

**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

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**NOTICE OF PROPOSED RULEMAKING**

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The Commissioner of the Department of Insurance, Securities, and Banking, pursuant to the authority set forth in § 104 of the Health Insurers and Credentialing Intermediaries Uniform Credentialing Form Amendment Act of 2001, effective April 13, 2002 (D.C. Law 14-96, D.C. Official Code § 31-3254) (2005 Supp.) hereby gives notice of his intent to adopt the following rules to be included in Chapter 42 of Title 26 of the District of Columbia Municipal Regulations (DCMR) in not less than 30 days from the date of publication of this notice. The rules provide for a uniform credentialing form to be used by health care providers when submitting an application to be credentialed or re-credentialed for a provider panel of a health insurer or an entity listed in § 44-501(a) of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48, D.C. Official Code § 44-501) (2001).

This second Notice of Proposed Rulemaking supercedes the notice as published in the D.C. Register on February 14, 2003 at 50 DCR 11264

26 DCMR is amended by adding a new Chapter 42, Uniform Credentialing and Re-credentialing Form, to read as follows:

**CHAPTER 42**

**UNIFORM CREDENTIALING AND RE-CREDENTIALING FORM**

**4200            APPLICABILITY**

4200.1        Each health insurer or its credentialing intermediary, and § 44-501(a) entities listed in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48, D.C. Official Code § 44-501) must comply with these rules one hundred twenty (120) days after the promulgation of the final regulations.

**4201            APPLICATION FOR BECOMING CREDENTIALLED OR  
RE-CREDENTIALLED**

4201.1        Each health insurer or its credentialing intermediary, and § 44-501(a) entities shall accept the current credentialing/re-credentialing form attached to this chapter as Appendix 39-1 as the sole application for

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credentialing and re-credentialing of a healthcare provider for participation on a provider panel.

4201.2 A copy of the "Provider Application" may be obtained from the department.

4201.3 The "Provider Application" form is available in hard copy and on-line at the department's website at [www.disb.dc.gov](http://www.disb.dc.gov).

## 4202 PENALTIES

4202.1 The commissioner may impose a penalty not to exceed \$500.00 against any health insurer or § 44-501(a) entity for each violation of the Act, by the health insurer, the § 44-501(a) entity, or authorized credentialing intermediary.

4202.2 Any health insurer or § 44-501(a) entity found by the Commissioner to be in violation of the Act shall be notified in writing by the Commissioner of the basis of the violation and the amount of the penalty.

4202.3 The health insurer or § 44-501(a) entity shall pay the penalty in the notice or respond in writing to the Commissioner with an explanation of its conduct within thirty (30) days.

## 4203-4298 RESERVED

## 4299 DEFINITIONS

4299.1 When used in this chapter, the following terms and phrases shall have the meanings ascribed:

"Act" means the Health Insurers and Credentialing Intermediaries Uniform Credentialing Form Act of 2002 (D.C. Law 14-96; D.C. Official Code § 31-3251 *et seq.*) (2005 Supp.).

"Commissioner" means Commissioner of the District of Columbia Department of Insurance and Securities Regulation.

"Credentialing intermediary" means a person to whom a health insurer has delegated credentialing or re-credentialing authority and responsibility.

"Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare

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arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

"Provider application" means the uniform credentialing form that the Commissioner of this department adopted to comply with the Health Insurers and Credentialing Intermediaries Uniform Credentialing Form statute.

"Provider panel" means providers that contract with a health insurer to provide health care services to the enrollees under a health benefit plan of the health insurer.

"Uniform credentialing form" means the form designed by the Commissioner through regulation for use by a health insurer or its credentialing intermediary for credentialing and re-credentialing of a health care provider for participation on a provider panel.

"§ 44-501 entity" means an agency, organization, facility, or distinct part of any of them, licensed under D.C. Official Code § 44-501 *et seq.* (2001).

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after publication of this notice in the D.C. Register. Comments should be filed with Leslie Johnson, Hearing Officer, 810 First street, N.E., Suite 701, Washington, D.C. 20002. Copies of these rules may be obtained at the address stated above.

**APPENDIX 39-1**

**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE.  
SECURITIES AND BANKING**

**PROVIDER APPLICATION**

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## Provider Application

CORRECT NUMBERS  
AND LETTERS

A B C 1 2 3

CORRECT  
MARK

X

INCORRECT  
MARKS

✓

CAUTION: AUTOMATICALLY APPLIES IN NO-CASE FORMATING,  
COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE  
MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.**Instructions**  
Read all instructions  
carefully prior to  
submitting your  
application.**Tips to avoid processing delays**

1. Complete only this application and its supplemental forms. Do not use another provider's application.
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

**NOTE:** Fields with asterisks (\*) indicate that a response is required. All other fields will be considered not applicable if left blank.**SECTION I****Personal Information and Professional IDs****Provider Type**
☐ ☐

Code list is found on page 36. Enter the  
associated 3-digit code in the space  
provided.

YES

NO

DO YOU PROVIDE EXCLUSIVE SERVICES TO THE SPANISH-SPEAKING  
U.S. PATIENTS AND ETHNIC GROUPS IN PROFESSIONAL NURSING  
PRACTICE? (N/A, YES, NO, OTHER)

**Name**

Do not use nicknames  
or initials, unless they  
are part of your legal  
name.

LAST NAME\*

FIRST NAME\*

HAVE YOU EVER USED ANOTHER NAME?

YES

NO

IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME

OTHER FIRST NAME



DATE STARTED USING OTHER NAME

DATE STOPPED USING OTHER NAME

**General Information**

Only enter a Foreign  
National Identification  
Number if you do not  
have a SSN. Do not  
enter National Provider  
Identification (NPI)  
number here.

Code lists are found on  
pages 36-43. Enter the  
associated 3-digit code  
in the space provided.

GENDER

MALE

FEMALE

DATE OF BIRTH

CITY OF BIRTH

STATE OF BIRTH

COUNTRY OF BIRTH

SSN

FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)

PIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH

LANGUAGES YOU SPEAK

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

LANGUAGE CODE

**Home Address**

NUMBER

STREET

CITY

STATE

ZIP CODE

TELEPHONE

NOTE: CAOH will use  
this method for  
application follow-up.

E-MAIL

FAX

PREFERRED METHOD OF CONTACT

E-MAIL

FAX

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

\* REQUIRED RESPONSE NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP

### Personal Information and Professional IDs (Continued)

**DEA EXPIRATION DATE**

**EXPIRATION DATE**

**LICENSE EXPIRATION DATE**

1. **المادة 1:** **الهدف من القانون** هو تنظيم العلاقات بين المدينين والمدينات في إطار الأسرة، وضمان حقوقهم وواجباتهم.

EXPANSE EXPANSION DATE

**EIGHTH FIVE**

## WORKERS COMPENSATION NUMBER

ECFMS CERTIFICATE ISSUE DATE (OPEN U.S./CANADIAN GRADUATE ONLY)

Section 2		Education and Training	
<b>Undergraduate School(s)</b> Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.		<b>UNDERGRADUATE SCHOOL</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> OFFICIAL NAME OF UNDERGRADUATE SCHOOL <div style="border: 1px solid black; height: 20px; width: 100%;"></div> ADDRESS <div style="border: 1px solid black; height: 20px; width: 100%;"></div> CITY <div style="border: 1px solid black; height: 20px; width: 100%;"></div> STATE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> ZIP/POSTAL CODE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> COUNTRY CODE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> TELEPHONE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> FAX <div style="border: 1px solid black; height: 20px; width: 100%;"></div> START DATE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> END DATE (GRADUATION DATE) <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DEGREE AWARDED <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>Professional School(s)</b> Provide the appropriate information for the school that issued your professional degree.  Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and the Fifth Pathway Institution where you completed your training on Supplemental Page 20.		<b>GRADUATE TYPE:</b> <input type="checkbox"/> U.S. OR CANADIAN GRADUATE <input type="checkbox"/> NON-U.S./CANADIAN GRADUATE <input type="checkbox"/> FIFTH PATHWAY GRADUATE	
Code lists are found on pages 28-33. Enter the appropriate 3-digit code in the space provided.  If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.		<b>U.S. OR CANADIAN SCHOOL</b> SCHOOL CODE (U.S./CANADIAN ONLY) <div style="border: 1px solid black; height: 20px; width: 100%;"></div> NAME OF U.S./CANADIAN SCHOOL <div style="border: 1px solid black; height: 20px; width: 100%;"></div> START DATE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> END DATE (GRADUATION DATE) <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DEGREE AWARDED <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		<b>NON - U.S. OR CANADIAN SCHOOL</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL <div style="border: 1px solid black; height: 20px; width: 100%;"></div> ADDRESS <div style="border: 1px solid black; height: 20px; width: 100%;"></div> CITY <div style="border: 1px solid black; height: 20px; width: 100%;"></div> COUNTRY CODE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> POSTAL CODE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> START DATE <div style="border: 1px solid black; height: 20px; width: 100%;"></div> END DATE (GRADUATION DATE) <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DEGREE AWARDED <div style="border: 1px solid black; height: 20px; width: 100%;"></div> DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

• REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.



## DISTRICT OF COLUMBIA REGISTER

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Section 3		Professional / Medical Specialty Information											
<b>Primary Specialty</b>  Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	BOARD CERTIFIED?	YES <input type="checkbox"/>		NO <input type="checkbox"/>		RE-CERTIFICATION DATE (IF APPLICABLE) MM DD YY YY YY YY		EXPIRATION DATE (IF APPLICABLE) MM DD YY YY YY YY		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
	CERTIFYING BOARD CODE	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
	IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR CERTIFYING BOARD CODE		<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON MM DD YY YY YY YY		<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM							
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.												
<b>Secondary Specialty</b>  Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.  If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.	SPECIALTY CODE	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	BOARD CERTIFIED?	YES <input type="checkbox"/>		NO <input type="checkbox"/>		RE-CERTIFICATION DATE (IF APPLICABLE) MM DD YY YY YY YY		EXPIRATION DATE (IF APPLICABLE) MM DD YY YY YY YY		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
	CERTIFYING BOARD CODE	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
	IF NOT BOARD CERTIFIED (SELECT ONE)	<input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR CERTIFYING BOARD CODE		<input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON MM DD YY YY YY YY		<input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM							
	IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.												

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## Professional / Medical Specialty Information (Continued)

Do you hold the following certifications? If yes, provide expiration dates.

[illegible]

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

CHECK HERE TO  
USE THE OFFICE  
MANAGER AND  
ADDRESS OF THE  
PRIMARY PRACTICE  
LOCATION AS THE  
CREDENTIALING  
INFORMATION.

**NOTE:**

Even if you checked the boxes above, please provide the e-mail address, if available.

LAST NAME  
 FIRST NAME  
 NUMBER STREET SUITE/BUILDING  
 CITY STATE ZIP CODE  
 TELEPHONE FAX  
 E-MAIL ADDRESS

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Section 4		Practice Location Information	
<b>Primary Practice Location</b>  If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-28.  <b>NOTE:</b> "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.  If Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise in the box.		<b>NOTE:</b> IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITH THE APPLICANT SETTING ON PAGE 1, YOU ARE NOT REQUIRED TO PROVIDE CONTACT INFORMATION ABOVE. SECTION MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.  CURRENTLY PRACTICING AT THIS ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE) SUBSIDIARY / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE) NUMBER STREET SUITE/BUILDING CITY STATE ZIP CODE SEND GENERAL CORRESPONDENCE HERE? <input type="checkbox"/> YES <input type="checkbox"/> NO TELEPHONE FAX OFFICE E-MAIL ADDRESS INDIVIDUAL TAX ID GROUP TAX ID PRIMARY TAX ID (ONE ONLY) USE INDIVIDUAL TAX ID USE GROUP TAX ID	
<b>Office Manager or Business Office Staff Contact</b>  List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.		LAST NAME FIRST NAME TELEPHONE FAX E-MAIL ADDRESS	
<b>Billing Contact</b>  CHECK HERE TO USE OFFICE NUMBER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/>  <b>NOTE:</b> Even if you checked the box above, please provide the E-mail Address of the Billing Contact.		LAST NAME FIRST NAME NUMBER STREET SUITE/BUILDING CITY STATE ZIP CODE TELEPHONE FAX E-MAIL ADDRESS	

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Section 4		Practice Location Information (Continued)																																														
<b>Payment and Remittance</b>  YOUR CHECK PAYABLE TO INFORMATION SHOULD BE CONSISTENT WITH YOUR IRS.  CHECK WHERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYER INFORMATION.  <b>NOTE:</b> Even if you checked the box above, please provide the E-mail Address of the Payer Contact.	ELECTRONIC BILLING CAPABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO BILLING DEPARTMENT OF HOSPITAL-BASED																																															
	CHECK PAYABLE TO:																																															
	LAST NAME:																																															
	FIRST NAME:																																															
	NUMBER:	STREET:	CITY/STATE/ZIP:																																													
	OFF:	STATE:	ZIP CODE:																																													
	TELEPHONE:	FAX:																																														
	E-MAIL ADDRESS:																																															
	<b>Office Hours</b> (USE 24-HOUR FORMAT AND ROUND TO THE NEAREST HALF HOUR)																																															
	<b>NOTE:</b> After hours back office telephone will be used only by the health plan and will not be published under any circumstances.	<table border="1"> <thead> <tr> <th></th> <th>STATE</th> <th>AREA</th> <th>ZIP</th> <th>AREA</th> <th>STATE</th> <th>AREA</th> <th>ZIP</th> <th>AREA</th> </tr> </thead> <tbody> <tr> <td>MONDAY</td> <td></td><td></td><td></td><td></td> <td>FRIEDY</td> <td></td><td></td><td></td> </tr> <tr> <td>TUESDAY</td> <td></td><td></td><td></td><td></td> <td>SATURDAY</td> <td></td><td></td><td></td> </tr> <tr> <td>WEDNESDAY</td> <td></td><td></td><td></td><td></td> <td>SUNDAY</td> <td></td><td></td><td></td> </tr> <tr> <td>THURSDAY</td> <td></td><td></td><td></td><td></td> <td></td> <td></td><td></td><td></td> </tr> </tbody> </table>		STATE	AREA	ZIP	AREA	STATE	AREA	ZIP	AREA	MONDAY					FRIEDY				TUESDAY					SATURDAY				WEDNESDAY					SUNDAY				THURSDAY									
	STATE	AREA	ZIP	AREA	STATE	AREA	ZIP	AREA																																								
MONDAY					FRIEDY																																											
TUESDAY					SATURDAY																																											
WEDNESDAY					SUNDAY																																											
THURSDAY																																																
AFTER HOURS BACK OFFICE TELEPHONE: <input type="checkbox"/> YES <input type="checkbox"/> NO ANSWERING SERVICE: <input type="checkbox"/> YES <input type="checkbox"/> NO VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE: <input type="checkbox"/> YES <input type="checkbox"/> NO VOICE MAIL WITH OTHER INSTRUCTIONS: <input type="checkbox"/> YES <input type="checkbox"/> NO																																																
<b>Open Practice Status</b>  ACCEPT NEW PATIENTS INTO THIS PRACTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYER? <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO  IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED): ARE THERE ANY PRACTICE LIMITATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO GENDER LIMITATIONS: <input type="checkbox"/> MALE ONLY <input type="checkbox"/> FEMALE ONLY <input type="checkbox"/> NONE AGE LIMITATIONS: <input type="checkbox"/> MINIMUM AGE <input type="checkbox"/> MAXIMUM AGE LIST OTHER LIMITATIONS:																																																

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## DISTRICT OF COLUMBIA REGISTER

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## Section 4

## Practice Location Information (Continued)

Mid-Level  
Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

☐☐

YES NO

IF YES, PLEASE PROVIDE THE INFORMATION BELOW

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

ML

PRACTITIONER TYPE (E.G., PA,  
NP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

ML

PRACTITIONER TYPE (E.G., PA,  
NP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

ML

PRACTITIONER TYPE (E.G., PA,  
NP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

ML

PRACTITIONER TYPE (E.G., PA,  
NP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

ML

PRACTITIONER TYPE (E.G., PA,  
NP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

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Section 4: Practice Location Information (Continued)	
<b>Partners/ Associates</b>  Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.  If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	<b>LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE</b>  <div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>COVERING COLLEAGUE (Y/N)?</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>COVERING COLLEAGUE (Y/N)?</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>COVERING COLLEAGUE (Y/N)?</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>COVERING COLLEAGUE (Y/N)?</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
<b>Covering Colleagues</b>  Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.  If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.	<b>LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE</b>  <div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>
	<div> <div>LAST NAME</div> <div>FIRST NAME</div> <div>ML</div> <div>SPECIALTY CODE</div> <div>PROVIDER TYPE (CODE PG 36)</div> </div>

Section 5: Hospital Affiliations	
<b>Admitting Arrangements</b>  DO YOU HAVE HOSPITAL PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?	<div> <div>TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?</div> </div>
	<div> <div>TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?</div> </div>
	<div> <div>TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?</div> </div>
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\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.



## Section 5

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

## Hospital Affiliations (Continued)

## Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL	
HOSPITAL NAME	
NUMBER	STREET
CITY	
STATE	ZIP CODE
TELEPHONE	FAX
DEPARTMENT NAME	
DEPARTMENT DIRECTOR'S LAST NAME	
DEPARTMENT DIRECTOR'S FIRST NAME	
MMYYYY	MMYYYY
AFFILIATION START DATE	AFFILIATION END DATE
FULL UNRESTRICTED PRIVILEGES? YES NO	
ARE PRIVILEGES TEMPORARY? YES NO	
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?	
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)	
OTHER HOSPITAL	
HOSPITAL NAME	
NUMBER	STREET
CITY	
STATE	ZIP CODE
TELEPHONE	FAX
DEPARTMENT NAME	
DEPARTMENT DIRECTOR'S LAST NAME	
DEPARTMENT DIRECTOR'S FIRST NAME	
MMYYYY	MMYYYY
AFFILIATION START DATE	AFFILIATION END DATE
FULL UNRESTRICTED PRIVILEGES? YES NO	
ARE PRIVILEGES TEMPORARY? YES NO	
OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?	
ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)	
PLEASE EXPLAIN TERMINATED AFFILIATION	

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.



APR 14 2006

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 Professional Liability Insurance Carrier	
<b>Professional Liability Insurance Carrier</b>  IMPORTANT: IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. <input type="checkbox"/>	CARRIER OR SELF-INSURED NAME* NUMBER* STREET* SUITE/BUILDING* CITY* STATE* ZIP CODE* ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE* DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO POLICY INCLUDES TAIL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO POLICY NUMBER* SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE OF COVERAGE? <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED AMOUNT OF COVERAGE PER OCCURRENCE \$ AMOUNT OF COVERAGE AGGREGATE \$
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	CARRIER OR SELF-INSURED NAME* NUMBER* STREET* SUITE/BUILDING* CITY* STATE* ZIP CODE* ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE* DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO POLICY INCLUDES TAIL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO POLICY NUMBER* SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE OF COVERAGE? <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> SHARED AMOUNT OF COVERAGE PER OCCURRENCE \$ AMOUNT OF COVERAGE AGGREGATE \$
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<b>Section 7 Work History and References</b> <b>Military Duty</b> Are you currently on active military duty or military reserve? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Work History</b> Include a chronological work history for the past 10 years. A longer period may be required by your healthcare entity. If you have additional work history, use the Supplemental Work History Form on page 32.	WORK HISTORY PRACTICE / EMPLOYER NAME NUMBER STREET SUITE/BUILDING CITY STATE ZIP/POSTAL CODE

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Section 7: Work History and References (Continued)																																																																																																	
<b>Work History</b> Do not list current positions. Those should be listed in Section 4.  Include a chronological work history for the past 10 years.  A larger period may be required by your healthcare entity.  If you have additional work history, use the Supplemental Work History Form on page 32.	<table border="1"><tr><td colspan="10">TELEPHONE</td><td colspan="10">FAX</td></tr><tr><td colspan="2">M M</td><td colspan="2">Y Y</td><td colspan="2">Y Y</td><td colspan="2">Y Y</td><td colspan="2">M M</td><td colspan="2">Y Y</td><td colspan="2">Y Y</td><td colspan="2">Y Y</td></tr><tr><td colspan="2">COUNTRY CODE</td><td colspan="8">START DATE</td><td colspan="2">COUNTRY CODE</td><td colspan="8">END DATE</td></tr><tr><td colspan="20">REASON FOR DEPARTURE (IF APPLICABLE)</td></tr><tr><td colspan="20"></td></tr></table>	TELEPHONE										FAX										M M		Y Y		Y Y		Y Y		M M		Y Y		Y Y		Y Y		COUNTRY CODE		START DATE								COUNTRY CODE		END DATE								REASON FOR DEPARTURE (IF APPLICABLE)																																							
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**Section B****Disclosure Questions**

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

**Allied Health Providers**

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

**Disclosure Questions****LICENSE**

1. ☐ YES ☐ NO Have your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?

**HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS**

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions for reasons other than non-compliance of medical records when quality of care was not adversely affected or have proceedings toward any of those ever been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as TRSs, PEOs)?

**EDUCATION, TRAINING AND BOARD CERTIFICATION**

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

**DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION**

10. ☐ YES ☐ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

**MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION**

11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, delayed, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

**OTHER SANCTIONS OR INVESTIGATIONS**

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled not to contend to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

**PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY**

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

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**Section 8****Disclosure Questions (Continued)****Disclosure Questions**

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

**IMPORTANT**  
If you answered "Yes" to question #18, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

**MALPRACTICE CLAIMS HISTORY**

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.

**CRIMINAL/CIVIL HISTORY**

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

**ABILITY TO PERFORM JOB**

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?  
[“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law.” The term does include, however, the unlawful use of prescription controlled substances.]
24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

## Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant the clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

**Authorization of Investigation Concerning Application for Participation.** I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s), the Entity's affiliated entities and their representatives, employees, and/or designated agents, and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

**Authorization of Third-Party Sources to Release Information Concerning Application for Participation.** I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentialing verification, corporations, contractors, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s) information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation. I, or with the Entity, I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

**Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as they be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being for or being contemplated and/or were (or are) in preparation.

**Release from Liability.** I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and with due diligence which acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, omissions or any other claims based on statements made in good faith and without malice or misconduct in such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditors executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of any privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPD/HPDS reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity and must be submitted online or in writing, and must be dated and signed by me (they may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration, denial or revocation of Participation, and/or immediate suspension or termination of Participation. This action may be decided by the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature:

Name (print):

M M D D Y Y Y Y

DATE SIGNED:

# Professional IDs Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1: Personal Information and Professional IDs			
<b>Professional IDs</b>  Include all additional state licenses, DEA registration and State Controlled Dangerous Substance (CDS) certification numbers.  Provide all current and previous licenses/certifications.  If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.	FEDERAL DEA NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	DEA ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	DEA STATE OF REGISTRATION <input type="text"/> <input type="text"/>	DEA EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	FEDERAL DEA NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	DEA ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	DEA STATE OF REGISTRATION <input type="text"/> <input type="text"/>	DEA EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	CDS CERTIFICATE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CDS ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	CDS STATE OF REGISTRATION <input type="text"/> <input type="text"/>	CDS EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	CDS CERTIFICATE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CDS ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
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	STATE LICENSE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	LICENSE ISSUING STATE <input type="text"/> <input type="text"/>	LICENSE ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE STATUS CODE <input type="text"/> <input type="text"/> <input type="text"/>	LICENSE EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	LICENSE TYPE <input type="text"/> <input type="text"/> <input type="text"/>	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	
STATE LICENSE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	LICENSE ISSUING STATE <input type="text"/> <input type="text"/>	LICENSE ISSUE DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	LICENSE STATUS CODE <input type="text"/> <input type="text"/> <input type="text"/>	LICENSE EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	LICENSE TYPE <input type="text"/> <input type="text"/> <input type="text"/>	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.	

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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## Other Relevant Education Supplemental Form

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 2	Education and Training
<b>Fifth Pathway Education</b>	<b>FIFTH PATHWAY GRADUATES ONLY</b> <div style="margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="font-size: 8px; margin-top: 2px;">INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)</div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="font-size: 8px; margin-top: 2px;">ADDRESS</div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; height: 15px; width: 60%;"></div> <div style="border: 1px solid black; height: 15px; width: 10%;"></div> <div style="border: 1px solid black; height: 15px; width: 25%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>CITY</span> <span>STATE</span> <span>ZIP CODE</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 40%;"></div> <div style="border: 1px solid black; height: 15px; width: 20%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>TELEPHONE</span> <span>FAX</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <small>DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL?</small>  <input type="checkbox"/> YES <input type="checkbox"/> NO         </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>START DATE</small> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>END DATE (GRADUATION DATE)</small> </div> </div> </div>
<b>Other Relevant Education</b>  <small>If you need to report additional Education, photocopy this page as needed and submit as instructed.</small>	<div style="margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="font-size: 8px; margin-top: 2px;">INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)</div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; height: 15px; width: 25%;"></div> <div style="border: 1px solid black; height: 15px; width: 50%;"></div> <div style="border: 1px solid black; height: 15px; width: 20%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>NUMBER</span> <span>STREET</span> <span>SUITE/BUILDING</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 60%;"></div> <div style="border: 1px solid black; height: 15px; width: 10%;"></div> <div style="border: 1px solid black; height: 15px; width: 25%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>CITY</span> <span>STATE</span> <span>ZIP/POSTAL CODE</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 40%;"></div> <div style="border: 1px solid black; height: 15px; width: 20%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>TELEPHONE</span> <span>FAX</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <small>DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL?</small>  <input type="checkbox"/> YES <input type="checkbox"/> NO         </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>START DATE</small> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>END DATE (GRADUATION DATE)</small> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">D</div><div style="border: 1px solid black; padding: 2px;">E</div><div style="border: 1px solid black; padding: 2px;">G</div><div style="border: 1px solid black; padding: 2px;">R</div><div style="border: 1px solid black; padding: 2px;">E</div><div style="border: 1px solid black; padding: 2px;">E</div> <small>DEGREE AWARDED</small> </div> </div> </div>
	<div style="margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="font-size: 8px; margin-top: 2px;">INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)</div> <div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; height: 15px; width: 25%;"></div> <div style="border: 1px solid black; height: 15px; width: 50%;"></div> <div style="border: 1px solid black; height: 15px; width: 20%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>NUMBER</span> <span>STREET</span> <span>SUITE/BUILDING</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 60%;"></div> <div style="border: 1px solid black; height: 15px; width: 10%;"></div> <div style="border: 1px solid black; height: 15px; width: 25%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>CITY</span> <span>STATE</span> <span>ZIP/POSTAL CODE</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="border: 1px solid black; height: 15px; width: 40%;"></div> <div style="border: 1px solid black; height: 15px; width: 20%;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> <span>TELEPHONE</span> <span>FAX</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <small>DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL?</small>  <input type="checkbox"/> YES <input type="checkbox"/> NO         </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>START DATE</small> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">M</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div><div style="border: 1px solid black; padding: 2px;">Y</div> <small>END DATE (GRADUATION DATE)</small> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px;">D</div><div style="border: 1px solid black; padding: 2px;">E</div><div style="border: 1px solid black; padding: 2px;">G</div><div style="border: 1px solid black; padding: 2px;">R</div><div style="border: 1px solid black; padding: 2px;">E</div><div style="border: 1px solid black; padding: 2px;">E</div> <small>DEGREE AWARDED</small> </div> </div> </div>

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.



APR 14 2006

## Other Training Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

Section 2	Education and Training																																																												
<p><b>Training</b></p> <p>List all postgraduate training programs you attended. Use one section per institution.</p> <p>If you need to report additional Training, photocopy this page as needed and submit as instructed.</p> <p>Code lists are found on pages S6-43. Enter the associated 3-digit code in the space provided.</p>	<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)</p> <p>NUMBER STREET SUBBUILDING</p> <p>CITY STATE ZIP/POSTAL CODE</p> <p>COUNTRY CODE TELEPHONE FAX</p> </div> <div style="width: 25%;"> <p>SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOLS)</p> </div> </div> <p>DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN:</p> <p>_____</p> <p>_____</p> <p>_____</p>																																																												
<p>List each department separately, if applicable.</p> <p>List Internship/Residency, Fellowship and Other programs separately.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td style="width: 30%;"><input type="checkbox"/> FELLOWSHIP</td> <td style="width: 30%;"><input type="checkbox"/> OTHER</td> <td style="width: 10%;">M M Y Y Y Y</td> <td style="width: 10%;">M M Y Y Y Y</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;">START DATE</td> <td style="text-align: center;">END DATE</td> </tr> <tr> <td colspan="5">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="5">NAME OF DIRECTOR</td> </tr> <tr> <td><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td><input type="checkbox"/> FELLOWSHIP</td> <td><input type="checkbox"/> OTHER</td> <td>M M Y Y Y Y</td> <td>M M Y Y Y Y</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;">START DATE</td> <td style="text-align: center;">END DATE</td> </tr> <tr> <td colspan="5">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="5">NAME OF DIRECTOR</td> </tr> <tr> <td><input type="checkbox"/> INTERNSHIP/RESIDENCY</td> <td><input type="checkbox"/> FELLOWSHIP</td> <td><input type="checkbox"/> OTHER</td> <td>M M Y Y Y Y</td> <td>M M Y Y Y Y</td> </tr> <tr> <td colspan="3"></td> <td style="text-align: center;">START DATE</td> <td style="text-align: center;">END DATE</td> </tr> <tr> <td colspan="5">DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)</td> </tr> <tr> <td colspan="5">NAME OF DIRECTOR</td> </tr> </table>	<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y	M M Y Y Y Y				START DATE	END DATE	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					NAME OF DIRECTOR					<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y	M M Y Y Y Y				START DATE	END DATE	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					NAME OF DIRECTOR					<input type="checkbox"/> INTERNSHIP/RESIDENCY	<input type="checkbox"/> FELLOWSHIP	<input type="checkbox"/> OTHER	M M Y Y Y Y	M M Y Y Y Y				START DATE	END DATE	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)					NAME OF DIRECTOR				
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DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)																																																													
NAME OF DIRECTOR																																																													

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APR 14 2006

## Additional Specialty Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

Section 3 Professional / Medical Specialty Information										
<b>Additional Specialty</b>  <small>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</small>	<table style="width: 100%;"> <tr> <td style="width: 25%;">SPECIALTY CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></td> <td style="width: 25%;">INITIAL CERTIFICATION DATE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></td> <td style="width: 50%; vertical-align: top;"> DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?   HMO <input type="checkbox"/> YES <input type="checkbox"/> NO   PPO <input type="checkbox"/> YES <input type="checkbox"/> NO   POS <input type="checkbox"/> YES <input type="checkbox"/> NO </td> </tr> <tr> <td>BOARD CERTIFIED? <input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>RECERTIFICATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></td> <td></td> </tr> <tr> <td>CERTIFYING BOARD CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></td> <td>EXPIRATION DATE (IF APPLICABLE) <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/></td> <td></td> </tr> </table> <div style="margin-top: 10px;"> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> IF NOT BOARD CERTIFIED, SELECT ONE: <input type="checkbox"/> I HAVE TAKEN EXAM, RESULTS PENDING FOR <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> CERTIFYING BOARD CODE </div> <div style="width: 30%;"> <input type="checkbox"/> I INTEND TO SIT FOR AN EXAM ON <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> </div> <div style="width: 30%;"> <input type="checkbox"/> I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM </div> </div> </div> <div style="margin-top: 10px; font-size: 0.8em;"> IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK. </div> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>	SPECIALTY CODE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	INITIAL CERTIFICATION DATE <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?  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\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

## Partners/Associates Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

Section 4	Practice Location Information			
<p><b>Partner/Associates</b></p> <p>Use this page to report additional partners/associates at the designated practice location.</p> <p><b>IMPORTANT:</b></p> <p>In the box provided, indicate to which practice location this page belongs.</p> <p>Check "Covering Colleague?" if he/she provides coverage for you at this location.</p> <p>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</p> <p>If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.</p>	SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS			
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FIRST NAME <input style="width: 100%; border: 1px solid black;" type="text"/>	ML <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	PROVIDER TYPE (CODE PG 36) <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/>		
LAST NAME <input style="width: 100%; border: 1px solid black;" type="text"/>	SPECIALTY CODE <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/>	COVERING COLLEAGUE (Y/N)? <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>		
FIRST NAME <input style="width: 100%; border: 1px solid black;" type="text"/>	ML <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	PROVIDER TYPE (CODE PG 36) <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/>		
LAST NAME <input style="width: 100%; border: 1px solid black;" type="text"/>	SPECIALTY CODE <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/>	COVERING COLLEAGUE (Y/N)? <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>		
FIRST NAME <input style="width: 100%; border: 1px solid black;" type="text"/>	ML <input style="width: 20px; height: 20px; border: 1px solid black;" type="checkbox"/>	PROVIDER TYPE (CODE PG 36) <input style="width: 20px; height: 20px; border: 1px solid black;"/> <input style="width: 20px; height: 20px; border: 1px solid black;"/>		

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOWUP.

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## Practice Location Information Supplemental Form

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Section 4	Practice Location Information - Page 1 of 5	
<b>Additional Practice Location</b>  <b>IMPORTANT</b> In the box provided, indicate to which practice location this page belongs.  For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.	<b>LOCATION# #</b> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px;"></span>	
	CURRENTLY PRACTICING AT THIS ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO      IF NO, WHAT IS YOUR EXPECTED START DATE? <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>	
	PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE) <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
	GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE) <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
<b>Office Manager or Business Office Contact</b>  List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.	NUMBER <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span> STREET <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span> SUITE/BUILDING <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>	
	CITY <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span> STATE <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> ZIP CODE <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>	
	TELEPHONE <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span> FAX <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span>	
	E-MAIL ADDRESS <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>	
<b>Billing Contact</b>  CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION <input type="checkbox"/>	LAST NAME <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	
	FIRST NAME <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span>	
	NUMBER <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span> STREET <span style="border: 1px solid black; display: inline-block; width: 100px; height: 15px;"></span> SUITE/BUILDING <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>	
	CITY <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span> STATE <span style="border: 1px solid black; display: inline-block; width: 20px; height: 15px;"></span> ZIP CODE <span style="border: 1px solid black; display: inline-block; width: 40px; height: 15px;"></span>	
TELEPHONE <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span> FAX <span style="border: 1px solid black; display: inline-block; width: 60px; height: 15px;"></span>		
E-MAIL ADDRESS <span style="border: 1px solid black; display: inline-block; width: 150px; height: 15px;"></span>		

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## Practice Location Information Supplemental Form

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Section 4	Practice Location Information, Page 3 of 5			
<p><b>Additional Practice Location</b> (Continued)</p> <p><b>IMPORTANT</b> In the box provided, indicate to which practice location this page belongs.</p> <p>If you have additional partners/associates at this location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.</p> <p>Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.</p>	<p>→ LOCATION # <span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span></p>			
	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE			
	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
	LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
	LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
	LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>
	LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE				
<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	
<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	<div style="border: 1px solid black; height: 15px; width: 100%;"></div> <div style="border: 1px solid black; height: 15px; width: 100%;"></div>	
LAST NAME	FIRST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	

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## Hospital Affiliations

**TIP** Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

**THIS SPACE HAS BEEN PURPOSELY LEFT BLANK**

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

# Professional Liability Insurance Carrier Supplemental Form

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 Professional Liability Insurance Carrier	
<b>Other Professional Liability Insurance Carrier</b>  List secondary / second layer / future or previous carrier(s).  For second layer coverage list name of hospital/organization providing coverage.  If you need additional space for insurance coverage, photocopy this page as needed and submit as instructed.	<div> <div>CARRIER OR SELF-INSURED NAME</div> <div> <div>NUMBER</div> <div>STREET</div> <div>CITY</div> <div>STATE</div> <div>ZIP CODE</div> </div> </div> <div> <div>SELF-INSURED?</div> <div>YES</div> <div>NO</div> </div> <div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> </div> <div> <div>ORIGINAL EFFECTIVE DATE</div> <div>EFFECTIVE DATE</div> <div>EXPIRATION DATE</div> </div> <div> <div>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</div> <div>YES</div> <div>NO</div> </div> <div> <div>POLICY INCLUDES TAX COVERAGE?</div> <div>YES</div> <div>NO</div> </div> <div> <div>AMOUNT OF COVERAGE PER OCCURRENCE</div> <div>AMOUNT OF COVERAGE AGGREGATE</div> </div> <div> <div>POLICY NUMBER</div> </div>
	<div> <div>CARRIER OR SELF-INSURED NAME</div> <div> <div>NUMBER</div> <div>STREET</div> <div>CITY</div> <div>STATE</div> <div>ZIP CODE</div> </div> </div> <div> <div>SELF-INSURED?</div> <div>YES</div> <div>NO</div> </div> <div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> </div> <div> <div>ORIGINAL EFFECTIVE DATE</div> <div>EFFECTIVE DATE</div> <div>EXPIRATION DATE</div> </div> <div> <div>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</div> <div>YES</div> <div>NO</div> </div> <div> <div>POLICY INCLUDES TAX COVERAGE?</div> <div>YES</div> <div>NO</div> </div> <div> <div>AMOUNT OF COVERAGE PER OCCURRENCE</div> <div>AMOUNT OF COVERAGE AGGREGATE</div> </div> <div> <div>POLICY NUMBER</div> </div>
	<div> <div>CARRIER OR SELF-INSURED NAME</div> <div> <div>NUMBER</div> <div>STREET</div> <div>CITY</div> <div>STATE</div> <div>ZIP CODE</div> </div> </div> <div> <div>SELF-INSURED?</div> <div>YES</div> <div>NO</div> </div> <div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> </div> <div> <div>ORIGINAL EFFECTIVE DATE</div> <div>EFFECTIVE DATE</div> <div>EXPIRATION DATE</div> </div> <div> <div>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</div> <div>YES</div> <div>NO</div> </div> <div> <div>POLICY INCLUDES TAX COVERAGE?</div> <div>YES</div> <div>NO</div> </div> <div> <div>AMOUNT OF COVERAGE PER OCCURRENCE</div> <div>AMOUNT OF COVERAGE AGGREGATE</div> </div> <div> <div>POLICY NUMBER</div> </div>
	<div> <div>CARRIER OR SELF-INSURED NAME</div> <div> <div>NUMBER</div> <div>STREET</div> <div>CITY</div> <div>STATE</div> <div>ZIP CODE</div> </div> </div> <div> <div>SELF-INSURED?</div> <div>YES</div> <div>NO</div> </div> <div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> </div> <div> <div>ORIGINAL EFFECTIVE DATE</div> <div>EFFECTIVE DATE</div> <div>EXPIRATION DATE</div> </div> <div> <div>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</div> <div>YES</div> <div>NO</div> </div> <div> <div>POLICY INCLUDES TAX COVERAGE?</div> <div>YES</div> <div>NO</div> </div> <div> <div>AMOUNT OF COVERAGE PER OCCURRENCE</div> <div>AMOUNT OF COVERAGE AGGREGATE</div> </div> <div> <div>POLICY NUMBER</div> </div>
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	<div> <div>CARRIER OR SELF-INSURED NAME</div> <div> <div>NUMBER</div> <div>STREET</div> <div>CITY</div> <div>STATE</div> <div>ZIP CODE</div> </div> </div> <div> <div>SELF-INSURED?</div> <div>YES</div> <div>NO</div> </div> <div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> <div>DATE</div> <div>MONTH</div> <div>YEAR</div> </div> <div> <div>ORIGINAL EFFECTIVE DATE</div> <div>EFFECTIVE DATE</div> <div>EXPIRATION DATE</div> </div> <div> <div>DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?</div> <div>YES</div> <div>NO</div> </div> <div> <div>POLICY INCLUDES TAX COVERAGE?</div> <div>YES</div> <div>NO</div> </div> <div> <div>AMOUNT OF COVERAGE PER OCCURRENCE</div> <div>AMOUNT OF COVERAGE AGGREGATE</div> </div> <div> <div>POLICY NUMBER</div> </div>
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\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

Work History																								
WORK HISTORY																								
PRACTICE / EMPLOYER NAME																								
NUMBER					STREET										SUITE/BUILDING									
CITY					STATE					ZIP/POSTAL CODE														
TELEPHONE										FAX														
COUNTRY CODE					START DATE					END DATE														
REASON FOR DEPARTURE IF APPLICABLE																								
WORK HISTORY																								
PRACTICE / EMPLOYER NAME																								
NUMBER					STREET										SUITE/BUILDING									
CITY					STATE					ZIP/POSTAL CODE														
TELEPHONE										FAX														
COUNTRY CODE					START DATE					END DATE														
REASON FOR DEPARTURE IF APPLICABLE																								

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

**F**

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

### Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history that have occurred since graduation from professional school and are longer than three months in duration, or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y
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[illegible]

CAP START DATE		M	M	Y	Y	Y	Y	CAP END DATE		M	M	Y	Y	Y	Y
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[illegible]

GAP START DATE		M	M	Y	Y	Y	Y	GAP END DATE		M	M	Y	Y	Y	Y
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[illegible]

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y
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[illegible]

GAP START DATE	M	M	Y	Y	Y	Y	GAP END DATE	M	M	Y	Y	Y	Y
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[illegible]

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

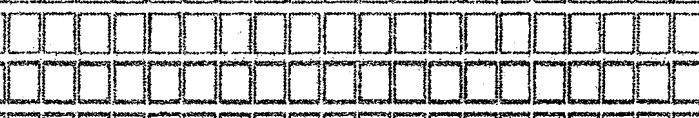
\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

## Disclosure Questions

**If you need additional space to explain a Yes response, photocopy this page as needed and submit as instructed.**

**QUESTION 1**

### EXPLANATION



**QUESTION #**

--	--

**EXPLANATION**

**QUESTION 1**

--	--	--

### EXPLANATION

[illegible]

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

# Malpractice Claims Explanation Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

<b>Section 8</b>		<b>Malpractice Claims Explanation</b>	
<b>Malpractice Claims Explanation</b> Use this form to report any "Yes" response to Disclosure Question #18.  If you need additional space to explain a Yes response, photocopy this page as needed and submit as included.		DATE OF OCCURRENCE	MMDDYYYY
		DATE CLAIM WAS FILED	MMDDYYYY
STATUS OF CLAIM (NOTE: IF CASE IS PENDING, SELECT OPEN)		IF SETTLED, ENTER DATE CLAIM WAS SETTLED	
<input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED		MMDDYYYY	
PROFESSIONAL LIABILITY CARRIER INVOLVED (USE BOTH LINES IF NECESSARY)			
NUMBER    STREET    SUITE/BOX/ROOM CITY    STATE    ZIP CODE TELEPHONE    POLICY NUMBER			
\$    AMOUNT OF AWARD OR SETTLEMENT		METHOD OF RESOLUTION: <input type="checkbox"/> DISMISSED <input type="checkbox"/> SETTLED <input type="checkbox"/> MEDIATION <input type="checkbox"/> ARBITRATION <input type="checkbox"/> JUDGMENT FOR DEFENDANT(S) <input type="checkbox"/> JUDGMENT FOR PLAINTIFF(S)	
DESCRIPTION OF ALLEGATIONS (USE ALL FOUR LINES BELOW, IF NECESSARY)			
WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT? <input type="checkbox"/> PRIMARY DEFENDANT <input type="checkbox"/> CO-DEFENDANT    NUMBER OF OTHER CO-DEFENDANTS (IF ANY)			
YOUR INVOLVEMENT IN CASE (ATTENDING, CONSULTING, ETC.)			
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)			
DID THE ALLEGED INJURY RESULT IN DEATH?		TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

## Code Lists

## Provider Type Codes

001 Medical Doctor (MD)	030 Licensed Practical Nurse	041 Optometrist
002 Doctor of Dental Surgery (DDS)	031 Marriage/Family Therapist	042 Pharmacist
003 Doctor of Dental Medicine (DMD)	032 Massage Therapist	043 Physical Therapist
004 Doctor of Podiatric Medicine (DPM)	033 Naturopath	044 Physician Assistant
005 Doctor of Chiropractic (DC)	034 Neuropsychologist	045 Professional Counselor
007 Osteopathic Doctor (DO)	035 Midwife	046 Registered Nurse
020 Acupuncturist	036 Nurse-Midwife	047 Registered Nurse First Assistant
021 Alcohol/Drug Counselor	037 Nurse Practitioner	048 Respiratory Therapist
022 Audiologist	038 Nutritionist	049 Speech Pathologist
023 Biofeedback Technician	039 Occupational Therapist	
024 Certified Registered Nurse Anesthetist	040 Optician	
025 Christian Science Practitioner		
026 Clinical Nurse Specialist		
027 Clinical Psychologist		
028 Clinical Social Worker		
029 Dietician		

## License Status Codes

001 Active	008 Pending	015 Temporary
002 Canceled	009 Probation	016 Terminated
003 Denied	010 Provisional	017 Time Limited
004 Expired	011 Rescinded	018 Unrestricted
005 Inactive	012 Revoked	019 Other
006 Lapsed	013 Suspended	
007 Limited	014 Surrendered	

## Country Codes

004 Afghanistan	174 Comoros	334 Heard Island and McDonald Islands	498 Moldova
009 Albania	178 Congo	340 Honduras	499 Monaco
012 Algeria	180 Congo, Democratic Republic of the	341 Hong Kong	500 Mongolia
014 American Samoa	184 Cook Islands	348 Hungary	501 Montserrat
020 Andorra	188 Cook Island	352 Iceland	504 Morocco
024 Angola	284 Cote d'Ivoire	358 India	508 Mozambique
029 Argentina	191 Croatia	359 Indonesia	104 Myanmar
034 Australia and Barbuda	192 Cuba	360 Indonesia	518 Namibia
032 Argentina	196 Cyprus	364 Iran	520 Nepal
031 Armenia	203 Czech Republic	368 Iraq	524 Niger
035 Aruba	208 Denmark	372 Ireland	528 Netherlands
036 Austria	262 Djibouti	376 Israel	530 Netherlands Antilles
040 Azerbaijan	212 Dominica	380 Italy	540 New Caledonia
044 Bahamas	214 Dominican Republic	384 Jamaica	554 New Zealand
048 Bahrain	226 Ecuador	392 Japan	558 Nicaragua
050 Bangladesh	810 Egypt	400 Jordan	562 Niger
052 Barbados	222 El Salvador	398 Kazakhstan	566 Nigeria
112 Belarus	226 Equatorial Guinea	404 Kenya	570 Niue
056 Belgium	232 Eritrea	408 Kiribati	574 Norfolk Island
064 Belize	234 Estonia	412 Korea, North	580 Northern Mariana Islands
068 Benin	231 Ethiopia	416 Korea, South	578 Norway
060 Bermuda	238 Falkland Islands (Malvinas)	414 Kuwait	512 Oman
064 Bhutan	234 Faroe Islands	417 Kyrgyzstan	586 Pakistan
068 Bolivia	242 Fiji	418 Laos	582 Palau
070 Bosnia and Herzegovina	246 Finland	420 Latvia	591 Panama
072 Botswana	250 France	422 Lebanon	595 Papua New Guinea
074 Bouvet Island	249 France, Metropolitan	426 Lesotho	600 Paraguay
076 Brazil	254 French Guiana	430 Liberia	604 Peru
086 British Indian Ocean Territory	258 French Polynesia	434 Libya	608 Philippines
096 Brunei Darussalam	260 French Southern Territories	438 Liechtenstein	612 Pitcairn
100 Bulgaria	266 Gabon	440 Lithuania	616 Poland
054 Burkina Faso	270 Gambia	442 Luxembourg	620 Portugal
058 Burundi	268 Georgia	446 Macao	624 Puerto Rico
116 Cambodia	276 Germany	450 Macedonia	634 Qatar
120 Cameroon	268 Ghana	454 Madagascar	638 Reunion
124 Canada	292 Gibraltar	458 Malawi	642 Romania
132 Cape Verde	300 Greece	458 Malaysia	646 Russian Federation
136 Cayman Islands	304 Greenland	462 Maldives	648 Rwanda
140 Central African Republic	308 Grenada	466 Mali	654 Saint Helena
148 Chad	312 Guadeloupe	470 Malta	658 Saint Kitts and Nevis
152 Chile	316 Guam	474 Marshall Islands	662 Saint Lucia
156 China	320 Guatemala	478 Mauritania	666 Saint Pierre and Miquelon
162 Christmas Island	324 Guinea	480 Mauritius	670 Saint Vincent and the Grenadines
166 Cocos (Keeling) Islands	624 Guinea-Bissau	484 Mexico	
170 Colombia	328 Guyana	488 Micronesia	
	332 Haiti		



## Code Lists

## Country Codes (continued)

882 Samoa	Sandwich Islands	772 Tokelau	548 Vanuatu
674 San Marino	724 Spain	776 Tonga	336 Vatican City State (Holy See)
678 São Tomé and Príncipe	844 Sri Lanka	780 Trinidad and Tobago	862 Venezuela
682 Saudi Arabia	736 Sudan	788 Tunisia	704 Viet Nam
686 Scotland	740 Suriname	792 Turkey/T95 Turkmenistan	092 Virgin Islands, British
688 Senegal	744 Swaziland and Jan Mayen	796 Turks and Caicos Islands	850 Virgin Islands, U.S.
690 Seychelles	748 Switzerland	798 Tuvalu	876 Wallis and Futuna Islands
694 Sierra Leone	752 Sweden	800 Uganda	732 Western Sahara (provisional)
702 Singapore	756 Switzerland	804 Ukraine	887 Yemen
706 Slovakia	760 Syria	784 United Arab Emirates	894 Yugoslavia
708 Slovenia	764 Taiwan	826 United Kingdom	894 Zambia
090 Solomon Islands	762 Tajikistan	840 United States	716 Zimbabwe
704 Somalia	834 Tanzania	581 U.S. Minor Outlying Islands	
710 South Africa	764 Thailand	658 Uruguay	
239 South Georgia and the South	768 Togo	658 Uzbekistan	

## Language Codes

004 Abkhazian	061 Kinyarwanda	121 Tonga
002 Akan (Orono)	062 Kirgiz	122 Tsonga
003 Aka	063 Kikundi	123 Turkish
004 Akkadian	064 Korean	124 Turkmen
005 Albanian	065 Kurdish	125 Twi
006 Amharic	066 Lachin	126 Ugar
007 Arabic	067 Latin	127 Ukrainian
008 Armenian	068 Latvian, Lettish	128 Urdu
009 Assamese	069 Lingala	129 Uzbek
010 Avestan	070 Lithuanian	130 Vietnamese
011 Basotho	071 Macedonian	131 Wolapuk
012 Basque	072 Malagasy	132 Welsh
013 Bengali, Bangla	073 Malay	133 Wolof
014 Bhojpur	074 Malayalam	134 Xhosa
015 Bihari	075 Maltese	135 Yiddish
016 Bislama	076 Maori	136 Yoruba
017 Bantu	077 Māori	10 Zerbajani
018 Bulgarian	078 Moldavian	137 Zhuang
019 Burmese	079 Mongolian	138 Zulu
020 Byelorussian	080 Hindi	
021 Cambodian	081 Nepali	
022 Catalan	082 Norwegian	
023 Chinese	083 Occitan	
024 Corsican	084 Ojibwa	
025 Croatian	085 Pashto/Pushto	
026 Czech	086 Persian (Farsi)	
027 Danish	087 Polish	
028 Dutch	088 Portuguese	
146 English	089 Punjabi	
030 Esperanto	090 Quechua	
031 Estonian	091 Rhaeto-Romanic	
032 Faroese	092 Romanian	
100 Fiji	093 Russian	
034 Finnish	094 Samoan	
035 French	095 Sangha	
036 Frisian	096 Sanskrit	
037 Galician	097 Scot Gaelic	
038 Georgian	098 Serbian	
039 German	099 Serbo-Croatian	
040 Greek	100 Sesotho	
041 Greenlandic	101 Setswana	
042 Guaraní	102 Shona	
043 Gujarati	103 Sindhi	
044 Hausa	104 Singhalese	
045 Hebrew	105 Slovak	
046 Hindi	106 Slovenian	
047 Hungarian	107 Somali	
048 Icelandic	108 Spanish	
049 Indonesian	109 Sundanese	
050 Interlingua	110 Swahili	
051 Interlingue	111 Swedish	
052 Inuktitut	112 Tagalog	
053 Iupuk	113 Tamil	
054 Irish	114 Tatar	
055 Italian	115 Telugu	
056 Japanese	116 Thai	
057 Javanese	117 Tibetan	
058 Kanda	118 Tigrinya	
059 Khasi		
060 Kazakh		

## Code Lists

## U.S./Canadian Professional School Codes

## Alabama

- 900 University of Alabama School of Dentistry
- 901 University of Alabama School of Medicine
- 902 University of South Alabama College of Medicine

## Arkansas

- 003 University of Arkansas College of Medicine

## Arizona

- 500 Arizona College of Osteopathic Medicine
- 604 University of Arizona College of Medicine

## California

- 801 California College of Podiatric Medicine
- 400 Cleveland Chiropractic College of Los Angeles
- 005 Keck School of Medicine
- 401 Life Chiropractic College West
- 301 Loma Linda University School of Dentistry
- 006 Loma Linda University School of Medicine
- 402 Los Angeles College of Chiropractic
- 403 Palmer College of Chiropractic West
- 404 Quantum University/SCCC
- 007 Stanford University School of Medicine
- 501 Tufts University College of Osteopathic Medicine
- 008 UCLA School of Medicine
- 909 University of California
- 010 University of California, Irvine, College of Medicine
- 302 University of California, Los Angeles School of Dentistry
- 011 University of California, San Diego, School of Medicine
- 305 University of California, San Francisco, School of Dentistry
- 012 University of California, San Francisco, School of Medicine
- 304 University of Southern California School of Dentistry
- 305 University of the Pacific School of Dentistry
- 502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

## Colorado

- 906 University of Colorado School of Dentistry
- 013 University of Colorado School of Medicine

## Connecticut

- 405 University of Bridgeport College of Chiropractic
- 307 University of Connecticut School of Dental Medicine
- 014 University of Connecticut School of Medicine
- 015 Yale University School of Medicine

## District of Columbia

- 016 George Washington University
- 017 Georgetown University School of Medicine
- 308 Howard University College of Dentistry
- 018 Howard University College of Medicine

## Florida

- 800 Barry University School of Graduate Medical Sciences
- 309 Nova Southeastern University College of Dentistry
- 503 Nova Southeastern University College of Osteopathic Medicine
- 310 University of Florida College of Dentistry
- 019 University of Florida College of Medicine
- 020 University of Miami School of Medicine
- 021 University of South Florida College of Medicine

## Georgia

- 022 Emory University School of Medicine
- 406 Life Chiropractic College
- 311 Medical College of Georgia School of Dentistry
- 023 Medical College of Georgia School of Medicine
- 024 Mercer University School of Medicine
- 025 Morehouse School of Medicine

## Hawaii

- 026 John A. Burns School of Medicine

## Iowa

- 802 College of Podiatric Medicine and Surgery, Des Moines University
- 504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
- 407 Palmer College of Chiropractic
- 312 University of Iowa College of Dentistry
- 027 University of Iowa College of Medicine

## Illinois

- 028 Chicago Medical School, Finch University of Health Sciences
- 029 Loyola University Chicago, Stritch School of Medicine
- 505 Midwestern University, Chicago College of Osteopathic Medicine
- 408 National College of Chiropractic
- 313 Northwestern University Dental School
- 030 Northwestern University Medical School
- 031 Rush Medical College of Rush University
- 804 School College of Podiatric Medicine at Finch University
- 314 Southern Illinois University School of Dental Medicine
- 032 Southern Illinois University School of Medicine
- 033 University of Chicago, The Pritzker School of Medicine
- 315 University of Illinois at Chicago College of Dentistry
- 034 University of Illinois College of Medicine

## Indiana

- 316 Indiana University School of Dentistry
- 035 Indiana University School of Medicine

## Kansas

- 036 University of Kansas School of Medicine

## Kentucky

- 506 Pikeville College, School of Osteopathic Medicine
- 317 University of Kentucky College of Dentistry
- 037 University of Kentucky College of Medicine
- 318 University of Louisville School of Dentistry
- 038 University of Louisville School of Medicine

## Louisiana

- 319 Louisiana State University School of Dentistry
- 039 Louisiana State University School of Medicine in New Orleans
- 040 Louisiana State University School of Medicine in Shreveport
- 041 Tulane University School of Medicine

## Massachusetts

- 042 Boston University School of Medicine
- 320 Boston University, Goldman School of Dental Medicine
- 043 Harvard Medical School
- 321 Harvard School of Dental Medicine
- 322 Tufts University School of Dental Medicine
- 044 Tufts University School of Medicine
- 045 University of Massachusetts Medical School

## Maryland

- 046 Johns Hopkins University School of Medicine
- 047 Uniformed Services University of the Health Sciences
- 048 University of Maryland School of Medicine
- 323 University of Maryland, Baltimore, College of Dental Surgery

## Maine

- 507 University of New England, College of Osteopathic Medicine

## Michigan

- 049 Michigan State University College of Human Medicine
- 508 Michigan State University, College of Osteopathic Medicine
- 324 University of Detroit Mercy School of Dentistry
- 050 University of Michigan Medical School
- 525 University of Michigan School of Dentistry
- 051 Wayne State University School of Medicine

## Minnesota

- 052 Mayo Medical School
- 409 Northwestern College of Chiropractic
- 053 University of Minnesota, Duluth School of Medicine
- 054 University of Minnesota Medical School, Twin Cities
- 326 University of Minnesota School of Dentistry

## Missouri

- 410 Cleveland Chiropractic College of Kansas City
- 509 Kinksville College of Osteopathic Medicine
- 411 Logan Chiropractic College
- 055 Saint Louis University School of Medicine
- 510 University of Health Sciences, College of Osteopathic Medicine
- 056 University of Missouri, Columbia School of Medicine
- 327 University of Missouri, Kansas City School of Dentistry
- 057 University of Missouri, Kansas City School of Medicine
- 058 Washington University in St. Louis School of Medicine

## Code Lists

## U.S. / Canadian Professional School Codes (continued)

## Mississippi

- 328 University of Mississippi School of Dentistry  
059 University of Mississippi School of Medicine

## North Carolina

- 060 Duke University School of Medicine  
061 The Brody School of Medicine at East Carolina University  
329 University of North Carolina at Chapel Hill School of Dentistry  
062 University of North Carolina at Chapel Hill School of Medicine  
063 Wake Forest University School of Medicine

## North Dakota

- 064 University of North Dakota School of Medicine and Health Sciences

## Nebraska

- 330 Creighton University School of Dentistry  
065 Creighton University School of Medicine  
066 University of Nebraska College of Medicine  
334 University of Nebraska Medical Center, College of Dentistry

## New Hampshire

- 067 Dartmouth Medical School

## New Jersey

- 068 Robert Wood Johnson Medical School  
069 University of Medicine and Dentistry of New Jersey (UMDNJ)  
332 UMDNJ New Jersey Dental School  
331 UMDNJ School of Osteopathic Medicine

## New Mexico

- 070 University of New Mexico School of Medicine

## Nevada

- 071 University of Nevada School of Medicine

## New York

- 072 Albany Medical College  
073 Albert Einstein College of Medicine  
074 Columbia University College of Physicians and Surgeons  
333 Columbia University School of Dental and Oral Surgery  
075 Joan & Sanford J. Weill Medical College of Cornell University  
076 Mount Sinai School of Medicine of New York University  
412 New York Chiropractic College  
512 NY College of Osteopathic Medicine of the NY Institute of Technology  
077 New York Medical College  
334 New York University Feder Dental Center  
078 New York University School of Medicine  
335 State University of New York at Buffalo School of Dental Medicine  
082 State University of New York at Buffalo School of Medicine  
336 State University of New York at Stony Brook School of Dental Medicine  
081 State University of New York at Stony Brook School of Medicine  
079 State University of New York College of Medicine  
080 State University of New York Upstate Medical University  
083 University of Rochester School of Medicine and Dentistry

## Ohio

- 337 Case Western Reserve University School of Dentistry  
084 Case Western Reserve University School of Medicine  
085 Medical College of Ohio  
086 Northeastern Ohio Universities College of Medicine  
083 Ohio College of Podiatric Medicine  
338 Ohio State University College of Dentistry  
087 Ohio State University College of Medicine and Public Health  
513 Ohio University College of Osteopathic Medicine  
088 University of Cincinnati College of Medicine  
089 Wright State University School of Medicine

## Oklahoma

- 514 Oklahoma State University, College of Osteopathic Medicine  
339 University of Oklahoma College of Dentistry  
090 University of Oklahoma College of Medicine

## Oregon

- 091 Oregon Health & Science University School of Medicine  
340 Oregon Health Sciences University School of Dentistry  
413 Western States Chiropractic College

## Pennsylvania

- 092 Jefferson Medical College of Thomas Jefferson University

- 515 Lake Erie College of Osteopathic Medicine  
093 MCP Hahnemann University School of Medicine  
094 Pennsylvania State University College of Medicine  
516 Philadelphia College of Osteopathic Medicine  
341 Temple University School of Dentistry  
095 Temple University School of Medicine  
805 Temple University School of Podiatric Medicine  
342 University of Pennsylvania School of Dental Medicine  
096 University of Pennsylvania School of Medicine  
343 University of Pittsburgh School of Dental Medicine  
097 University of Pittsburgh School of Medicine

## Puerto Rico

- 098 Ponce School of Medicine  
099 Universidad Central del Caribe School of Medicine  
100 University of Puerto Rico School of Medicine  
344 University of Puerto Rico School of Dentistry

## Rhode Island

- 101 Brown Medical School

## South Carolina

- 545 Medical University of South Carolina College of Dental Medicine  
102 Medical University of South Carolina College of Medicine  
414 Sherman College of Chiropractic  
103 University of South Carolina School of Medicine

## South Dakota

- 104 University of South Dakota School of Medicine

## Tennessee

- 105 East Tennessee State University  
346 Meharry Medical College School of Dentistry  
106 Meharry Medical College School of Medicine  
347 University of Tennessee College of Dentistry  
407 University of Tennessee College of Medicine  
108 Vanderbilt University School of Medicine

## Texas

- 348 Baylor College of Dentistry  
109 Baylor College of Medicine  
415 Parker College of Chiropractic  
416 Texas Chiropractic College  
110 Texas Tech University Health Sciences Center School of Medicine  
111 The Texas A & M University System College of Medicine  
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine  
349 University of Texas Health Science Center at Houston Dental School  
350 University of Texas Health Science Center at San Antonio Dental School  
112 University of Texas Medical Branch at Galveston  
113 University of Texas Medical School at Houston  
114 University of Texas Medical School at San Antonio  
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

## Utah

- 116 University of Utah School of Medicine

## Virginia

- 417 Eastern VA Medical School of the Medical College of Hampton Roads  
118 University of Virginia School of Medicine Health System  
351 Virginia Commonwealth University School of Dentistry  
119 Virginia Commonwealth University School of Medicine

## Vermont

- 120 University of Vermont College of Medicine

## Washington

- 352 University of Washington School of Dentistry  
421 University of Washington School of Medicine

## Wisconsin

- 353 Marquette University School of Dentistry  
422 Medical College of Wisconsin  
123 University of Wisconsin Medical School

## West Virginia

- 124 Joan C. Edwards School of Medicine at Marshall University  
518 West Virginia School of Osteopathic Medicine  
354 West Virginia University School of Dentistry  
125 West Virginia University School of Medicine

## Code Lists

## U.S./Canadian Professional School Codes (continued)

## Canada

355	Dalhousie University Faculty of Dentistry
126	Dalhousie University Faculty of Medicine
357	Uaval University Faculty of Dentistry
127	Uaval University Faculty of Medicine
356	McGill University Faculty of Dentistry
128	McGill University Faculty of Medicine
129	McMaster University School of Medicine
130	Memorial University of Newfoundland Faculty of Medicine
131	Queen's University Faculty of Health Sciences
132	The University of Western Ontario Faculty of Medicine & Dentistry
133	Université de Montréal Faculty of Medicine
134	Université de Sherbrooke Faculty of Medicine
358	University of Alberta Faculty of Dentistry
135	University of Alberta Faculty of Medicine
359	University of British Columbia Faculty of Dentistry
136	University of British Columbia Faculty of Medicine
137	University of Calgary Faculty of Medicine
360	University of Manitoba Faculty of Dentistry
138	University of Manitoba Faculty of Medicine
361	University of Montreal Faculty of Dentistry
139	University of Ottawa Faculty of Medicine
362	University of Saskatchewan College of Dentistry
140	University of Saskatchewan College of Medicine
363	University of Toronto Faculty of Dentistry
141	University of Toronto Faculty of Medicine
364	University of Western Ontario Faculty of Dentistry

## Specialty Codes: ABA 90 Only

247	Allergy & Immunology	287	Internal Medicine, Hematology	416	Orthopaedic Surgery, Orthopaedic Trauma
246	Allergy & Immunology, Allergy	288	Internal Medicine, Hematology & Oncology	457	Orthopaedic Surgery, Sports Medicine
291	Allergy & Immunology, Clinical & Laboratory Immunology	458	Internal Medicine, Hepatology	419	Otolaryngology
249	Anesthesiology	293	Internal Medicine, Infectious Disease	331	Otolaryngology
235	Anesthesiology, Addiction Medicine	451	Internal Medicine, Interventional Cardiology	458	Otolaryngology, Otolaryngologic Allergy
259	Anesthesiology, Critical Care Medicine	453	Internal Medicine, Magnetic Resonance Imaging (MRI)	459	Otolaryngology, Otolaryngology/Facial Plastic Surgery
120	Anesthesiology, Pain Medicine	325	Internal Medicine, Medical Oncology	332	Otolaryngology, Otolaryngology & Neurotology
383	Clinical Pharmacology	369	Internal Medicine, Nephrology	357	Otolaryngology, Pediatric Otolaryngology
357	Colon & Rectal Surgery	378	Internal Medicine, Pulmonary Disease	417	Otolaryngology, Plastic Surgery of the Head & Neck
283	Dermatology	380	Internal Medicine, Rheumatology	480	Pain Medicine, Interventional Pain Medicine
292	Dermatology, Clinical & Laboratory	397	Internal Medicine, Sports Medicine	357	Pain Medicine
444	Dermatology, Dermatological Surgery	433	Laboratories, Clinical Medical Laboratory	358	Pathology, Anatomic Pathology
295	Dermatology, Dermatopathology	481	Legal Medicine	349	Pathology, Anatomic Pathology & Clinical Pathology
394	Dermatology, MOHS-Micrographic Surgery	270	Medical Genetics, Clinical Biochemical Genetics	250	Pathology, Blood Banking & Transfusion Medicine
445	Dermatology, Pediatric Dermatology	261	Medical Genetics, Clinical Cytogenetics	344	Pathology, Chemical Pathology
288	Emergency Medicine	217	Medical Genetics, Clinical Genetics (M.D.)	302	Pathology, Clinical Pathology/Laboratory Medicine
445	Emergency Medicine, Emergency Medical Services	288	Medical Genetics, Clinical Molecular Genetics	262	Pathology, Cytopathology
427	Emergency Medicine, Medical Toxicology	455	Medical Genetics, Molecular Genetic Pathology	263	Pathology, Dermatopathology
346	Emergency Medicine, Pediatric Emergency Medicine	454	Medical Genetics, Ph.D. Medical Genetics	275	Pathology, Forensic Pathology
395	Emergency Medicine, Sports Medicine	486	Neonatal-Perinatal Medicine	360	Pathology, Hematology
446	Emergency Medicine, Undersea and Hyperbaric Medicine	308	Neuropathology	298	Pathology, Immunopathology
393	Facial Plastic Surgery	409	Neurological Surgery	304	Pathology, Medical Microbiology
272	Family Practice	330	Neuromusculoskeletal Medicine & OMM	461	Pathology, Molecular Genetic Pathology
447	Family Practice, Addiction Medicine	410	Neuromusculoskeletal Medicine, Sports Medicine	312	Pathology, Neuropathology
297	Family Practice, Adolescent Medicine	317	Nuclear Medicine	356	Pathology, Pediatric Pathology
448	Family Practice, Adult Medicine	318	Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	243	Pediatrics
282	Family Practice, Geriatric Medicine	345	Nuclear Medicine, Nuclear Cardiology	229	Pediatrics, Adolescent Medicine
396	Family Practice, Sports Medicine	316	Nuclear Medicine, Nuclear Imaging & Therapy	295	Pediatrics, Clinical & Laboratory Immunology
225	General Practice	321	Obstetrics & Gynecology	462	Pediatrics, Developmental-Behavioral Pediatrics
479	Hospitalist	260	Obstetrics & Gynecology, Critical Care Medicine	354	Pediatrics, Medical Toxicology
301	Internal Medicine	326	Obstetrics & Gynecology, Gynecologic Oncology	556	Pediatrics, Neurodevelopmental Disabilities
449	Internal Medicine, Addiction Medicine	265	Obstetrics & Gynecology, Gynecology	345	Pediatrics, Pediatric Allergy & Immunology
294	Internal Medicine, Adolescent Medicine	303	Obstetrics & Gynecology, Maternal & Fetal Medicine	346	Pediatrics, Pediatric Cardiology
248	Internal Medicine, Allergy & Immunology	320	Obstetrics & Gynecology, Obstetrics	347	Pediatrics, Pediatric Critical Care Medicine
255	Internal Medicine, Cardiovascular Disease	271	Obstetrics & Gynecology, Reproductive Endocrinology	465	Pediatrics, Pediatric Emergency Medicine
294	Internal Medicine, Clinical & Laboratory Immunology	328	Ophthalmology	349	Pediatrics, Pediatric Endocrinology
253	Internal Medicine, Clinical Cardiac Electrophysiology	441	Oral & Maxillofacial Surgery		
257	Internal Medicine, Critical Care Medicine	411	Orthopaedic Surgery		
267	Internal Medicine, Endocrinology, Diabetes & Metabolism	412	Orthopaedic Surgery, Adult Reconstructive		
275	Internal Medicine, Gastroenterology	456	Orthopaedic Surgery, Foot and Ankle		
285	Internal Medicine, Geriatric Medicine	406	Orthopaedic Surgery, Hand Surgery		
		415	Orthopaedic Surgery, Orthopaedic Surgery of the Spine		

## Code Lists

## Specialty Codes - MD/DO Only

350 Pediatrics, Pediatric Gastroenterology	471 Preventive Medicine, Sports Medicine	366 Neurology
351 Pediatrics, Pediatric Hematology-Oncology	431 Preventive Medicine, Undersea and Hyperbaric Medicine	Public Health & General Preventive Medicine
352 Pediatrics, Pediatric Infectious Diseases	314 Preventive Medicine/Occupational Environmental Medicine	252 Radiology, Body Imaging
355 Pediatrics, Pediatric Nephrology	370 Psychiatry & Neurology, Addiction Medicine	173 Radiology, Diagnostic Radiology
359 Pediatrics, Pediatric Pulmonology	473 Psychiatry & Neurology, Addiction Psychiatry	430 Radiology, Diagnostic Ultrasound
361 Pediatrics, Pediatric Rheumatology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	314 Radiology, Neuroimaging
368 Pediatrics, Sports Medicine	315 Psychiatry & Neurology, Clinical Neuropsychology	319 Radiology, Nuclear Radiology
365 Physical Medicine & Rehabilitation	274 Psychiatry & Neurology, Forensic Psychiatry	360 Radiology, Pediatric Radiology
450 Physical Medicine & Rehabilitation, Pain Medicine	373 Psychiatry & Neurology, Geriatric Psychiatry	380 Radiology, Radiation Oncology
369 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	477 Radiology, Radiological Physics
465 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	100 Psychiatry & Neurology, Neurology	381 Radiology, Therapeutic Radiology
469 Physical Medicine & Rehabilitation, Sports Medicine	313 Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology	384 Radiology, Vascular & Interventional Radiology
419 Plastic Surgery	474 Psychiatry & Neurology, Pain Medicine	434 Supplier
470 Plastic Surgery, Plastic Surgery within the Head and Neck	368 Psychiatry & Neurology, Psychiatry	399 Surgery
407 Plastic Surgery, Surgery of the Hand	475 Psychiatry & Neurology, Sports Medicine	410 Surgery, Pediatric Surgery
242 Preventive Medicine, Aerospace Medicine	476 Psychiatry & Neurology, Vascular	420 Surgery, Plastic and Reconstructive Surgery
420 Preventive Medicine, Medical Technology		405 Surgery, Surgery of the Hand
112 Preventive Medicine, Occupational Medicine		425 Surgery, Surgical Critical Care

## Specialty Codes - DDS, DMD, DPM

DD5 / Dent	DPM	DC
2 Dentist	9 Podiatrist	1 Chiropractor
43 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
436 Dentist, General Practice	225 Podiatrist, General Practice	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	227 Podiatrist, Primary Pediatric Medicine	8 Chiropractor, Occupational Medicine
439 Dentist, Oral and Maxillofacial Radiology	226 Podiatrist, Public Medicine	9 Chiropractor, Orthopedic
20 Dentist, Oral and Maxillofacial Surgery	228 Podiatrist, Radiology	10 Chiropractor, Radiology
43 Dentist, Otolaryngology and Dentofacial Orthopedics	229 Podiatrist, Sports Medicine	11 Chiropractor, Sports Physician
17 Dentist, Pediatric Dentistry		12 Chiropractor, Thermography
18 Dentist, Periodontics		
19 Dentist, Prosthodontics		

## Specialty Codes - Allied Providers

501 Acupuncturist	753 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
503 Audiologist	754 Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
504 Audiologist, Assistive Technology Practitioner	755 Clinical Nurse Specialist, Psychiatric/Mental Health, Community
505 Audiologist, Assistive Technology Supplier	756 Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
531 Children's Scientist Practitioner	757 Clinical Nurse Specialist, Rehabilitation
727 Clinical Nurse Specialist	759 Clinical Nurse Specialist, School
728 Clinical Nurse Specialist, Acute Care	758 Clinical Nurse Specialist, Transplantation
729 Clinical Nurse Specialist, Adult Health	760 Clinical Nurse Specialist, Women's Health
730 Clinical Nurse Specialist, Chronic Care	513 Counselor
731 Clinical Nurse Specialist, Community Health/Public Health	514 Counselor, Addiction (Substance Use Disorder)
732 Clinical Nurse Specialist, Critical Care Medicine	515 Counselor, Mental Health
733 Clinical Nurse Specialist, Emergency	516 Counselor, Professional
734 Clinical Nurse Specialist, Ethics	533 Dietitian, Registered
735 Clinical Nurse Specialist, Family Health	536 Dietitian, Registered, Nutrition, Metabolic
736 Clinical Nurse Specialist, Gerontology	534 Dietitian, Registered, Nutrition, Pediatric
737 Clinical Nurse Specialist, Holistic	535 Dietitian, Registered, Nutrition, Renal
738 Clinical Nurse Specialist, Home Health	651 Licensed Practical Nurse
739 Clinical Nurse Specialist, Inpatient	517 Marriage & Family Therapist
740 Clinical Nurse Specialist, Long-Term Care	547 Massage Therapist
741 Clinical Nurse Specialist, Medical-Surgical	549 Midwife, Certified
742 Clinical Nurse Specialist, Neonatal	552 Midwife, Certified Nurse
743 Clinical Nurse Specialist, Neuroscience	551 Naturopath
744 Clinical Nurse Specialist, Occupational Health	553 Neuropsychologist
745 Clinical Nurse Specialist, Oncology	653 Nurse Anesthetist, Certified Registered
746 Clinical Nurse Specialist, Oncology, Pediatrics	654 Nurse Practitioner
747 Clinical Nurse Specialist, Pediatrics	655 Nurse Practitioner, Acute Care
748 Clinical Nurse Specialist, Perinatal	656 Nurse Practitioner, Adult Health
749 Clinical Nurse Specialist, Perioperative	658 Nurse Practitioner, Community Health
750 Clinical Nurse Specialist, Psychiatric/Mental Health	657 Nurse Practitioner, Critical Care Medicine
751 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	659 Nurse Practitioner, Family
752 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent	

## Code Lists

## Specialty Codes - Allied Providers (continued)

660	Nurse Practitioner, Gerontology	675	Registered Nurse, Critical Care Medicine
661	Nurse Practitioner, Neonatal	682	Registered Nurse, Diabetes Educator
662	Nurse Practitioner, Neonatal, Critical Care	683	Registered Nurse, Dialysis, Peritoneal
670	Nurse Practitioner, Obstetrics & Gynecology	684	Registered Nurse, Emergency
671	Nurse Practitioner, Occupational Health	685	Registered Nurse, Enterostomal Therapy
683	Nurse Practitioner, Pediatrics	686	Registered Nurse, Flight
684	Nurse Practitioner, Pediatrics, Critical Care	688	Registered Nurse, Gastroenterology
666	Nurse Practitioner, Perinatal	687	Registered Nurse, General Practice
667	Nurse Practitioner, Primary Care	689	Registered Nurse, Gerontology
665	Nurse Practitioner, Psych/Mental Health	691	Registered Nurse, Hemodialysis
668	Nurse Practitioner, School	690	Registered Nurse, Home Health
669	Nurse Practitioner, Women's Health	692	Registered Nurse, Hospice
537	Nutritionist	694	Registered Nurse, Infection Control
538	Nutritionist, Nutrition, Education	693	Registered Nurse, Infusion Therapy
555	Occupational Therapist	695	Registered Nurse, Lactation Consultant
556	Occupational Therapist, Ergonomics	696	Registered Nurse, Maternal/Neonatal
557	Occupational Therapist, Hand	697	Registered Nurse, Medical-Surgical
558	Occupational Therapist, Human Factors	699	Registered Nurse, Neonatal Intensive Care
559	Occupational Therapist, Neurorehabilitation	700	Registered Nurse, Neonatal, Low-Risk
560	Occupational Therapist, Pediatrics	701	Registered Nurse, Nephrology
561	Occupational Therapist, Rehabilitation, Driver	702	Registered Nurse, Neuroscience
563	Optician	698	Registered Nurse, Nurse-Massage Therapist (NMT)
565	Optometrist	705	Registered Nurse, Nutrition Support
566	Optometrist, Contact and Contact Management	719	Registered Nurse, Obstetric, High-Risk
567	Optometrist, Low Vision Rehabilitation	720	Registered Nurse, Obstetric, Inpatient
571	Optometrist, Occupational Vision	721	Registered Nurse, Occupational Health
568	Optometrist, Pediatrics	722	Registered Nurse, Oncology
569	Optometrist, Sports Vision	723	Registered Nurse, Ophthalmic
570	Optometrist, Vision Therapy	724	Registered Nurse, Orthopedic
573	Pharmacist	725	Registered Nurse, Ostomy Care
574	Pharmacist, General Practice	723	Registered Nurse, Otolaryngology & Head-Neck
575	Pharmacist, Hospital Pharmacy	704	Registered Nurse, Pain Management
576	Pharmacist, Nutrition Support	706	Registered Nurse, Pediatric Oncology
577	Pharmacist, Pharmacotherapy	705	Registered Nurse, Pediatrics
578	Pharmacist, Psychopharmacy	710	Registered Nurse, Perinatal
580	Physical Therapist	714	Registered Nurse, Plastic Surgery
581	Physical Therapist, Cardiopulmonary	708	Registered Nurse, Psych/Mental Health
582	Physical Therapist, Electrophysiology, Clinical	709	Registered Nurse, Psych/Mental Health, Adult
582	Physical Therapist, Ergonomics	707	Registered Nurse, Psych/Mental Health, Child & Adolescent
584	Physical Therapist, Geriatrics	712	Registered Nurse, Rehabilitation
585	Physical Therapist, Hand	713	Registered Nurse, Reproductive Endocrinology/Infertility
586	Physical Therapist, Human Factors	715	Registered Nurse, School
587	Physical Therapist, Neurology	716	Registered Nurse, Urology
589	Physical Therapist, Orthopedic	718	Registered Nurse, Women's Health Care, Ambulatory
588	Physical Therapist, Pediatrics	717	Registered Nurse, Wound Care
589	Physical Therapist, Sports	617	Respiratory Therapist, Certified
592	Physician Assistant	618	Respiratory Therapist, Certified, Critical Care
593	Physician Assistant, Medical	620	Respiratory Therapist, Certified, Educational
594	Physician Assistant, Surgical	619	Respiratory Therapist, Certified, Emergency Care
596	Psychologist	622	Respiratory Therapist, Certified, General Care
597	Psychologist, Addiction (Substance Use Disorder)	621	Respiratory Therapist, Certified, Geriatric Care
598	Psychologist, Adult Development & Aging	625	Respiratory Therapist, Certified, Home Health
599	Psychologist, Behavioral	626	Respiratory Therapist, Certified, Neonatal/Pediatrics
602	Psychologist, Child, Youth & Family	627	Respiratory Therapist, Certified, Palliative/Hospice
600	Psychologist, Clinical	629	Respiratory Therapist, Certified, Patient Transport
601	Psychologist, Counseling	624	Respiratory Therapist, Certified, Pulmonary Diagnostics
603	Psychologist, Educational	626	Respiratory Therapist, Certified, Pulmonary Function Technologist
604	Psychologist, Exercise & Sports	625	Respiratory Therapist, Certified, Pulmonary Rehabilitation
605	Psychologist, Family	630	Respiratory Therapist, Certified, SNF/Subacute Care
606	Psychologist, Forensic	631	Respiratory Therapist, Registered
607	Psychologist, Health	632	Respiratory Therapist, Registered, Critical Care
608	Psychologist, Men & Masculinity	634	Respiratory Therapist, Registered, Educational
609	Psychologist, Mental Retardation & Developmental Disabilities	633	Respiratory Therapist, Registered, Emergency Care
610	Psychologist, Psychoanalysis	636	Respiratory Therapist, Registered, General Care
611	Psychologist, Psychotherapy	635	Respiratory Therapist, Registered, Geriatric Care
612	Psychologist, Psychotherapy, Group	637	Respiratory Therapist, Registered, Home Health
613	Psychologist, Rehabilitation	642	Respiratory Therapist, Registered, Neonatal/Pediatrics
614	Psychologist, School	641	Respiratory Therapist, Registered, Palliative/Hospice
615	Psychologist, Women	643	Respiratory Therapist, Registered, Patient Transport
672	Registered Nurse	638	Respiratory Therapist, Registered, Pulmonary Diagnostics
673	Registered Nurse, Addiction (Substance Use Disorder)	640	Respiratory Therapist, Registered, Pulmonary Function Technologist
674	Registered Nurse, Administrator	639	Respiratory Therapist, Registered, Pulmonary Rehabilitation
711	Registered Nurse, Ambulatory Care	644	Respiratory Therapist, Registered, SNF/Subacute Care
681	Registered Nurse, Cardiac Rehabilitation	646	Social Worker, Clinical
676	Registered Nurse, Case Management	648	Specialist/Technologist, Other, Biomedical Engineering
677	Registered Nurse, College Health	506	Speech-Language Pathologist
678	Registered Nurse, Community Health	649	Technician, Other, Biomedical Engineering
680	Registered Nurse, Contraception Care	502	Other, Not Listed
679	Registered Nurse, Continuing Education/Staff Development		

## Code Lists

## Specialty Boards Allied Providers

940 Academy of Certified Social Workers  
 1150 ACNM Certification Council  
 360 American Academy of Ambulatory Care Nursing  
 1560 American Academy of Anesthesiologist Assistants  
 230 American Academy of Audiology  
 570 American Academy of Experts in Traumatic Stress  
 270 American Academy of Health Providers in the Addictive Disorders  
 200 American Academy of Medical Acupuncture  
 405 American Academy of Nurse Practitioners  
 380 American Academy of Nursing  
 1300 American Academy of Optometry  
 1460 American Academy of Physician Assistants  
 1110 American Association for Marriage and Family Therapy  
 350 American Association of Critical Care Nurses  
 1590 American Association of Nurse Anesthetists  
 300 American Association of Pastoral Counselors  
 480 American Association of Sex Educators, Counselors and Therapists  
 710 American Board Medical Psychotherapists  
 280 American Board of Addiction Medicine  
 950 American Board of Examiners in Clinical Social Work  
 720 American Board of Medical Psychotherapists & Psychodiagnostics  
 400 American Board of Nursing Specialties  
 1240 American Board of Nutrition  
 1300 American Board of Occupational Medicine  
 1060 American Board of Ophthalmology  
 1570 American Board of Physical Therapy Specialties  
 700 American Board of Professional Psychology  
 1430 American Naturopath Certification Board

350 American Nurses Credentialing Center  
 740 American Psychological Association  
 750 American Psychological Society  
 760 American Psychotherapy Association  
 290 American Society of Addiction Medicine  
 1650 American Speech-Language-Hearing Association  
 250 Biofeedback Certification Institute of America  
 1430 Board of Pharmaceutical Specialties  
 1250 Commission on Dietetic Registration  
 960 Employee Assistance Professionals Association  
 780 National Association for the Advancement of Psychoanalysis  
 1450 National Association of Boards of Pharmacy  
 1600 National Association of Nurse Anesthetists  
 770 National Association of School Psychologists  
 980 National Association of Social Workers  
 1310 National Board for Certification in Occupational Therapy  
 1490 National Board for Certification of Orthopaedic Physician Assistants  
 790 National Board for Certified Clinical Hypnotherapists  
 510 National Board for Certified Counselors  
 1690 National Board for Respiratory Care  
 520 National Board of Addiction Examiners  
 680 National Board of Cognitive Behavioral Therapists  
 1550 National Board of Examiners in Optometry  
 1690 National Certification Board for Therapeutic Massage and Bodywork  
 210 National Certification Commission for Acupuncture and Oriental Medicine  
 1470 National Institute for Standards in Pharmacist Credentialing  
 220 Other - Not Listed

## Specialty Boards MD / DOBS? DMD/DO/ DPM

## MD Boards

043 American Board of Allergy & Immunology  
 045 American Board of Anesthesiology  
 046 American Board of Colon & Rectal Surgery  
 047 American Board of Dermatology  
 048 American Board of Emergency Medicine  
 049 American Board of Family Medicine  
 050 American Board of Internal Medicine  
 051 American Board of Medical Genetics  
 052 American Board of Neurological Surgery  
 053 American Board of Nuclear Medicine  
 054 American Board of Obstetrics & Gynecology  
 055 American Board of Ophthalmology  
 109 American Board of Oral & Maxillofacial Surgeons  
 056 American Board of Orthopedic Surgery  
 057 American Board of Otolaryngology  
 058 American Board of Pathology  
 059 American Board of Pediatrics  
 060 American Board of Physical Medicine & Rehabilitation  
 061 American Board of Plastic Surgery  
 062 American Board of Preventive Medicine  
 063 American Board of Psychiatry & Neurology  
 064 American Board of Radiology  
 065 American Board of Surgery  
 066 American Board of Thoracic Surgery  
 067 American Board of Urology  
 142 Boards other than ABMS/AOA

## Dental Boards

110 American Board of Endodontics  
 111 American Board of Oral & Maxillofacial Pathology  
 112 American Board of Oral & Maxillofacial Radiology  
 109 American Board of Oral & Maxillofacial Surgeons

108 American Board of Orthodontics  
 112 American Board of Pediatric Dentistry  
 111 American Board of Periodontology  
 115 American Board of Prosthodontics  
 106 American Board of Public Health Dentistry  
 120 Boards other than ABMS/AOA

## DO Boards

118 American Osteopathic Board of Anesthesiology  
 119 American Osteopathic Board of Dermatology  
 120 American Osteopathic Board of Emergency Medicine  
 121 American Osteopathic Board of Family Practice  
 122 American Osteopathic Board of Internal Medicine  
 123 American Osteopathic Board of Neurology and Psychiatry  
 124 American Osteopathic Board of Nuclear Medicine  
 125 American Osteopathic Board of Obstetrics and Gynecology  
 126 American Osteopathic Board of Ophthalmology  
 127 American Osteopathic Board of Otolaryngology and Head & Neck Surgery  
 128 American Osteopathic Board of Pathology  
 129 American Osteopathic Board of Pediatrics  
 130 American Osteopathic Board of Preventive Medicine  
 131 American Osteopathic Board of Radiology  
 132 American Osteopathic Board of Surgery  
 133 American Osteopathic Board of Thoracic Surgery  
 134 American Osteopathic Board of Urology  
 135 American Osteopathic Board of Rehabilitation Medicine  
 136 American Osteopathic Board of Sports Medicine

## DPM Boards

140 American Board of Medical Specialists in Podiatry  
 137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine  
 138 American Board of Podiatric Surgery  
 158 American Council of Certified Podiatric Surgeons and Physicians



**DISTRICT OF COLUMBIA  
DEPARTMENT OF INSURANCE, SECURITIES, AND BANKING**

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**NOTICE OF PROPOSED RULEMAKING**

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The Commissioner of the Department of Insurance, Securities, and Banking ("Commissioner"), pursuant to the authority set forth in section 8 of the Prompt Payment Act of 2002 (Act), effective July 23, 2002, D.C. Law 14-176, D.C. Official Code § 31-3137 (2005 Supp.), hereby gives notice of his intent to add a new Chapter 88, entitled Health Benefit Plans Prompt Payment, to Title 26 of the D.C. Municipal Regulations (Insurance), in not less than thirty days from the date of publication of this notice in the *D.C. Register*. The purpose of this new chapter is to establish a uniform outpatient mental health information release form to be used by a provider and accepted by a health insurer when a health insurer requests a treatment plan in order to adjudicate a medical health claim for outpatient mental health services..

Title 26 DCMR (Insurance) is amended by adding a new Chapter 88, Health Benefit Plans Prompt Payment to read as follows:

**CHAPTER 88            HEALTH BENEFIT PLANS PROMPT PAYMENT**

**8800            CLAIM FORM FOR OUTPATIENT MENTAL HEALTH SERVICES**

8800.1            When a health insurer requests a treatment plan from a provider of outpatient mental health services, the provider shall submit the information on a form approved by the Commissioner. (See Appendix "Release of Mental Health Information for Outpatient Mental Health Treatment" form)

**8899            DEFINITIONS**

8899.1            "Commissioner" means the Commissioner of the Department of Insurance, Securities, and Banking.

"Health benefits plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement. The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance;



medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

“Health insurer” means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

“Provider” means any hospital, group of health professionals, or health professional licensed, or authorized by reciprocity or endorsement, to practice a health occupation by the District of Columbia or any state.

Persons desiring to comment on these proposed rules should submit comments in writing to Leslie E. Johnson, Hearing Officer, Department of Insurance, Securities and Banking, 810 First Street, N.E. Suite 701, Washington, D.C. 20002, not later than 30 days after publication of this notice in the *D.C. Register*.

APR 14 2006

APPENDIX

## District of Columbia

**Release of Mental Health Information for Outpatient Mental Health Treatment**  
 This form is designed to authorize the disclosure of the mental health information listed below by the individual practitioner to determine entitlement and payment of claims for reimbursement. It is not to be used for in-patient or partial hospitalization.

Carrier or Appropriate Recipient:

CLIENT INFORMATION										PRACTITIONER INFORMATION									
CLIENT'S FIRST NAME					CLIENT'S DATE OF BIRTH					PRACTITIONER ID# or TAX ID					PHONE NUMBER				
MEMBERSHIP NUMBER										PRACTITIONER NAME, LICENSE#, ADDRESS & PHONE (Fax optional)									
AUTHORIZATION NUMBER (If Applicable)																			
										Date Client First Seen For This Episode Of Treatment									
Status? <input type="radio"/> Voluntary <input type="radio"/> Involuntary <b>MULTIAXIAL DIAGNOSIS CODE* (PLEASE COMPLETE ALL FIVE AXES)</b> *DSM, ICD or Other Recognized Code																			
AXIS I		Dx Code				Dx Code				Dx Code				Dx Code					
AXIS II		Dx Code				Dx Code				Dx Code				Dx Code					
AXIS III (if relevant)																			
AXIS IV		Severity of current psychosocial stressors																	
		<input type="radio"/> None <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe																	
AXIS V: GAF Score		Highest Past Year				Current													
Current Medications and Prescribing Practitioner (if applicable):																			
Reason for Continuing Treatment and Treatment Goals:																			
Prognosis (limited to estimated duration of treatment):																			
<b>Authorization Request Details</b> <i>Modality of treatment maybe conveyed via CPT code or by describing in the field provided below.</i> <i>(Modality examples: individual psychotherapy, group psychotherapy, medication management)</i>																			
CPT Code										Complete this section only if a second CPT/Modality is needed.									
										CPT Code									
Modality:										Modality:									
Frequency (once a week, etc.):										Frequency (once a week, etc.):									
Requested Start Date of Authorization:										Requested Start Date of Authorization:									
Client's Consent: By signing below, I agree to share this information with the designated 3 <sup>rd</sup> party payer (administrator). I also understand that, "The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978. Disclosures may only be made pursuant to a valid authorization by the Client or as provided in Titles III and IV of that Act. The Act provides for civil damages and criminal penalties for violations."																			
Signature of Client										Date:									
- or -																			
Signature of practitioner*:										Date:									
*My signature attests that I have consent from the Client to release this information.																			

PUBLIC SERVICE COMMISSION OF THE DISTRICT OF COLUMBIA  
1333 H STREET, N.W., SUITE 200, WEST TOWER  
WASHINGTON, DC 20005

NOTICE OF PROPOSED RULEMAKING

TT00-5, IN THE MATTER OF VERIZON WASHINGTON, DC INC.'S PUBLIC  
SPACE OCCUPANCY SURCHARGE GENERAL REGULATIONS TARIFF,  
P.S.C.-D.C. No. 201

1. The Public Service Commission of the District of Columbia ("Commission") hereby gives notice, pursuant to Section 2-505 of the District of Columbia Code,<sup>1</sup> of its intent to act upon the proposed tariff of Verizon Washington, DC Inc., ("Verizon DC")<sup>2</sup> in not less than 30 days from the date of publication of this Notice of Proposed Rulemaking ("NOPR") in the *D.C. Register*.

2. Pursuant to D.C. Code Section 10-1141.6,<sup>3</sup> Verizon DC filed with the Commission an updated Public Space Occupancy Surcharge Rider ("PSOS") on March 23, 2006.<sup>4</sup> In the tariff filing, Verizon DC explains the process for recovering from its customers the D.C. Public Rights-of-Way fees paid by Verizon DC to the District Columbia Government. Verizon DC proposes to amend the following tariff pages:

GENERAL REGULATIONS TARIFF, P.S.C.-D.C. No. 201

Section 1A

Original Page 2

3. Verizon DC states that the updated calculations are based on estimated receipts from June 2006 until June 2007.<sup>5</sup> Verizon DC also indicates that the revised surcharge will take effect July 1, 2006 and that the surcharge will increase by \$0.36 (\$0.05 Centrex) because of the declining number of customer lines.<sup>6</sup>

<sup>1</sup> D. C. Code, 2001 Ed. § 2-505.

<sup>2</sup> *TT00-5, In The Matter Of Verizon Washington, Dc Inc.'s Public Space Occupancy Surcharge General Regulations Tariff, P.S.C.-D.C. No. 201 ("TT00-5")*, Letter to Dorothy Wideman, Commission Secretary, from J. Henry Ambrose, Vice President for Regulatory Matters of Verizon DC, re: TT00-5, filed March 23, 2006 (hereinafter referred to as "Application").

<sup>3</sup> D.C. Code, 2001 Ed. § 10-1141.06, states that "Each public utility company regulated by the Public Service Commission shall recover from its utility customers all lease payments which it pays to the District of Columbia pursuant to this title through a surcharge mechanism applied to each unit of sale and the surcharge amount shall be separately stated on each customer's monthly billing statement."

<sup>4</sup> *TT00-5*, Application at 1.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

4. This filing may be reviewed at the Office of the Commission Secretary, 1333 H Street, N.W., Seventh Floor, East Tower, Washington, D.C. 20005, between the hours of 9:00 a.m. and 5:30 p.m., Monday through Friday. Copies of the proposed tariff pages are available upon request, at a per-page reproduction cost.

5. Comments on the tariff must be made in writing to Dorothy Wideman, Commission Secretary, at the above address. All comments must be received within 30 days of the date of publication of this NOPR in the *D.C. Register*. Persons wishing to file reply comments may do so no later than 45 days of the date of publication of this NOPR in the *D.C. Register*. Once the comment and reply comment periods have expired, the Commission will take final rulemaking action on Verizon DC's filing. The Commission does not intend to prevent the Company from implementing its filed surcharges. However, if the Commission discovers any inaccuracies, Verizon DC may be subject to a reconciliation of the surcharges.