

# Uniform Credentialing Application

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

This form must be completed in full and typed or printed legibly (i.e. do not state “see CV”). Write “N/A” in areas that do not apply to you. 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
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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

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Mailing Address City State Zip Code

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

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

Graduation Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(2) \_\_\_\_\_  
Institution Degree Awarded

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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

\_\_\_\_\_ Department or Service  
 Reason for Discontinuance

(2) \_\_\_\_\_ \_\_\_ Primary \_\_\_ Secondary  
 Facility Name

\_\_\_\_\_ ( )  
 Complete Mailing Address City State Zip Code Telephone Number

From: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ to \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Dates of Appointment (mo/day/year) Staff Category

\_\_\_\_\_ Department or Service  
 Reason for Discontinuance

**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	<u>DEA</u>	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
<u>Oklahoma</u>	<u>BNDD</u>				
State	Type	Number	Original Date of Issue	Expiration Date	
_____	_____	_____	____-____-____	____-____-____	
State	<u>CDS</u>	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 Certification Expires ____ - ____ - ____
Date Initially Certified ____ - ____ - ____	Date Most Recently Recertified ____ - ____ - ____	

Subspecialty or Added Qualification ____ - ____ - ____	Name of Board ____ - ____ - ____	Date Certification Expires ____ - ____ - ____
Date Initially Certified ____ - ____ - ____	Date Most Recently Recertified ____ - ____ - ____	

**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:	_____	_____	_____	_____	_____	_____	_____

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 (\_\_\_\_) \_\_\_\_\_

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?

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

Name	Provider Type	License Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

If yes, please list: \_\_\_\_\_

Yes  No Other: \_\_\_\_\_

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 (\_\_\_\_) \_\_\_\_\_

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.

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Lined writing area with 30 horizontal lines.