ADMINISTRATIVE INITIAL PRACTITIONER CREDENTIALING CHECKLIST

To expedite processing of your application in the UNMH VAPC3/Choice Network , please complete this application in its entirety and a

PERSONAL

Name:						
	Legal Last Name	*Legal First Name*		*Legal Middle Name*		*Other Name(s) Used*
Check One	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐		
	☐	☐	☐	☐	*Other*_____	
U. S. Citizen: ☐ Yes ☐ No						☐ Yes ☐ No
Gender: ☐ M ☐ F						
Date of Birth:						
Foreign Language (s):					Read ☐	Speak ☐ Write ☐
Specialty :						

IDENTIFICATION NUMBERS

Social Security:	
UPIN:	
NPI:	
Organizational NPI	
ECFMG*(If applicable)*:	

CURRENT SERVICE/PRACTICE LOCATION

If more than one practice location please

PROFESSIONAL EXPERIENCE / WORK HISTORY

PLEASE USE MONTH / YEAR FORMAT. *In chronological order, list professional experience attained since completion of medical school to the present.* ***Explain all breaks, greater than 6 months.*** *If necessary, attach additional 8-1/2 x 11 sheet(s).*

Location		From:	To:
Street :			
City	ST	Zip:	
Type of Practice:	Contact Person:		
Type of Discharge:	Rank Achieved:		

Location From: To:

MALPRACTICE/LIABI LITY INSURANCE

MALPRACTICE/LIABILITY INSURANCE (Attach copy of current malpractice certi ficate)		
CURRENT CARRIER:	POLICY #:	
ADDRESS:	CITY, ST, ZIP:	
AMOUNTS OF COVERAGE:	ISSUE DATE:	EXP DATE:

PROFESSIONAL LIABILITY CLAIMS HISTORY
DETAIL/EXPLANATION

Please provide the following information for all current open, settled, dismissed and/or judgments for professional liability claims filed against you within the last ten years. Please answer the following questions for EACH claim. Duplicate this page as necessary.

Patient name:	Plaintiff name (if other than patient):		
Your involvement in the case (Attending, consulting):	Date of occurrence (month/day/year):		
Your status in the case (Primary or co-defendant):	Date claim was filed (month/day/year):		
Professional liability insurance carrier involved:			
Additional defendants:			
Describe the allegation and alleged injury to the patient:			
Provide explanation or information of the events leading to the allegation:			
Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No	Court Case #:	State:	County/Parish:

Federal Court (US District Court) Case Number:

SPECIALTY BOARD CERT IFICATIONS

Are you Board Certified? ☐ Yes ☐ No ☐ Not Applicable

Note: *If you are not Board Certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Ce*
Center, or the National Certification Commission, or accepted for examination in your specialty,
please give a brief explanation

PROFESSIONAL PRACTIC E QUESTIONS

If you answer "Yes" to any question, please give details: *including name, address, and telephone number of significant parties, expl*

CERTIFICATION/ATTESTATION AND
CONSENT TO THE INSPECTION OF RECORDS AND DOCUMENTS
RELEASE OF INFORMATION AND LIABILITY

I certify and attest to the fact that all the information submitted by me in this application is true and accurate to the best of my knowledge and belief.

I authorize TriWest Healthcare Alliance, its professional staff and legal representatives for the purpose of evaluating my professional competence, character, criminal history and ethical conduct, to contact and consult with administrators and members of the professional staff of any treatment facility, institution, professional society, school, employer, law enforcement agency, or practice with which I have been associated. In addition, I consent to the inspection by TriWest Healthcare Alliance, its professional staff and legal representatives of all records and documents, including health records at other treatment facilities that may be material for evaluation of my professional qualifications. I also release from liability all individuals or organizations for their acts performed in good faith and without malice who honestly initiate and respond to the inquiries authorized for use by TriWest Healthcare Alliance. I am willing that a photocopy of this

PLEASE INCLUDE A COPY OF YOUR W-9 (REQUIRED)