

CREDENTIALING APPLICATION

1. Complete the application: sign and date. (DDN does NOT accept STAMPED signatures)
2. Make copies of the supporting documents listed below:
 - ✓ W-9 Form or Taxpayer Identification Number Request
 - ✓ Additional Locations (please attach a separate sheet with practice information)
 - ✓ Dental License (provide copies for EVERY state in which you are licensed)
 - ✓ **Federal** DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
 - ✓ **American Board/Specialty Certificate** (if applicable)
 - ✓ Professional Liability Insurance Declaration Page for each State in which you practice – showing insurance carrier, dentist's name, policy #, effective and expiration dates and coverage limits of no less than \$1million/\$3 million. (If expiration date is within weeks of this application, updated documentation must be submitted)
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) 462-1832 x5364

Name:	_____		
	Last	First	MI
Individual NPI:	_____ - _____ - _____		
DEA Information:	Do you currently hold a Federal DEA registration in every state you practice in?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If DEA is PENDING : Above DDS will not write prescriptions until DEA is finalized.		_____
			DDS' Initials

ER/After Hours Number:	_____		
Corporate NPI:	_____ - _____ - _____		
	If more than one location please ATTACH A SEPARATE SHEET with the above information		

***This Credentialing Application cannot be processed until it is completed in full.
Please maintain a copy of this Credentialing Application for your records.***

DeCare Dental Networks, LLC (DDN) maintains all information gathered as part of the credentialing or re-credentialing process in a confidential manner and will not communicate or reproduce any information obtained during the process. DDN strictly enforces the provisions designed to safeguard information and ensure confidentiality.

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 currently limited, suspended or revoked in the state in which you practice?
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 with limits of \$1million/\$3 million?

Disclosure Question Explanation

COMPLETE ONLY IF you answered "YES" to Disclosure Questions #1, #2 or #3.
Attach separate sheet if necessary.

Malpractice Claim(s)

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

Board Action(s)

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

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)



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 Exempt from tax under 501(a)

Reason, if any (check) 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 Form 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 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.

<u>Oklahoma</u>					
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)

	<u>DEA</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____/____/____	____/____/____	
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____/____/____	____/____/____	
<u>Oklahoma</u>	<u>BNDD</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____/____/____	____/____/____	
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.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:	_____	_____	_____	_____	_____	_____	_____

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.

<u>Name</u>	<u>Provider Type</u>	<u>License Number</u>

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.

<u>Attached</u>	<u>Item</u>
_____	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 will 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.

A large rectangular area containing 30 horizontal lines, intended for writing or drawing.