yes," provide a full explanation on a separate sheet. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney defending you and any other relevant details, including the clinical background of the suit, as well as the sum and substance of the findings in such actions or proceedings.

Corrective or Disciplinary Action

If the answer to any of the questions above is "Yes," provide a full explanation on a separate sheet. The explanation must include all relevant details, including the name and address of the attorney defending you, the name and address of any insurance company/companies providing professional liability coverage when the action occurred, the clinical background of the action, and the sum and substance of the findings in such actions or proceedings.

1. ❑ Yes ❑ No Have you ever been reported to the National Practitioner Data Bank, Healthcare Integrity and/or Protection Data Bank?
2. ❑ Yes ❑ No Has your employment, medical staff appointment, panel participation, affiliation or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused or limited in any hospital, health care facility or managed care organization, IPA or PPO including to avoid disciplinary action for reasons related to professional competence or conduct?
3. ❑ Yes ❑ No Has your license to practice your profession in any jurisdiction ever been limited, restricted, suspended, revoked, denied or subject to probationary conditions?
4. ❑ Yes ❑ No Have you ever involuntarily relinquished your license to practice your profession in any state?
5. ❑ Yes ❑ No Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (including Medicare, Medicaid or a managed care organization)?
6. ❑ Yes ❑ No Has your narcotics registration certificate(s) federal or state ever been voluntarily or involuntarily limited, restricted, denied renewal, suspended, revoked or is currently being challenged?
7. ❑ Yes ❑ No Have you ever been denied membership, membership renewal or been subject to any professional review, censure or reprimand in any medical organization or professional society -- local, state or national?
8. ❑ Yes ❑ No Have you ever been subject to disciplinary action by a state agency or professional body (i.e. Medical Society, IPRO, OPMC)?
9. ❑ Yes ❑ No Has your specialty board certification or qualification ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?
10. ❑ Yes ❑ No Do you have any pending misconduct charges against you in this state or any other state?
11. ❑ Yes ❑ No Have you ever been convicted of, or currently under investigation for, a misdemeanor or felony in any jurisdiction?
12. ❑ Yes ❑ No Are you presently subject to any suspension, revocation, discontinuance, limitation, restriction or monitoring proceedings?
13. ❑ Yes ❑ No Have you ever been cited for violation of patient rights as set forth by the Federal Law and/or NYS Department of Health or any other state department of health?
14. ❑ Yes ❑ No Have you ever been the subject of, or party to, an investigation or other legal action related to waste, fraud, abuse, medical record documentation, and/or any other aspect of the business practice of medicine?

Last Name	First Initial

Attestation

1. ❑ True ❑ False I attest that the information provided in this application is complete, true and accurate.
2. ❑ True ❑ False I agree to update this Uniform Application Form while it is being processed, should there be any change in the information provided.
3. ❑ True ❑ False I understand that any misrepresentation, misstatement or omission from this application could result in the immediate rejection of this application or subsequent revocation of any privileges/membership granted and subject to reporting according to NYS regulations.
4. ❑ True ❑ False I am currently able to perform the clinical privileges that I have requested from each specific hospital, health care facility and/or managed care organization to which I direct this Uniform Application Form. I do not have any health problems that could affect my ability to perform the privileges requested.
5. ❑ True ❑ False I am not currently using any illegal drug, nor have I during the past two years.

Signature

1. **Before signing this Uniform Application Form**, please make enough copies for each hospital, managed care organization or other health care entity with which you seek affiliation. Each entity requires an **original signature**. Therefore, it is ***vital*** that you make your copies prior to signing this form. Forms without original signatures will not be processed.
2. **You are responsible for mailing** a copy of the Uniform Application Form to each entity with which you seek affiliation.
3. **Be sure to attach all requested documents** to each copy of the Uniform Application Form before mailing.
4. **Please retain the unsigned original application once it is completed** in the event you would like to apply to another entity at a future date.

I hereby waive any confidentiality provision concerning the information provided in this application, pursuant to New York State Public Health Law section 2805-k.

Signature_____ Date_____

A CHECKLIST IS PROVIDED ON THE NEXT PAGE TO ASSIST YOU IN PREPARING THIS APPLICATION.

Last Name	First Initial

Checklist

Please provide an explanation on a separate sheet for any missing items and attach copies of all requested items. Your Application will not be considered complete and cannot be processed without all of the following documentation:

- ❑ **Completed Uniform Application Form**
- ❑ **Individual NPI Number (page 13)**
- ❑ **Group NPI Number(s) if applicable (page 13)**
- ❑ **Taxonomy Code**
- ❑ **Copy of Photo ID**
- ❑ **Signed and dated Release Statement for each entity to which you are applying for privileges, employment, panel participation or membership.**
- ❑ **Copy of current board certifications/qualifying letters.**
- ❑ **Dated Curriculum Vitae**
- ❑ **Copies of professional diplomas**
- ❑ **Applicable training certificates**
- ❑ **CME documentation**
- ❑ **Copy of current NYS license registration certificate**
- ❑ **Other current state licenses and registration certificates**
- ❑ **Copy of current DEA registration certificate**
- ❑ **ECFMG/USMLE certificate**
- ❑ **Copy of current infection control training certificate**
- ❑ **Current malpractice insurance face sheet(s)**
- ❑ **Explanations for Yes/No answers on a separate sheet**
- ❑ **Current Health Assessment Form, completed, dated and signed by your personal physician**
- ❑ **Original signature and date on each copy of the Uniform Application Form for each of your affiliations**
- ❑ **Original, unsigned copy for your files and future use**