DeCare Dental℠ NETWORKS

CREDENTIALING APPLICATION

EASY AS 1, 2, 3!!!

1. Complete the simple application, including consent form: sign and date.
   (DDN does NOT accept STAMPED signatures)
2. Make copies of the supporting documents listed below:
   - ✓ Dental License (provide copies for EVERY state in which you are licensed)
   - ✓ DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
   - ✓ Board/Specialty Certificate (if applicable)
   - ✓ Professional Liability Insurance Declaration Page - to include name of each provider covered, effective and expiration dates, insurance carrier, coverage limits of no less than $1million/$3 million.
     -If expiration date is within weeks of this application, updated documentation must be submitted.
   - ✓ W-9 Form or Taxpayer Identification Number Request

3. Mail the application along with a signed DeCare Dental Networks, LLC Contracting Dentist Agreement to:

DeCare Dental Networks, LLC
Attn: National Credentialing
P.O. Box 1175
Minneapolis, MN 55440-1175

OR, *TO EXPEDITE*, APPLICATION CAN BE FAXED TO:

FAX: (866) 286-8840
QUESTIONS? Call (866)232-8658

Name:	_____ Last First MI
Individual NPI:	___ ___ - ___ ___ ___ - ___ ___ ___ ___ ___
DEA Information:	Do you currently hold a DEA registration? ☐ Yes ☐ No **If DEA is PENDING**: Above DDS will not write prescriptions until DEA is finalized. _____ DDS' Initials

ER/After Hours Number:	(_____)_____
Corporate NPI:	__ ___ - ___ ___ ___ - ___ ___ ___ ___ ___
Office Email:	_____
	If more than one location please ATTACH A SEPARATE SHEET with the above information.

For the above specialty, I am: ☐ Educationally Qualified (attach copy of specialty cert)
☐ **Board Certified *** (attach certificate copy from Specialty **Board**)

* Date of Certification: _____ Expiration Date: _____

PROFESSIONAL LIABILITY ADDENDUM

Complete addendum if you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

Malpractice Claim(s)

Date of Occurrence: _____ Settlement Amount: _____
Name & Address of Insurance Carrier: _____
Current Status of Claim: _____ Date Claim Resolved: _____
Details of Allegations: _____
_____
_____
_____
_____

Board Action(s)

Date of Occurrence: _____ Date of Satisfaction/Closure: _____ Amount of Fine Paid: _____
Details of Action (conditions, limitations, etc.) Attach copy of Board Action/Corrective Action: _____
_____
_____
_____
_____

DISCLOSURE QUESTIONS

Please complete the Professional Liability Addendum in this application if any of the following questions are answered in the affirmative.

1. ☐Yes ☐No Is your dental license in the state in which you practice currently limited, suspended or revoked?
2. ☐Yes ☐No Has a professional entity (licensing board, Medicare/Medicaid, DEA, Hospital) ever stipulated, restricted, revoked, suspended or in any way limited you or your practice?
3. ☐Yes ☐No Have you ever had any malpractice (professional liability) claims or lawsuits brought against you (includes pending or dismissed claims or lawsuits, settlements or final judgments)?
4. ☐Yes ☐No Is your Professional Liability current?

DISCLOSURE QUESTIONS AND PROVIDER CONSENT

I certify that the information furnished on the DeCare Dental Networks, LLC (DDN) *Application for Contracting* is complete and accurate. I acknowledge that my eligibility to become a participating dentist is contingent upon the provision of complete and accurate information in this application. I agree to inform DDN within ten (10) days of notice of any material changes in such information, whether before or after entering into an agreement with DDN for the provision of dental services. I agree to notify DDN of any changes in malpractice coverage, including the insurance carrier and policy number within ten (10) days of the date any such changes occur. I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines. I understand that my application may require DDN to review information related to me on file with other entities, including but not limited to, state licensing boards, specialty boards, professional societies, malpractice carriers, and the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank administered by the U.S. Government. I hereby consent to and authorize the release of such information by any such entity that requires authorization. I authorize photocopies of this authorization to be used by DDN.

Signature _____ **Date** _____

Name _____
(please print or type)

DeCare Dental™

NETWORKS

Request for Taxpayer Identification Number and Certification (SUBSTITUTE FORM W-9)

Instructions: Please type or print clearly. Sign, date and return to requester in the enclosed envelope. **Do not send to the IRS**

Business Entity: Name of the entity that provides dental services per IRS. (As used to apply for your Tax Identification Number (TIN). This appears on Form SS-4, on your Quarterly Withholding Form 941, or on your annual IRS Tax Return.)

_____

Business Name: (Name used to advertise for business, if different from above name.)

_____

Business Address: _____
Address (number, street and apt or suite no.)

_____
City, State and ZIP code

Taxpayer Identification Number (TIN)

Enter your TIN, which corresponds to the business entity listed above. This may be an Employer Identification Number (EIN) or your Social Security Number (SSN) dependent upon how you file your tax returns with the IRS. This is the Tax Identification Number you use when you submit claims.

TIN | | | | | | | | | | **Check one**: This is my ☐ EIN or ☐ SSN

Please check appropriate box: ☐ Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other _____

If you use a different Tax Identification Number at another office location, please copy this form and complete the copied form with the additional Tax Identification Number and office location information.

Qualifying Exemption Reason, if any (check)

☐ Exempt from tax under 501(a)

☐ The United States or any of its agencies or instrumentalities

☐ A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.

Certification: (1) I certify under penalty of perjury that the Taxpayer Identification Number I have provided is correct.
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
(3) I am a U.S. person (including a U.S. resident alien).
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

Signature: _____ **Office Phone:** (____) _____

Print signer's name & title: _____ **Date:** _____

DeCare Dental Networks, LLC
ATTN: National Network
P.O. Box 1175 • Minneapolis, MN 55440-1175
FAX: 1-866-286-8840

See back of form for additional information.

Purpose of Form

A person who is registered to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use From W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. **Certify the TIN you are giving is correct (or you are waiting for a number to be issued),**
2. **Certify you are not subject to backup withholding, or**
3. **Claim exemption from backup withholding if you are a U.S. exempt payee.**

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding?
Persons making certain payments to you must withhold and pay to the IRS 28% of such payments under certain conditions. This is called "backup withholding". Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real Estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.
Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.
Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.
Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

December, 1999

Dear Health Care Professional:

In 1998, the Oklahoma Legislature passed a law dealing with credentials verification. That law directed the Board of Health to promulgate rules and the Oklahoma State Department of Health to develop a uniform credentialing application. The application will be used to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

The Department has developed the attached Uniform Credentialing Application. Although many of the items apply primarily to physicians, this form has been designed for use by all health care professionals.

Please note these specific instructions:

1. **DO NOT submit this form to the Oklahoma State Department of Health.**
2. **Contact the facility or organization to which you plan to apply before submitting this form to find out what addendum, supplemental form, additional information, or additional items will be required.**
3. **All items must be completed.**
4. **If an item is not applicable, please so state.**
5. **Please print legibly or type.**
6. **Be sure to sign and date the application.**
7. **If additional space is needed, please attach additional sheets.**

The application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. The form is available on the Department's website at **www.health.state.ok.us**. For questions about the form you may contact the Department at (405) 271-6868. The form may also be available online at the different facilities and organizations to which you will be making application.

Protective Health Services
Oklahoma State Department of Health

Uniform Credentialing Application

63 O.S. Supp. 1998, Section 1-106.2

Please note: Although many of the items apply primarily to physicians, this form has been designed to be used by all health care professionals. If an item does not apply to you, write "N/A".

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"). All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to: _____

_____

Date: _____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION.

SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix

Professional Degree _____ Gender: ___ Male ___ Female

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ NPID (formerly UPIN)_____

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Place of Birth Citizenship

_____
Visa Type Visa Number (provide copy) Expiration Date

_____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: _____

This Section continues on next page.

-Section 2 Continued-

Office Street Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Mailing Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Billing Address (If Different From Claims Payment Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Claims Payment Address (If Different From Office Billing Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Make Checks Payable To: _____

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice) | Subspecialty | % Of Time

Secondary Specialty | Subspecialty | % Of Time

Do you wish to be listed as:
___ Primary Care Provider ___ Specialist ___ Hospitalist ___ On-Call ___ Other (specify)_____
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

___ Yes ___ No Are you accepting new patients?

___ Yes ___ No Are you willing, in the future to accept new patients?

___ Yes ___ No Do you admit your own patients to hospitals?

If no, please explain how your patients will be admitted, which hospital and who will provide patient care.

___ Yes ___ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?

___ Yes ___ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) | ( ) | ( )
Phone Number | Fax Number | Answering Service Number

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) | ( ) | ( )
Phone Number | Fax Number | Answering Service Number

List any restrictions on your practice (i.e. patient age and gender): _____

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(2) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(3) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed: ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(2) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(3) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

(4) Type of Program:
___ Internship ___ Residency ___ Fellowship ___ Preceptorship ___ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(2) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(3) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) _____ ___ Primary ___ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

(2) _____ ___ Primary ___ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) _____ ___ Primary ___ Secondary
Facility Name

_____ (_____)
Complete Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) _____
Name and Nature of Affiliation

_____ (_____)
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) _____
Name and Nature of Affiliation

_____ (_____)
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) _____
Name and Nature of Affiliation

_____ (_____)
Mailing Address City State Zip Code Telephone Number

From:___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

_____
Location Branch of Service

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

_____
Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

Oklahoma _____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ __ __ - __ __ - __ __ __ __
USMLE/ECFMG Number Certification Date

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

_____ DEA _____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ DEA _____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

Oklahoma BNDD _____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

_____ CDS _____ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
State Type Number Original Date of Issue Expiration Date

BOARD CERTIFICATION

Are you Board Certified? ___ Yes ___ No _____
Name of Board

__ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __ __ __ - __ __ - __ __ __ __
Date Initially Certified Date Most Recently Recertified Date Certification Expires

___ Yes ___ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification — Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified
__ __ - __ __ - __ __ __ __ Date Most Recently Recertified
__ __ - __ __ - __ __ __ __ Date Certification Expires

Subspecialty or Added Qualification — Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified
__ __ - __ __ - __ __ __ __ Date Most Recently Recertified
__ __ - __ __ - __ __ __ __ Date Certification Expires

BOARD QUALIFICATIONS

___ Yes ___ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

___ Yes ___ No Are you planning to take the exam?

___ Yes ___ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral __ __ - __ __ - __ __ __ __

Written __ __ - __ __ - __ __ __ __

Other __ __ - __ __ - __ __ __ __

Subspecialty or Added Qualification — Name of Board

Date Qualified __ __ - __ __ - __ __ __ __ Date Qualification Expires __ __ - __ __ - __ __ __ __

Classifications:

___ Yes ___ No Are you certified in CPR? Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Basic Life Support (BLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Advanced Cardiac Life Support (ACLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Health Care Provider (CoreC) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Advanced Trauma Life Support (ATLS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Neonatal Advanced Life Support (NALS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Pediatric Advanced Life Support (PALS) Expires __ __ - __ __ - __ __ __ __

___ Yes ___ No Other_____ Expires __ __ - __ __ - __ __ __ __

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

___ Solo ___ Partnership ___ Single-Specialty Group ___ Multi-Specialty Group Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ___ Yes ___ No Reference Lab? ___ Yes ___ No On Site? ___ Yes ___ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

___ Yes ___ No Radiology
___ Yes ___ No EKG
___ Yes ___ No Audiology
___ Yes ___ No Treadmill
___ Yes ___ No Sigmoidoscopy
___ Yes ___ No Wheelchair/handicapped access?
___ Yes ___ No Other services for the disabled?
If yes, please list:_____
___ Yes ___ No Other:_____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

___ Yes ___ No Does this office meet all state and local fire, safety and sanitation requirements?

___ Yes ___ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

___ Yes ___ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

___ Solo ___ Partnership ___ Single-Specialty Group ___ Multi-Specialty Group ___ Other (specify) _____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ___ Yes ___ No Reference Lab? ___ Yes ___ No On Site? ___ Yes ___ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

___ Yes ___ No Radiology
___ Yes ___ No EKG
___ Yes ___ No Audiology
___ Yes ___ No Treadmill
___ Yes ___ No Sigmoidoscopy
___ Yes ___ No Wheelchair/handicapped access?
___ Yes ___ No Other services for the disabled?
If yes, please list: _____
___ Yes ___ No Other: _____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

___ Yes ___ No Does this office meet all state and local fire, safety and sanitation requirements?

___ Yes ___ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

___ Yes ___ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
_____	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
_____	Current Federal DEA Registration Certificate
_____	Emergency Care Training Certificates (CPR, etc., if certified)
_____	Photo Identification
_____	Curriculum Vitae
_____	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:
Practitioners are reminded that each organization <u>will</u> require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

_____

_____

_____

_____

_____

_____

_____

_____

_____