

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

NOTICE OF PROPOSED RULEMAKING

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) (2004 Supp.) hereby gives notice of his intent to adopt upon publication of this notice in the D.C. Register, the following rules to be included in Chapter 42 of Title 26 of the District of Columbia Municipal Regulations (DCMR). 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 participation on a provider panel of a health insurer or an entity listed in § 2 (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, as codified at D.C. Official Code § 44-501(a).

This second Notice of Proposed Rulemaking supercedes the Notice of Proposed Rulemaking as published in the D.C. Register on February 14, 2003 at 50 DCR 1535.

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 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 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 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.*) (2004 Supp.).

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

"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 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 the Department of Insurance, Securities and Banking 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(a) entity” means an agency, organization, facility, or distinct part of any of them, listed in § 2 (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, as codified at D.C. Official Code § 44-501 (a).

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 the date of the 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.

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 CORRECT MARK: X INCORRECT MARKS:

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 30 - 34.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type MD, DO, DC, DDS, DMD, DPM ONLY* YES NO DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING? (EX. EMERGENCY ROOM PHYSICIANS, PATHOLOGISTS, RADIOLOGISTS, ANESTHESIOLOGISTS ETC.)

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

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME? YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE:

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME DATE STOPPED USING OTHER NAME

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME DATE STOPPED USING OTHER NAME

General Information

Only enter a National Identification Number if you do not have a SSN.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

GENDER*: MALE FEMALE DATE OF BIRTH* / /

SSN*: / / - / / - / /

NATIONAL IDENTIFICATION NUMBER NIO COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK:

LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

E-MAIL: / / /

FAX: / / /

PREFERRED METHOD OF CONTACT*: E-MAIL FAX NOTE: All correspondence for application follow-up will use this method.

3047

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

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Section 1 Personal Information and Professional IDs. (Continued)

Professional IDs
 Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.
 Provide all current and previous licenses/certifications.
 If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 17.

FEDERAL DEA NUMBER	DEA STATE OF REGISTRATION	DEA EXPIRATION DATE
CDS CERTIFICATE NUMBER	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE
STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE
IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		

Other ID Numbers
 If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 17.

ARE YOU A PARTICIPATING MEDICARE PROVIDER? YES NO	MEDICARE NUMBER	UPIN
ARE YOU A PARTICIPATING MEDICAID PROVIDER? YES NO	MEDICAID NUMBER	
ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)		ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY)

Section 2 Education and Training

Professional School
 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.
 Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

GRADUATE TYPE:

U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./CANADIAN ONLY)	NAME OF U.S./CANADIAN SCHOOL
START DATE*	END DATE (I.E., GRADUATION DATE)*
DEGREE AWARDED*	

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL		
ADDRESS		
CITY	COUNTRY CODE	POSTAL CODE
START DATE*	END DATE (I.E., GRADUATION DATE)*	DEGREE AWARDED*

3048

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

3616

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

Section 2 Education and Training (Continued)

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY

STATE

ZIP CODE

Other Relevant Education

List any relevant degrees you have earned in addition to your professional degree.

If you have additional degrees to report, use the Other Relevant Education Supplemental Form on page 18.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

START DATE

END DATE (I.E., GRADUATION DATE)

DEGREE AWARDED

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 18.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

List each department separately, if applicable.

INTERNSHIP/RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

List Internship/Residency, Fellowship and Other programs separately.

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

INTERNSHIP/RESIDENCY

FELLOWSHIP

OTHER

START DATE

END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

3049

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

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Section 3		Professional / Medical Specialty Information								
Primary Specialty Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE:			INITIAL CERTIFICATION DATE:			DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO:	YES	NO
	BOARD CERTIFIED?	YES	NO	RECERTIFICATION DATE (IF APPLICABLE):				PPO:	YES	NO
	CERTIFYING BOARD CODE:			EXPIRATION DATE (IF APPLICABLE):				POS:	YES	NO
	IF NOT BOARD CERTIFIED (SELECT ONE):	I HAVE TAKEN EXAM, RESULTS PENDING FOR:		I INTEND TO SIT FOR AN EXAM ON:				I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.		
CERTIFYING BOARD CODE										
Secondary Specialty Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE:			INITIAL CERTIFICATION DATE:			DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO:	YES	NO
	BOARD CERTIFIED?	YES	NO	RECERTIFICATION DATE (IF APPLICABLE):				PPO:	YES	NO
	CERTIFYING BOARD CODE:			EXPIRATION DATE (IF APPLICABLE):				POS:	YES	NO
	IF NOT BOARD CERTIFIED (SELECT ONE):	I HAVE TAKEN EXAM, RESULTS PENDING FOR:		I INTEND TO SIT FOR AN EXAM ON:				I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.		
CERTIFYING BOARD CODE										
Additional Specialty Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.	SPECIALTY CODE:			INITIAL CERTIFICATION DATE:			DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?	HMO:	YES	NO
	BOARD CERTIFIED?	YES	NO	RECERTIFICATION DATE (IF APPLICABLE):				PPO:	YES	NO
	CERTIFYING BOARD CODE:			EXPIRATION DATE (IF APPLICABLE):				POS:	YES	NO
	IF NOT BOARD CERTIFIED (SELECT ONE):	I HAVE TAKEN EXAM, RESULTS PENDING FOR:		I INTEND TO SIT FOR AN EXAM ON:				I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.		
CERTIFYING BOARD CODE										
Practice Interests: Provide additional areas of professional practice interest.										

3050

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

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Section 4	Practice Location Information		
Primary Practice Location	NOTE: IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION BELOW. THE REMAINDER OF SECTION 4 MAY BE LEFT BLANK. YOU MAY THEN PROCEED TO SECTION 6 ON PAGE 10.		
	<p>Currently practicing at this address? YES NO</p> <p>If no, what is your expected start date?</p> <p>PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*</p> <p>GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)</p> <p>NUMBER* STREET* SUITE/BLOG</p> <p>CITY* STATE* ZIP CODE*</p> <p>SEND GENERAL CORRESPONDENCE HERE? YES NO</p> <p>TELEPHONE* FAX</p> <p>OFFICE E-MAIL ADDRESS</p> <p>INDIVIDUAL TAX ID GROUP TAX ID</p> <p>PRIMARY TAX ID (ONE ONLY): USE INDIVIDUAL TAX ID USE GROUP TAX ID</p>		
<p>If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 21-25.</p> <p>NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.</p> <p>TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.</p>			

Office Manager or Business Office Staff Contact			
<p>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.</p>	LAST NAME*		
	FIRST NAME*	M.I.	
	TELEPHONE*	FAX	
	E-MAIL ADDRESS		

Credentialing Contact			
<p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS CREDENTIALING INFORMATION</p> <p>Note: Even if you checked the boxes above please provide the e-mail address, if available.</p>	LAST NAME		
	FIRST NAME*	M.I.	
	NUMBER	STREET	SUITE/BLOG
	CITY	STATE	ZIP CODE
	TELEPHONE	FAX	
	E-MAIL ADDRESS		

3051

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

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Section 4 Practice Location Information (Continued)

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*
 FIRST NAME* M.I.
 NUMBER* STREET* SUITE/BLDG
 CITY* STATE* ZIP CODE*
 TELEPHONE* FAX
 E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To.

ELECTRONIC BILLING CAPABILITIES? YES NO
 BILLING DEPARTMENT (IF HOSPITAL-BASED)
 CHECK PAYABLE TO*

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A-AM P=PM	END	A-AM P=PM		START	A-AM P=PM	END	A-AM P=PM
MONDAY:					FRIDAY:				
TUESDAY:					SATURDAY:				
WEDNESDAY:					SUNDAY:				
THURSDAY:									
24/7 PHONE COVERAGE? IF YES:					AFTER HOURS BACK OFFICE TELEPHONE				
YES NO	ANSWERING SERVICE				VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE		VOICE MAIL WITH OTHER INSTRUCTIONS		

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE? YES NO ACCEPT ALL NEW PATIENTS? YES NO
 ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR? YES NO ACCEPT NEW MEDICARE PATIENTS? YES NO
 ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL? YES NO ACCEPT NEW MEDICAID PATIENTS? YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN: (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS? GENDER LIMITATIONS: AGE LIMITATIONS: LIST OTHER LIMITATIONS:
 YES NO IF YES: MALE ONLY NONE MINIMUM AGE
 FEMALE ONLY MAXIMUM AGE

3052

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

3620

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

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

YES NO DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

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

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

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

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

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

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

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

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

M.I.

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

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

3053

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

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Section 4 Practice Location Information (Continued)

Languages

LANGUAGES
NON-ENGLISH LANGUAGES
SPOKEN BY OFFICE PERSONNEL:

		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE
INTERPRETERS AVAILABLE?	YES NO	LANGUAGES INTERPRETED:				
		LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE	LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS? YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:

		YES	NO	DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?		ACCESSIBLE BY PUBLIC TRANSPORTATION?		YES	NO
BUILDING?	YES NO	YES	NO	TEXT TELEPHONY (TTY)?		YES	NO	YES	NO
PARKING?	YES NO	YES	NO	AMERICAN SIGN LANGUAGE?		YES	NO	YES	NO
RESTROOM?	YES NO	YES	NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES?		YES	NO	YES	NO
OTHER HANDICAPPED ACCESS				OTHER DISABILITY SERVICES				OTHER TRANSPORTATION ACCESS	

Certifications

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

		EXPIRATION DATE:		EXPIRATION DATE:	
BASIC LIFE SUPPORT?	YES NO			ADV LIFE SUPPORT IN DB?	YES NO
CPRT?	YES NO			ADV TRAUMA LIFE SUPPORT?	YES NO
ADV CARDIAC LIFE SPT?	YES NO			PEDIATRIC ADVANCED LIFE SPT?	YES NO
NEONATAL ADVANCED LIFE SPT?	YES NO				

Services

Does this location provide any of the following services?

LABORATORY SERVICES?	YES NO	IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):					
RADIOLOGY SERVICES?	YES NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE:					
EKG'S?	YES NO	ALLERGY INJECTIONS?	YES NO	ALLERGY SKIN TESTING?	YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	YES NO
DRAWING BLOOD?	YES NO	AGE APPROPRIATE IMMUNIZATIONS?	YES NO	FLEXIBLE SIGMOIDOSCOPY?	YES NO	TYMPANOMETRY / AUDIOMETRY SCREENING?	YES NO
ASTHMA TREATMENT?	YES NO	OSTEOPATHIC MANIPULATION?	YES NO	IV HYDRATION/TREATMENT?	YES NO	CARDIAC STRESS TEST?	YES NO
PULMONARY FUNCTION TESTING?	YES NO	PHYSICAL THERAPY?	YES NO	CARE OF MINOR LACERATIONS?	YES NO		
IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?	YES NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?					
IF YES, WHO ADMINISTERS IT?		LAST NAME		FIRST NAME			

TYPE OF PRACTICE: (SELECT ONE ONLY)

SOLO PRACTICE SINGLE SPECIALTY GROUP MULTI-SPECIALTY GROUP

3054

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3622

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

Section 4 Practice Location Information (Continued)

Services <small>(Continued)</small>	<p>SERVICES (Continued)</p> <p>ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):</p>
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Partners/ Associates	<p>LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE</p>																								
<p>Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.</p> <p>If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 19. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.</p>	<table border="1"> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> <td>COVERING COLLEAGUE (Y/N)?</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> <td>PROVIDER TYPE (MD, ETC.)</td> </tr> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> <td>COVERING COLLEAGUE (Y/N)?</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> <td>PROVIDER TYPE (MD, ETC.)</td> </tr> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> <td>COVERING COLLEAGUE (Y/N)?</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> <td>PROVIDER TYPE (MD, ETC.)</td> </tr> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> <td>COVERING COLLEAGUE (Y/N)?</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> <td>PROVIDER TYPE (MD, ETC.)</td> </tr> </table>	LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)	LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)	LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)	LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)
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FIRST NAME	M.I.	PROVIDER TYPE (MD, ETC.)																							

Covering Colleagues	<p>LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE</p>												
<p>Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.</p> <p>If you have additional covering colleagues that are not partners at this location, use the Covering Colleagues Supplemental Form on page 20. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.</p>	<table border="1"> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> </tr> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> </tr> <tr> <td>LAST NAME</td> <td>SPECIALTY CODE</td> </tr> <tr> <td>FIRST NAME</td> <td>M.I.</td> </tr> </table>	LAST NAME	SPECIALTY CODE	FIRST NAME	M.I.	LAST NAME	SPECIALTY CODE	FIRST NAME	M.I.	LAST NAME	SPECIALTY CODE	FIRST NAME	M.I.
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FIRST NAME	M.I.												
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FIRST NAME	M.I.												

3055

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3623

DISTRICT OF COLUMBIA REGISTER

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

Section 5 Hospital Affiliations

Admitting Arrangements	DO YOU HAVE HOSPITAL PRIVILEGES?*	YES	NO	IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

Hospital Privileges If applicable, list all hospitals where you currently have privileges. If you have additional hospital privileges, use the Supplemental Hospital Privileges Form on page 26. TIP: Be certain your admission percentages add up to 100%. Otherwise, you will have to correct this error.	PRIMARY HOSPITAL								
	HOSPITAL NAME								
	NUMBER	STREET		SUITE/BLDG					
	CITY	STATE		ZIP CODE					
	TELEPHONE	FULL, UNRESTRICTED PRIVILEGES?	YES	NO	ARE PRIVILEGES TEMPORARY?	YES	NO	OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?	%
	TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)								

OTHER HOSPITAL								
HOSPITAL NAME								
NUMBER	STREET		SUITE/BLDG					
CITY	STATE		ZIP CODE					
TELEPHONE	FULL, UNRESTRICTED PRIVILEGES?	YES	NO	ARE PRIVILEGES TEMPORARY?	YES	NO	OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?	%
TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)								

OTHER HOSPITAL								
HOSPITAL NAME								
NUMBER	STREET		SUITE/BLDG					
CITY	STATE		ZIP CODE					
TELEPHONE	FULL, UNRESTRICTED PRIVILEGES?	YES	NO	ARE PRIVILEGES TEMPORARY?	YES	NO	OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?	%
TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.)								

3056

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

3624

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

Section 6 Professional Liability Insurance Coverage

Current Malpractice Insurance Carrier

IMPORTANT: IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION

SELF-INSURED? YES NO

CARRIER OR SELF-INSURED NAME (USE BOTH LINES IF NECESSARY)

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TYPE OF COVERAGE? INDIVIDUAL SHARED

ORIGINAL EFFECTIVE DATE EFFECTIVE DATE EXPIRATION DATE

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO

AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE

POLICY NUMBER

Previous Malpractice Insurance Carrier

Required only if with current carrier less than five (5) years.

SELF-INSURED? YES NO

CARRIER OR SELF-INSURED NAME (USE BOTH LINES IF NECESSARY)

NUMBER STREET SUITE/BLDG

CITY STATE ZIP CODE

TYPE OF COVERAGE? INDIVIDUAL SHARED

ORIGINAL EFFECTIVE DATE EFFECTIVE DATE EXPIRATION DATE

AMOUNT OF COVERAGE PER OCCURRENCE AMOUNT OF COVERAGE AGGREGATE

POLICY NUMBER

Section 7 Work History and References

Military Duty

YES NO Are you currently on active military duty or military reserve?*

Work History
Include a chronological work history for the past 5 years.

If you have additional work history, use the Supplemental Work History Form on page 27.

Note: Leave End Date blank to indicate "present"

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BLDG

CITY STATE POSTAL CODE

COUNTRY CODE START DATE END DATE

3057

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

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

Section 7 Work History and References (Continued)

Work History

Include a chronological work history for the past 5 years. This information must be complete if applicable.

If you have additional work history, use the Supplemental Work History Form on page 27.

Note: Leave End Date blank to indicate "present"

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

START DATE

END DATE

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

START DATE

END DATE

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

START DATE

END DATE

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER

STREET

SUITE/BLDG.

CITY

STATE

POSTAL CODE

COUNTRY CODE

START DATE

END DATE

3058

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

3626

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

Section 7 Work History and References (Continued)

Gaps in Work History

Include an explanation of any gap(s) six (6) months or greater.

YES NO DO YOU HAVE ANY WORK HISTORY GAPS GREATER THAN 6 MONTHS?*

GAP START DATE: GAP END DATE:

GAP START DATE: GAP END DATE:

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Note: You are required to provide exactly 3 references. Your application will not be complete without this information

LAST NAME* FIRST NAME* PROVIDER TYPE (MO, ETC.)

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

LAST NAME* FIRST NAME* PROVIDER TYPE (MO, ETC.)

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

LAST NAME* FIRST NAME* PROVIDER TYPE (MO, ETC.)

NUMBER* STREET* APT/SUITE/BLDG

CITY* STATE* ZIP CODE*

3059

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

3627

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

Section 8

Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 28.

LICENSURE

- 1. YES NO Has your license to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily surrendered or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?*
- 2. YES NO Have you ever received a reprimand or been fined by any state licensing board?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

- 3. YES NO Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
- 4. YES NO Have you voluntarily surrendered, limited your privileges or not reapplied for privileges?*
- 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 IPAs, PHOs)?*

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, 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 denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

- 11. YES NO Have you ever been disciplined, excluded from, debarred, 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 or have you ever been the subject of an investigation within the last ten years 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?*
- 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 been the subject of investigation within the last ten years by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
- 15. YES NO Have you ever been convicted of, pled guilty to, pled nolo contendere 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 Have you ever been investigated, sanctioned, reprimanded or cautioned within the last ten years by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation within the last ten years 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?*

3160

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

3628

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

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 28.

IMPORTANT: If you answered "Yes" to question #19, you must complete the Supplemental Malpractice Claims Explanation Form on page 29 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. YES NO Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)?* If yes, you must complete a Supplemental Malpractice Claims History Explanation Form that was included with your application materials. Use one form for each malpractice case.

CRIMINAL/CIVIL HISTORY

20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?*

21. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged 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?*

3061

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

3629

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 and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Plans" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Plans" 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 me 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 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 credentials verification, corporations, companies, 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 in, 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 may 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 (or are 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 without malice unless such 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, defamation or any other claims based on statements made in good faith and without malice or misconduct of 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 auditor 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, and requirements 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 my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). 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 disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. 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)*

DATE SIGNED*

3062

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		
Professional IDs	FEDERAL DEA NUMBER	DEA STATE OF REGISTRATION	DEA EXPIRATION DATE:
Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.	FEDERAL DEA NUMBER	DEA STATE OF REGISTRATION	DEA EXPIRATION DATE:
Provide all current and previous licenses/certifications.	FEDERAL DEA NUMBER	DEA STATE OF REGISTRATION	DEA EXPIRATION DATE:
If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.	CDS CERTIFICATE NUMBER	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE:
	CDS CERTIFICATE NUMBER	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE:
	CDS CERTIFICATE NUMBER	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE:
	STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE:
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
	STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE:
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
	STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE:
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
	STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE:
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
	STATE MEDICAL LICENSE NUMBER	LICENSE ISSUING STATE	LICENSE EXPIRATION DATE:
	IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO		
	MEDICARE NUMBER		
	MEDICAID NUMBER		

3063

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

3631

Other Relevant Education and Training Supplemental Form

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

Section 2 **Education and Training**

Other Relevant Education

List any relevant degrees you have earned in addition to your professional degree.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)					
NUMBER	STREET			SUITE/BLDG.	
CITY		STATE	POSTAL CODE		
COUNTRY CODE	START DATE	END DATE (I.E., GRADUATION DATE)	DEGREE AWARDED		

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)				SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)	
NUMBER	STREET			SUITE/BLDG.	
CITY		STATE	POSTAL CODE		
COUNTRY CODE					
List each department separately, if applicable.	INTERNSHIP/ RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				
List Internship/ Residency, Fellowship and Other programs separately.	INTERNSHIP/ RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				
	INTERNSHIP/ RESIDENCY	FELLOWSHIP	OTHER	START DATE	END DATE
	DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)				

3064

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

3632

Partners/Associates Supplemental Form

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

Section 4	Practice Location Information		
<p>Partner/ Associates</p> <p>Use this page to report additional partners/associates at the designated practice location.</p> <p>IMPORTANT:</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 30-34. 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>	<p>SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.</p> <p>→ LOCATION #:</p>	<p>PRIMARY PRACTICE</p> <p>PRACTICE NAME</p> <hr/> <p>PRACTICE ADDRESS</p>	
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>
<p>LAST NAME</p> <p>FIRST NAME</p>	<p>M.I.</p>	<p>SPECIALTY CODE</p> <p>COVERING COLLEAGUE (Y/N)?</p>	<p>PROVIDER TYPE (MD, ETC.)</p>

3065

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

3633

Covering Colleagues Supplemental Form

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

Section 4 Covering Colleagues	Practice Location Information		
<p>Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.</p> <p>IMPORTANT: In the box provided, indicate to which practice location this page belongs.</p> <p>Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.</p> <p>If you need to report additional Covering Colleagues, photocopy this page as needed and submit as instructed.</p>	SPECIFY PRACTICE LOCATION	INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.	
	LOCATION #:	PRIMARY PRACTICE	PRACTICE NAME
			PRACTICE ADDRESS
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)
	LAST NAME		SPECIALTY CODE
	FIRST NAME		M.I. PROVIDER TYPE (MD, ETC.)

3066

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

Practice Location Information Supplemental Form

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

Section 4	Practice Location Information				
<p>Additional Practice Location</p> <p>IMPORTANT: 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.</p> <p>TIP: Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.</p>	<p>→ LOCATION* #</p>				
	CURRENTLY PRACTICING AT THIS ADDRESS?	YES	NO	IF NO, WHAT IS YOUR EXPECTED START DATE?	
	PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*				
	GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)				
	NUMBER*	STREET*		SUITE/BLDG.	
	CITY*			STATE*	ZIP CODE*
	SEND GENERAL CORRESPONDENCE HERE?*	YES	NO	TELEPHONE*	FAX
	OFFICE E-MAIL ADDRESS				PRIMARY TAX ID (ONE ONLY):
	INDIVIDUAL TAX ID	GROUP TAX ID		USE INDIVIDUAL TAX ID	USE GROUP TAX ID
<p>Office Manager or Business Office Contact</p> <p>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.</p>	<p>LAST NAME*</p> <p>FIRST NAME*</p> <p>TELEPHONE*</p> <p>E-MAIL ADDRESS</p>				
	M.I.				
	FAX				
<p>Credentialing Contact</p> <p>CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS CREDENTIALING INFORMATION</p> <p>Note: Even if you checked the boxes above, please provide the e-mail address, if available.</p>	<p>LAST NAME</p> <p>FIRST NAME</p> <p>NUMBER</p> <p>STREET</p> <p>CITY</p> <p>TELEPHONE</p> <p>E-MAIL ADDRESS</p>				
	M.I.				
	FAX				
	NUMBER		STREET		SUITE/BLDG.
	CITY			STATE	ZIP CODE

3067

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

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 2 of 5

Additional Practice Location
(Continued)

IMPORTANT:
In the box provided, indicate to which practice location this page belongs.

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LOCATION #

BILLING CONTACT

LAST NAME*

FIRST NAME*

M.I.

NUMBER* STREET* SUITE/BLDG

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

Note:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

ELECTRONIC BILLING CAPABILITIES? YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO

Office Hours

(USE HH:MM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A-AM P-PM	END	A-AM P-PM	START	A-AM P-PM	END	A-AM P-PM
MONDAY:					FRIDAY:			
TUESDAY:					SATURDAY:			
WEDNESDAY:					SUNDAY:			
THURSDAY:								

Note:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE? IF YES: ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE

AFTER HOURS BACK OFFICE TELEPHONE VOICE MAIL WITH OTHER INSTRUCTIONS

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE? YES NO ACCEPT ALL NEW PATIENTS? YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR? YES NO ACCEPT NEW MEDICARE PATIENTS? YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL? YES NO ACCEPT NEW MEDICAID PATIENTS? YES NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

3068

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

3636

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 4 of 5

Additional Practice Location

(Continued)

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

→ **LOCATION* #**

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?*												YES		NO			
DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING:				DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*				YES		NO		ACCESSIBLE BY PUBLIC TRANSPORTATION?*		YES		NO	
BUILDING?*	YES	NO		TEXT TELEPHONY (TTY)?*	YES	NO		BUS?*	YES	NO			YES	NO			
PARKING?*	YES	NO		AMERICAN SIGN LANGUAGE?*	YES	NO		SUBWAY?*	YES	NO			YES	NO			
RESTROOM?*	YES	NO		MENTAL/PHYSICAL IMPAIRMENT SERVICES?*	YES	NO		REGIONAL TRAIN?*	YES	NO			YES	NO			
OTHER HANDICAPPED ACCESS				OTHER DISABILITY SERVICES				OTHER TRANSPORTATION ACCESS									

Certifications

Do you hold the following certifications? If yes, provide expiration dates.											
EXPIRATION DATE:											
BASIC LIFE SUPPORT?*	YES	NO		ADV LIFE SUPPORT IN OB?*	YES	NO		EXPIRATION DATE:			
CPR?*	YES	NO		ADV TRAUMA LIFE SUPPORT?*	YES	NO					
ADV CARDIAC LIFE SPT?*	YES	NO		PEDIATRIC ADVANCED LIFE SPT?*	YES	NO					
NEONATAL ADVANCED LIFE SPT?*	YES	NO									

Services

Does this location provide any of the following services?											
LABORATORY SERVICES?*	YES	NO	IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE):								
RADIOLOGY SERVICES?*	YES	NO	IF YES, PROVIDE X-RAY CERTIFICATION TYPE:								
EKG?*	YES	NO	ALLERGY INJECTIONS?*	YES	NO	ALLERGY SKIN TESTING?*	YES	NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?*	YES	NO
DRAWING BLOOD?*	YES	NO	AGE APPROPRIATE IMMUNIZATIONS?*	YES	NO	FLEXIBLE SIGMOIDOSCOPY?*	YES	NO	TYMPANOMETRY / AUDIOMETRY SCREENING?*	YES	NO
ASTHMA TREATMENT?*	YES	NO	OSTEOPATHIC MANIPULATION?*	YES	NO	IV HYDRATION/ TREATMENT?*	YES	NO	CARDIAC STRESS TEST?*	YES	NO
PULMONARY FUNCTION TESTING?*	YES	NO	PHYSICAL THERAPY?*	YES	NO	CARE OF MINOR LACERATIONS?*	YES	NO			
IS ANESTHESIA ADMINISTERED IN YOUR OFFICE?*	YES	NO	IF YES, WHAT CLASS/CATEGORY DO YOU USE?*								
IF YES, WHO ADMINISTERS IT?*											
ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES):											

3070

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

3638

Practice Location Information Supplemental Form

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

Section 4 Practice Location Information - Page 5 of 5

Additional Practice Location
(Continued)

→ **LOCATION* #**

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

IMPORTANT:

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 19. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

Code lists are found on pages 30-34. Enter the associated 3-digit code in the space provided.

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?	PROVIDER TYPE (MD, ETC.)

Covering Colleagues

Code lists are found on pages 30-34. 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 20. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	FIRST NAME	M.I.	SPECIALTY CODE	PROVIDER TYPE (MD, ETC.)

3071

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

Hospital Privileges (Current) Supplemental Form

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

Section 5

Hospital Affiliations

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional Hospital Privileges, photocopy this page as needed and submit as instructed.

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

OTHER HOSPITAL

HOSPITAL NAME _____

NUMBER _____ STREET _____ SUITE/BLDG _____

CITY _____ STATE _____ ZIP CODE _____

FULL, UNRESTRICTED PRIVILEGES? YES NO ARE PRIVILEGES TEMPORARY? YES NO

TELEPHONE _____

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? _____ %

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.) _____

OTHER HOSPITAL

HOSPITAL NAME _____

NUMBER _____ STREET _____ SUITE/BLDG _____

CITY _____ STATE _____ ZIP CODE _____

FULL, UNRESTRICTED PRIVILEGES? YES NO ARE PRIVILEGES TEMPORARY? YES NO

TELEPHONE _____

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? _____ %

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.) _____

OTHER HOSPITAL

HOSPITAL NAME _____

NUMBER _____ STREET _____ SUITE/BLDG _____

CITY _____ STATE _____ ZIP CODE _____

FULL, UNRESTRICTED PRIVILEGES? YES NO ARE PRIVILEGES TEMPORARY? YES NO

TELEPHONE _____

OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? _____ %

TYPE OF ADMITTING PRIVILEGES (E.G., ATTENDING, EMERITUS, ETC.) _____

3072

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

3640

Work History Supplemental Form

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

Section 7	Work History and References
<p>Work History</p> <p>Use this form to continue listing work history.</p> <p>Include a chronological work history for the past 5 years. This information must be complete if applicable.</p> <p>If you need to report additional Work History, photocopy this page as needed and submit as instructed.</p>	<p>WORK HISTORY</p> <p>PRACTICE / EMPLOYER NAME</p> <p>NUMBER STREET SUITE/BLDG</p> <p>CITY STATE POSTAL CODE</p> <p>COUNTRY CODE START DATE END DATE</p> <hr/> <p>WORK HISTORY</p> <p>PRACTICE / EMPLOYER NAME</p> <p>NUMBER STREET SUITE/BLDG</p> <p>CITY STATE POSTAL CODE</p> <p>COUNTRY CODE START DATE END DATE</p> <hr/> <p>WORK HISTORY</p> <p>PRACTICE / EMPLOYER NAME</p> <p>NUMBER STREET SUITE/BLDG</p> <p>CITY STATE POSTAL CODE</p> <p>COUNTRY CODE START DATE END DATE</p> <hr/> <p>WORK HISTORY</p> <p>PRACTICE / EMPLOYER NAME</p> <p>NUMBER STREET SUITE/BLDG</p> <p>CITY STATE POSTAL CODE</p> <p>COUNTRY CODE START DATE END DATE</p>

3073

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

3641

Disclosure Questions Supplemental Form

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

Section 8

Disclosure Questions

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

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

QUESTION #: EXPLANATION:

QUESTION #: EXPLANATION:

QUESTION #: EXPLANATION:

3074

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

3642

Malpractice Claims Explanation Supplemental Form

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

Section 8 Malpractice Claims Explanation

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

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

DATE OF OCCURRENCE:		DATE CLAIM WAS FILED:	
STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN):			
<input type="checkbox"/> OPEN	<input type="checkbox"/> CLOSED		
PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY):			
NUMBER*	STREET*	SUITE/BLOG	
CITY*	STATE*	ZIP CODE*	
TELEPHONE	POLICY NUMBER		
AMOUNT OF AWARD OR SETTLEMENT*	METHOD OF RESOLUTION?*	DISMISSED	SETTLED WITH PREJUDICE
		JUDGMENT FOR DEFENDANT(S)	MEDIATION
		JUDGMENT FOR PLAINTIFF(S)	ARBITRATION
		SETTLED WITHOUT PREJUDICE	
DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY):			
WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?*	PRIMARY DEFENDANT	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):			
TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?*			
		YES	NO

3075

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

3643

Code Lists

Country Codes

004	Afghanistan	626	East Timor (provisional)	434	Libya	670	Saint Vincent and the Grenadines
008	Albania	218	Ecuador	438	Liechtenstein	882	Samoa
012	Algeria	818	Egypt	440	Lithuania	674	San Marino
016	American Samoa	222	El Salvador	442	Luxembourg	678	São Tomé and Príncipe
020	Andorra	226	Equatorial Guinea	446	Macau	682	Saudi Arabia
024	Angola	232	Eritrea	807	Macedonia	683	Scotland
660	Anguilla	233	Estonia	450	Madagascar	686	Senegal
010	Antarctica	231	Ethiopia	454	Malawi	690	Seychelles
028	Antigua and Barbuda	238	Falkland Islands (Malvinas)	458	Malaysia	694	Sierra Leone
032	Argentina	234	Faroe Islands	462	Maldives	702	Singapore
051	Armenia	242	Fiji	466	Mali	703	Slovakia
533	Aruba	246	Finland	470	Malta	705	Slovenia
036	Australia	250	France	584	Marshall Islands	090	Solomon Islands
040	Austria	249	France, Metropolitan	474	Martinique	706	Somalia
031	Azerbaijan	254	French Guiana	478	Mauntania	710	South Africa
044	Bahamas	258	French Polynesia	480	Mauritius	239	South Georgia and the South Sandwich Islands
048	Bahrain	260	French Southern Territories	175	Mayotte	724	Spain
050	Bangladesh	266	Gabon	484	Mexico	144	Sri Lanka
052	Barbados	270	Gambia	583	Micronesia	736	Sudan
112	Belarus	268	Georgia	498	Moldova	740	Suriname
056	Belgium	278	Germany	492	Monaco	744	Svalbard and Jan Mayen
084	Belize	288	Ghana	496	Mongolia	748	Swaziland
204	Benin	292	Gibraltar	500	Montserrat	752	Sweden
060	Bermuda	300	Greece	504	Morocco	756	Switzerland
064	Bhutan	304	Greenland	508	Mozambique	760	Syria
068	Bolivia	308	Grenada	104	Myanmar	158	Taiwan
070	Bosnia and Herzegovina	312	Guadeloupe	516	Namibia	762	Tajikistan
072	Botswana	316	Guam	520	Nauru	834	Tanzania
074	Bouvet Island	320	Guatemala	524	Nepal	764	Thailand
076	Brazil	324	Guinea	528	Netherlands	768	Togo
086	British Indian Ocean Territory	624	Guinea-Bissau	530	Netherlands Antilles	772	Tokelau
096	Brunei Darussalam	328	Guyana	540	New Caledonia	776	Tonga
100	Bulgaria	332	Haiti	554	New Zealand	780	Trinidad and Tobago
854	Burkina Faso	334	Heard Island and McDonald Islands	558	Nicaragua	788	Tunisia
108	Burundi	340	Honduras	562	Niger	792	Turkey
118	Cambodia	344	Hong Kong	566	Nigeria	795	Turkmenistan
120	Cameroon	348	Hungary	570	Niue	796	Turks and Caicos Islands
124	Canada	352	Iceland	574	Norfolk Island	798	Tuvalu
132	Cape Verde	356	India	580	Northern Mariana Islands	800	Uganda
136	Cayman Islands	360	Indonesia	584	Norway	804	Ukraine
140	Central African Republic	364	Iran	512	Orman	784	United Arab Emirates
148	Chad	368	Iraq	586	Pakistan	826	United Kingdom
152	Chile	372	Ireland	589	Palau	840	United States
156	China	376	Israel	591	Panama	581	U.S. Minor Outlying Islands
162	Christmas Island	380	Italy	598	Papua New Guinea	858	Uruguay
166	Cocos (Keeling) Islands	384	Jamaica	600	Paraguay	860	Uzbekistan
170	Colombia	388	Japan	604	Peru	548	Vanuatu
174	Comoros	392	Jordan	608	Philippines	336	Vatican City State (Holy See)
178	Congo	400	Kazakhstan	612	Pitcairn	862	Venezuela
180	Congo, Democratic Republic of the	398	Kenya	616	Poland	704	Viet Nam
184	Cook Islands	404	Kiribati	620	Portugal	092	Virgin Islands, British
188	Costa Rica	296	Korea, North	630	Puerto Rico	850	Virgin Islands, U.S.
384	Cote d'Ivoire	408	Korea, South	634	Qatar	876	Wallis and Fortuna Islands
191	Croatia	410	Kuwait	638	Réunion	732	Western Sahara (provisional)
192	Cuba	414	Kyrgyzstan	642	Romania	887	Yemen
196	Cyprus	417	Laos	643	Russian Federation	891	Yugoslavia
203	Czech Republic	418	Latvia	646	Rwanda	894	Zambia
208	Denmark	428	Lebanon	654	Saint Helena	716	Zimbabwe
262	Djibouti	422	Lesotho	659	Saint Kitts and Nevis		
212	Dominica	426	Liberia	662	Saint Lucia		
214	Dominican Republic	430		666	Saint Pierre and Miquelon		

Language Codes

001	Abkhazian	016	Bislama	031	Estonian	046	Hindi
002	Afan (Oromo)	017	Breton	032	Faroese	047	Hungarian
003	Afar	018	Bulgarian	033	Fiji	048	Icelandic
004	Afrikaans	019	Burmese	034	Finnish	049	Indonesian
005	Albanian	020	Byelorussian	035	French	050	Interlingua
006	Amharic	021	Cambodian	036	Frisian	051	Interlingua
007	Arabic	022	Catalan	037	Galician	052	Inuktitut
008	Armenian	023	Chinese	038	Georgian	053	Inupiak
009	Assamese	024	Corsican	039	German	054	Irish
010	Zerbajani	025	Croatian	040	Greek	055	Italian
011	Bashkir	026	Czech	041	Greenlandic	056	Japanese
012	Basque	027	Danish	042	Guarani	057	Javanese
013	Bengali; Bangla	028	Dutch	043	Gujarati	058	Kannada
014	Bhutani	140	English	044	Hausa	059	Kashmiri
015	Bihari	030	Esperanto	045	Hebrew	060	Kazakh

Code Lists

Language Codes (continued)

061	Kinyarwanda	080	Nauru	100	Sesotho	120	Tigrinya
062	Kirghiz	081	Nepali	101	Setswana	121	Tonga
063	Kurundi	082	Norwegian	102	Shona	122	Tsonga
064	Korean	083	Occitan	103	Sindhi	123	Turkish
065	Kurdish	084	Oriya	104	Singhalese	124	Turkmen
066	Laothian	085	Pashto/Pushto	105	Siwati	125	Twi
067	Latin	086	Persian (Farsi)	106	Slovak	126	Uigur
068	Latvian/Lettish	087	Polish	107	Slovenian	127	Ukrainian
069	Lingala	088	Portuguese	108	Somali	128	Urdu
070	Lithuanian	089	Punjabi	109	Spanish	129	Uzbek
071	Macedonian	090	Quechua	110	Sundanese	130	Vietnamese
072	Malagasy	091	Rhaeto-Romance	111	Swahili	131	Volapuk
073	Malay	092	Romanian	112	Swedish	132	Welsh
074	Malayalam	093	Russian	113	Tagalog	133	Wolof
075	Maltese	094	Samoan	114	Tajik	134	Xhosa
076	Maori	095	Sangho	115	Tamil	135	Yiddish
077	Marathi	096	Sanskrit	116	Tatar	136	Yoruba
078	Moldavian	097	Scot Gaelic	117	Telugu	137	Zerbaigani
079	Mongolian	098	Serbian	118	Thai	138	Zhuang
		099	Serbo-Croatian	119	Tibetan		Zulu

U.S./Canadian Professional School Codes

Alabama

300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas

003 University of Arkansas College of Medicine

Arizona

500 Arizona College of Osteopathic Medicine
004 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 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 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
303 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

306 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 Scholl 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

Code Lists

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

Louisiana	New Mexico
319 Louisiana State University School of Dentistry	070 University of New Mexico School of Medicine
039 Louisiana State University School of Medicine in New Orleans	
040 Louisiana State University School of Medicine in Shreveport	Nevada
041 Tulane University School of Medicine	071 University of Nevada School of Medicine
Massachusetts	New York
042 Boston University School of Medicine	072 Albany Medical College
320 Boston University, Goldman School of Dental Medicine	073 Albert Einstein College of Medicine
043 Harvard Medical School	074 Columbia University College of Physicians and Surgeons
321 Harvard School of Dental Medicine	333 Columbia University School of Dental and Oral Surgery
322 Tufts University School of Dental Medicine	075 Joan & Sanford I. Weill Medical College of Cornell University
044 Tufts University School of Medicine	076 Mount Sinai School of Medicine of New York University
045 University of Massachusetts Medical School	412 New York Chiropractic College
Maryland	512 NY College of Osteopathic Medicine of the NY Institute of Technology
046 Johns Hopkins University School of Medicine	077 New York Medical College
047 Uniformed Services University of the Health Sciences	334 New York University Kriser Dental Center
048 University of Maryland School of Medicine	078 New York University School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery	335 State University of New York at Buffalo School of Dental Medicine
Maine	082 State University of New York at Buffalo School of Medicine
507 University of New England, College of Osteopathic Medicine	336 State University of New York at Stony Brook School of Dental Medicine
Michigan	081 State University of New York at Stony Brook School of Medicine
049 Michigan State University College of Human Medicine	079 State University of New York College of Medicine
508 Michigan State University, College of Osteopathic Medicine	080 State University of New York Upstate Medical University
324 University of Detroit Mercy School of Dentistry	083 University of Rochester School of Medicine and Dentistry
050 University of Michigan Medical School	
325 University of Michigan School of Dentistry	Ohio
051 Wayne State University School of Medicine	337 Case Western Reserve University School of Dentistry
Minnesota	084 Case Western Reserve University School of Medicine
052 Mayo Medical School	085 Medical College of Ohio
409 Northwestern College of Chiropractic	086 Northeastern Ohio Universities College of Medicine
053 University of Minnesota, Duluth School of Medicine	803 Ohio College of Podiatric Medicine
054 University of Minnesota Medical School, Twin Cities	338 Ohio State University College of Dentistry
326 University of Minnesota School of Dentistry	087 Ohio State University College of Medicine and Public Health
Missouri	513 Ohio University College of Osteopathic Medicine
410 Cleveland Chiropractic College of Kansas City	088 University of Cincinnati College of Medicine
509 Kirksville College of Osteopathic Medicine	089 Wright State University School of Medicine
411 Logan Chiropractic College	Oklahoma
055 Saint Louis University School of Medicine	514 Oklahoma State University, College of Osteopathic Medicine
510 University of Health Sciences, College of Osteopathic Medicine	339 University of Oklahoma College of Dentistry
056 University of Missouri, Columbia School of Medicine	090 University of Oklahoma College of Medicine
327 University of Missouri Kansas City School of Dentistry	Oregon
057 University of Missouri Kansas City School of Medicine	091 Oregon Health & Science University School of Medicine
058 Washington University in St. Louis School of Medicine	340 Oregon Health Sciences University School of Dentistry
Mississippi	413 Western States Chiropractic College
328 University of Mississippi School of Dentistry	Pennsylvania
059 University of Mississippi School of Medicine	092 Jefferson Medical College of Thomas Jefferson University
North Carolina	515 Laka Erie College of Osteopathic Medicine
060 Duke University School of Medicine	093 MCP Hahnemann University School of Medicine
061 The Brody School of Medicine at East Carolina University	094 Pennsylvania State University College of Medicine
329 University of North Carolina at Chapel Hill School of Dentistry	516 Philadelphia College of Osteopathic Medicine
062 University of North Carolina at Chapel Hill School of Medicine	341 Temple University School of Dentistry
063 Wake Forest University School of Medicine	095 Temple University School of Medicine
North Dakota	805 Temple University School of Podiatric Medicine
064 University of North Dakota School of Medicine and Health Sciences	342 University of Pennsylvania School of Dental Medicine
Nebraska	096 University of Pennsylvania School of Medicine
330 Creighton University School of Dentistry	343 University of Pittsburgh School of Dental Medicine
065 Creighton University School of Medicine	097 University of Pittsburgh School of Medicine
066 University of Nebraska College of Medicine	Puerto Rico
331 University of Nebraska Medical Center, College of Dentistry	098 Ponce School of Medicine
New Hampshire	099 Universidad Central del Caribe School of Medicine
067 Dartmouth Medical School	100 University of Puerto Rico School of Medicine
New Jersey	344 University of Puerto Rico School of Dentistry
068 Robert Wood Johnson Medical School	Rhode Island
069 University of Medicine and Dentistry of New Jersey (UMDNJ)	101 Brown Medical School
332 UMDNJ, New Jersey Dental School	South Carolina
511 UMDNJ, School of Osteopathic Medicine	345 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

Code Lists

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

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
- 107 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

- 117 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
- 121 University of Washington School of Medicine

Wisconsin

- 353 Marquette University School of Dentistry
- 122 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

Canada

- 355 Dalhousie University Faculty of Dentistry
- 126 Dalhousie University Faculty of Medicine
- 357 Laval University Faculty of Dentistry
- 127 Laval 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 - MD/DO Only

247 Allergy & Immunology	294 Internal Medicine, Clinical & Laboratory Immunology	260 Obstetrics & Gynecology, Critical Care Medicine
246 Allergy & Immunology, Allergy	253 Internal Medicine, Clinical Cardiac Electrophysiology	326 Obstetrics & Gynecology, Gynecologic Oncology
291 Allergy & Immunology, Clinical & Laboratory Immunology	257 Internal Medicine, Critical Care Medicine	286 Obstetrics & Gynecology, Gynecology
249 Anesthesiology	267 Internal Medicine, Endocrinology, Diabetes & Metabolism	303 Obstetrics & Gynecology, Maternal & Fetal Medicine
235 Anesthesiology, Addiction Medicine	275 Internal Medicine, Gastroenterology	320 Obstetrics & Gynecology, Obstetrics
258 Anesthesiology, Critical Care Medicine	285 Internal Medicine, Geriatric Medicine	271 Obstetrics & Gynecology, Reproductive Endocrinology
126 Anesthesiology, Pain Medicine	287 Internal Medicine, Hematology	328 Ophthalmology
363 Clinical Pharmacology	288 Internal Medicine, Hematology & Oncology	441 Oral & Maxillofacial Surgery
367 Colon & Rectal Surgery	450 Internal Medicine, Hepatology	411 Orthopaedic Surgery
263 Dermatology	299 Internal Medicine, Infectious Disease	412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
292 Dermatology, Clinical & Laboratory Dermatological Immunology	451 Internal Medicine, Interventional Cardiology	456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
444 Dermatology, Dermatological Surgery	453 Internal Medicine, Magnetic Resonance Imaging (MRI)	406 Orthopaedic Surgery, Hand Surgery
266 Dermatology, Dermatopathology	325 Internal Medicine, Medical Oncology	415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
264 Dermatology, MOHS-Micrographic Surgery	309 Internal Medicine, Nephrology	416 Orthopaedic Surgery, Orthopaedic Trauma
443 Dermatology, Pediatric Dermatology	378 Internal Medicine, Pulmonary Disease	457 Orthopaedic Surgery, Sports Medicine
268 Emergency Medicine	390 Internal Medicine, Rheumatology	119 Orthopedic
445 Emergency Medicine, Emergency Medical Services	397 Internal Medicine, Sports Medicine	331 Otolaryngology
427 Emergency Medicine, Medical Toxicology	433 Laboratories, Clinical Medical Laboratory	458 Otolaryngology, Otolaryngic Allergy
348 Emergency Medicine, Pediatric Emergency Medicine	481 Legal Medicine	459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
395 Emergency Medicine, Sports Medicine	278 Medical Genetics, Clinical Biochemical Genetics	332 Otolaryngology, Otolaryngology & Neurology
446 Emergency Medicine, Undersea and Hyperbaric Medicine	261 Medical Genetics, Clinical Cytogenetic	357 Otolaryngology, Pediatric Otolaryngology
391 Facial Plastic Surgery	277 Medical Genetics, Clinical Genetics (M.D.)	417 Otolaryngology, Plastic Surgery within the Head & Neck
272 Family Practice	280 Medical Genetics, Clinical Molecular Genetics	480 Pain Medicine, Interventional Pain Medicine
447 Family Practice, Addiction Medicine	455 Medical Genetics, Molecular Genetic Pathology	337 Pain Medicine
237 Family Practice, Adolescent Medicine	454 Medical Genetics, Ph.D. Medical Genetics	338 Pathology, Anatomic Pathology
448 Family Practice, Adult Medicine	306 Neonatal-Perinatal Medicine	340 Pathology, Anatomic Pathology & Clinical Pathology
282 Family Practice, Geriatric Medicine	308 Neopathology	250 Pathology, Blood Banking & Transfusion Medicine
396 Family Practice, Sports Medicine	409 Neurological Surgery	344 Pathology, Chemical Pathology
225 General Practice	330 Neuromusculoskeletal Medicine & OMM	302 Pathology, Clinical Pathology/Laboratory Medicine
479 Hospitalist	440 Neuromusculoskeletal Medicine, Sports Medicine	
301 Internal Medicine	317 Nuclear Medicine	
449 Internal Medicine, Addiction Medicine	318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine	
236 Internal Medicine, Adolescent Medicine	315 Nuclear Medicine, Nuclear Cardiology	
248 Internal Medicine, Allergy & Immunology	316 Nuclear Medicine, Nuclear Imaging & Therapy	
255 Internal Medicine, Cardiovascular Disease	321 Obstetrics & Gynecology	

Code Lists

Specialty Codes - MD/DO Only

262 Pathology, Cytopathology	Oncology	and Hyperbaric Medicine	252 Radiology, Body Imaging
265 Pathology, Dermatopathology	352 Pediatrics, Pediatric Infectious Diseases	114 Preventive Medicine/Occupational Environmental Medicine	173 Radiology, Diagnostic Radiology
273 Pathology, Forensic Pathology	355 Pediatrics, Pediatric Nephrology	370 Psychiatry & Neurology, Addiction Medicine	430 Radiology, Diagnostic Ultrasound
290 Pathology, Hematology	359 Pediatrics, Pediatric Pulmonology	473 Psychiatry & Neurology, Addiction Psychiatry	314 Radiology, Neuroradiology
298 Pathology, Immunopathology	361 Pediatrics, Pediatric Rheumatology	371 Psychiatry & Neurology, Child & Adolescent Psychiatry	319 Radiology, Nuclear Radiology
305 Pathology, Medical Microbiology	398 Pediatrics, Sports Medicine	313 Psychiatry & Neurology, Clinical Neurophysiology	260 Radiology, Pediatric Radiology
461 Pathology, Molecular Genetic Pathology	365 Physical Medicine & Rehabilitation	274 Psychiatry & Neurology, Forensic Psychiatry	380 Radiology, Radiation Oncology
312 Pathology, Neuropathology	468 Physical Medicine & Rehabilitation, Pain Medicine	373 Psychiatry & Neurology, Geriatric Psychiatry	477 Radiology, Radiological Physics
358 Pathology, Pediatric Pathology	389 Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	472 Psychiatry & Neurology, Neurodevelopmental Disabilities	381 Radiology, Therapeutic Radiology
244 Pediatrics	466 Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	100 Psychiatry & Neurology, Neurology	384 Radiology, Vascular & Interventional Radiology
239 Pediatrics, Adolescent Medicine	469 Physical Medicine & Rehabilitation, Sports Medicine	311 Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology	434 Supplier
295 Pediatrics, Clinical & Laboratory Immunology	419 Plastic Surgery	474 Psychiatry & Neurology, Pain Medicine	399 Surgery
462 Pediatrics, Developmental - Behavioral Pediatrics	470 Plastic Surgery, Plastic Surgery Within the Head and Neck	368 Psychiatry & Neurology, Psychiatry	416 Surgery, Pediatric Surgery
354 Pediatrics, Medical Toxicology	407 Plastic Surgery, Surgery of the Hand	475 Psychiatry & Neurology, Sports Medicine	420 Surgery, Plastic and Reconstructive Surgery
358 Pediatrics, Neurodevelopmental Disabilities	242 Preventive Medicine, Aerospace Medicine	476 Psychiatry & Neurology, Vascular Neurology	405 Surgery, Surgery of the Hand
345 Pediatrics, Pediatric Allergy & Immunology	429 Preventive Medicine, Medical Toxicology	366 Public Health & General Preventive Medicine	425 Surgery, Surgical Critical Care
346 Pediatrics, Pediatric Cardiology	112 Preventive Medicine, Occupational Medicine		413 Surgery, Surgical Oncology
347 Pediatrics, Pediatric Critical Care Medicine	471 Preventive Medicine, Sports Medicine		423 Surgery, Trauma Surgery
463 Pediatrics, Pediatric Emergency Medicine	431 Preventive Medicine, Undersea		400 Surgery, Vascular Surgery
349 Pediatrics, Pediatric Endocrinology			421 Thoracic Surgery (Cardiothoracic Vascular Surgery)
350 Pediatrics, Pediatric Gastroenterology			442 Transplant Surgery
351 Pediatrics, Pediatric Hematology-			424 Urology

Specialty Codes - DDS / DMD, DPM, DC

DDS / DMD	DPM	DC
2 Dentist	3 Podiatrist	1 Chiropractor
13 Dentist, Dental Public Health	231 Podiatrist, Foot & Ankle Surgery	5 Chiropractor, Internist
14 Dentist, Endodontics	230 Podiatrist, Foot Surgery	6 Chiropractor, Neurology
438 Dentist, General Practice	225 Podiatrist, General Practice	7 Chiropractor, Nutrition
16 Dentist, Oral and Maxillofacial Pathology	227 Podiatrist, Primary Podiatric 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
15 Dentist, Orthodontics 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 Boards

MD Boards	DO Boards	DPM Boards
044 American Board of Allergy & Immunology	108 American Board of Orthodontics	140 American Board of Medical Specialists in Podiatry
045 American Board of Anesthesiology	112 American Board of Pediatric Dentistry	137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
046 American Board of Colon & Rectal Surgery	111 American Board of Periodontology	138 American Board of Podiatric Surgery
047 American Board of Dermatology	115 American Board of Prosthodontics	139 American Council of Certified Podiatric Surgeons and Physicians
048 American Board of Emergency Medicine	106 American Board of Public Health Dentistry	
049 American Board of Family Practice	120 Boards other than ABMS/AOA	
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		
118 American Board of Ora & 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		
119 Boards other than ABMS/AOA		

**ZONING COMMISSION FOR THE DISTRICT OF COLUMBIA
NOTICE OF PROPOSED RULEMAKING**

Case No. 04 - 28 (TA)

(Text Amendment - DMV Driver's License Road Test Facilities - 11 DCMR)

The Zoning Commission for the District of Columbia, pursuant to the authority set forth in § 1 of the Zoning Act of 1938, approved June 20, 1938 (52 Stat. 797, 799; D.C. Official Code § 6-641.01), hereby gives notice of the intent to adopt an amendment to Chapters 1, 5, 6, 7, 8, 9, and 21 of the Zoning Regulations (11 DCMR). The proposed rule would permit Driver's License Road Test Facilities as a matter of right use in Special Purpose (SP), Mixed Use (CR), certain Commercial (C-2), certain Industrial (C-M), and certain Waterfront (W-2 and W-3) zone districts. Final rulemaking action shall be taken in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

The proposed text amendment is as follows:

Title 11 DCMR (Zoning) is proposed to be amended as follows:

- A. Section 199, DEFINITIONS, subsection 199.1, is amended to add the following new definition:

Driver's License Road Test Facility - a building and associated paved area used by the District of Columbia Department of Motor Vehicles in connection with road tests or other tests of driving ability given to applicants for drivers' licenses or endorsements.

- B. Section 501 USES AS A MATTER OF RIGHT (SP), subsection 501.1, is amended by adding a new subparagraph to read as follows:

(j) Driver's License Road Test Facility.

- C. Section 601 USES AS A MATTER OF RIGHT (CR), subsection 601.1, is amended by adding a new subparagraph to read as follows:

(y) Driver's License Road Test Facility.

- D. Section 721 USES AS A MATTER OF RIGHT (C-2), subsection 721.2, is amended by adding a new subparagraph to read as follows:

(y) Driver's License Road Test Facility.

- E. Section 801, USES AS A MATTER OF RIGHT (C-M), subsection 801.7, is amended by adding a new subparagraph to read as follows:

(m) Driver's License Road Test Facility.

F. Section 901, USES AS A MATTER OF RIGHT (W), is amended by adding a new § 901.6 to read as follows:

901.6 A Driver's License Road Test Facility shall be permitted within the W-2 and W-3 Districts.

G. Chapter 21, OFF-STREET PARKING REQUIREMENTS, is amended by inserting the following use in the table included in § 2101.1, SCHEDULE OF REQUIREMENTS FOR PARKING SPACES under "INSTITUTIONAL USES":

USES	NUMBER OF PARKING SPACES REQUIRED
Driver's License Road Test Facility	
C-2-A, C-3-A	4 spaces for each employee.
C-2-B, C-2-C, C-3-B, C-3-C, C-4 C-5, SP, CR, W-2, W-3	4 spaces for each employee.
C-M, M	4 spaces for each employee.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, to Clifford Moy, Acting Secretary to the Zoning Commission, Office of Zoning, 441 4th Street, N.W., Washington D.C. 20001. Comments must be received not later than thirty (30) days after the publication of this notice in the *D.C. Register*. A copy of this proposal may be obtained, at cost, by writing to the above address.

**ZONING COMMISSION FOR THE DISTRICT OF COLUMBIA
NOTICE OF PROPOSED RULEMAKING**

Case No. 04-29

**(Text Amendment –Fire and Emergency Medical Services Department of the District of
Columbia Facilities - 11 DCMR)**

The Zoning Commission for the District of Columbia, pursuant to the authority set forth in § 1 of the Zoning Act of 1938, approved June 20, 1938 (52 Stat. 797, 799; D.C. Official Code § 6-641.01), hereby gives notice of the intent to adopt an amendment to Chapters 1, 2, 3, 6, 7, 8, 9, and 21 of the Zoning Regulations (11 DCMR). The proposed rule would provide for Fire Stations, Fire Department Training Facilities, Fire Department Administrative Facilities, and Fire Department Support Facilities within the Zoning Regulations. Final rulemaking action shall be taken in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Title 11 DCMR (Zoning) is proposed to be amended as follows:

- A. Section 199, DEFINITIONS, subsection 199.1, is amended to add the following new definition:

Fire Department – the Fire and Emergency Medical Services Department of the District of Columbia

Fire Station- a building and associated land used by the Fire Department to house personnel and equipment in connection with the provision of fire, rescue, emergency medical, hazardous materials response, and other types of emergency services throughout the District of Columbia.

Fire Department Training Facility- a building and associated land used by the Fire Department to provide classroom and practical training for emergency services and support personnel. The facility may include training towers, live and simulated fire training buildings, training aides, driver training courses and administrative supports areas.

Fire Department Administrative Facility- a building (including the Fire Department's Headquarters) and associated land area used to provide administrative support to the Fire Department.

Fire Department Support Facility- a building and associated land used to provide fleet maintenance, facilities maintenance, communications, or other types of non-administrative support to the Fire Department.

- B. Section 201, USES AS A MATTER OF RIGHT (R-1), subsection 201.1 is amended by adding a new subparagraph (s) to read as follows:

(s) Fire Station.

C. Section 330, R-4 DISTRICTS: GENERAL PROVISIONS, subsection 330.5, is amended by adding a new subparagraph (j) to read as follows:

(j) Fire Department Administrative Facility.

D. Section 350, R-5 DISTRICTS: GENERAL PROVISIONS, subsection 350.4, is amended by adding a new subparagraph (h) to read as follows:

(h) Fire Department Support Facility, communications services only.

E. Section 601, USES AS A MATTER OF RIGHT (CR), subsection 601.1, is amended by adding a new subparagraphs to read as follows:

(z) Fire Station.

(aa) Fire Department Administrative Facility.

(bb) Fire Department Support Facility.

F. Section 701 USES AS A MATTER OF RIGHT (C-1), subsection 701.6, is amended by adding a new subparagraph (j) to read as follows:

(j) Fire Department Support Facility.

G. Section 801, USES AS A MATTER OF RIGHT (C-M), subsection 801.7, is amended by adding a new subparagraph () to read as follows:

(n) Fire Department Training Facility.

H. Section 901, USES AS A MATTER OF RIGHT (W) is amended as follows:

1. Subsection 901.1 (uses as a matter of right W-1, W-2, and W-3) is amended by adding new subparagraphs (x) through (z) to read as follows:

(x) Fire Station

(y) Fire Department Administrative Facility

(z) Fire Department Support Facility

2. Subsection 901.5 (uses as a matter of right W-0) is amended by inserting new subparagraphs for each of the following uses in alphabetical order.

(f) Fire Station

(g) Fire Department Administrative Facility

- I. Chapter 21, OFF-STREET PARKING REQUIREMENTS, is amended by inserting the following use in the table included in § 2101.1, SCHEDULE OF REQUIREMENTS FOR PARKING SPACES: under "INSTITUTIONAL USES":

USES	NUMBER OF PARKING SPACES REQUIRED
<u>Fire Station:</u>	
All R Districts, C-1, C-2-A, C-3-A	In excess of 2,000 ft. ² , 1 space for each 600 ft. ² of gross floor area and cellar floor area
All other districts	In excess of 2,000 ft. ² , 1 space for each 1,800 ft. ² of gross floor area
<u>Fire Department Training Facility:</u>	
C-M, M	In excess of 2,000 ft. ² , 1 space for each 1,800 ft. ² of gross floor area
<u>Fire Department Administrative Facility:</u>	
R-4 and R-5, C-1, C-2-A, C-3-A	In excess of 2,000 ft. ² , 1 space for each 600 ft. ² of gross floor area and cellar floor area
SP, CR, C-2-B, C-2-C, C-3-B, C-3-C, C-4, C-5(PAD), W-0, W-1, W-2, W-3, C-M, M	In excess of 2,000 ft. ² , 1 space for each 1,800 ft. ² of gross floor area
<u>Fire Department Support Facility:</u>	
R-5, C-1, C-2-A, C-3-A	In excess of 2,000 ft. ² , 1 space for each 600 ft. ² of gross floor area and cellar floor area
SP, CR, C-2-B, C-2-C, C-3-B, C-3-C, C-4, C-5(PAD), W-1, W-2, W-3, C-M, M	In excess of 2,000 ft. ² , 1 space for each 1,800 ft. ² of gross floor area

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, to Clifford Moy, Office of Zoning, 441 4th Street, N.W., Washington D.C. 20001. Comments must be received not later than thirty (30) days after the publication of this notice in the D.C. Register. A copy of this proposal may be obtained, at cost, by writing to the above address.