
Last Name

First Name

OFFICE USE ONLY

Date Received: _____

Degree

Date you expect to begin practice

Uniform Application Form

- This application has been developed by the Monroe County Medical Society, in conjunction with area hospitals, managed care organizations and other health care facilities.
- Use of this application enables you to **complete one form and submit copies** to regional hospitals, managed care organizations and other health care entities which utilize the form.
- Please be aware that each hospital, managed care organization or other health care entity may require submission of additional forms specific to the organization.
- This application must be completed entirely, with no gaps in time intervals. **All dates must identify month and year.**
- This application will be accepted only in typewritten or legibly printed form.
- You are responsible for making copies of the completed application, affixing an original signature to each, and sending them as instructed by the organizations with which you wish to affiliate.

Vital Data _____

Name _____
Last First Middle Initial Degree

Sex ___ M ___ F Date of Birth _____ SS # ____ - ____ - ____

Beeper/Pager # _____

Place of Birth _____
City State Country

Citizenship _____ If not a citizen of the USA, indicate your visa status _____

Alien Registration # _____

Other names, i.e. alias, AKA, maiden name, corporate name _____

Date of name change: _____

Last Name

First Initial

Requested Categories _____

If you are pursuing a Primary Care Status will you be following your patients when admitted or will you be using the hospitals' Hospitalist service?

___ Yes, Name Hospitals _____

___ No

Department/Service – For Hospital and Health Facility Appointments Only. See relevant hospital bylaws.

(1) _____ (2) _____

Specialty Category

Clinical Specialty _____

Subspecialty (1) _____ (2) _____

Staff Category – For Hospital Appointments Only. See relevant hospital bylaws.

(1) _____ (2) _____

Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists and Certified Nurse Midwives or any other discipline identify your Collaborating/Supervising physician and provide a copy of your agreement/statement.

Supervising/Collaborating Physicians – please identify who you are responsible for

(1) _____ (2) _____

(3) _____ (4) _____

Practice Type

Private Practice Employed If employed, by whom? _____

Contract Category – For MCOs and POs Only. Please see relevant MCO and/or PO bylaws.

Primary Care Specialty Both Consulting Allied Health

Primary Hospital Affiliation – _____

As a primary care physician will you be: Following your own patients? ___ Yes ___ No If yes, please identify the hospitals you will be attending at _____

Are you using the hospitalist program(s)? ___ Yes ___ No If yes, please identify the hospitals you will be using the hospitalist program at _____

Last Name

First Initial

Home/Personal Data _____

Home Address _____
Street

City _____ State _____ Zip Code _____

Home Phone # (____) _____ Is this number listed in the phone book? ___ Yes ___ No

Home Fax # (____) _____ Cellular # (____) _____

E-mail address _____

Foreign Language _____

Name of Spouse/Significant other (optional) _____

Primary Office _____

Primary Office Address _____
Street

City _____ State _____ Zip Code _____

Primary Office Phone # (____) _____ Primary Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Are Patients able to access you or someone covering for you 24/7 ___ Yes ___ No

Work E-mail _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Tax ID# _____ Website Address _____

Office Manager/Contact Person Name _____ Phone # (____) _____

Primary Office Hours	Your On-Site Hours	Languages Spoken On-Site	By Whom
Monday _____ AM to _____ PM	Monday _____ AM to _____ PM		
Tuesday _____ AM to _____ PM	Tuesday _____ AM to _____ PM		
Wednesday _____ AM to _____ PM	Wednesday _____ AM to _____ PM		
Thursday _____ AM to _____ PM	Thursday _____ AM to _____ PM		
Friday _____ AM to _____ PM	Friday _____ AM to _____ PM		
Saturday _____ AM to _____ PM	Saturday _____ AM to _____ PM		
Sunday _____ AM to _____ PM	Sunday _____ AM to _____ PM		

Last Name First Initial

Are you accepting new patients at this office? Y N Is this office wheelchair or handicap accessible? Y N

Is your primary office also your billing office? Y N

If no, what is your billing office address? _____
Street

City State Zip Code

Billing Office Phone # (____) _____ Billing Office Fax # (____) _____

E-mail Address _____

Does office bill electronically? Yes No If yes, what software is used? _____

Second & Third Office (if applicable) If you have more office locations, please copy this page complete in its entirety and attach to the application.

Second Office Address _____
Street

City State Zip Code

Second Office Phone # (____) _____ Second Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Work E-mail _____ Tax ID# _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Second Office Hours		Your On-Site Hours		Languages Spoken On-Site	By Whom
Monday	____ AM to ____ PM	Monday	____ AM to ____ PM		
Tuesday	____ AM to ____ PM	Tuesday	____ AM to ____ PM		
Wednesday	____ AM to ____ PM	Wednesday	____ AM to ____ PM		
Thursday	____ AM to ____ PM	Thursday	____ AM to ____ PM		
Friday	____ AM to ____ PM	Friday	____ AM to ____ PM		
Saturday	____ AM to ____ PM	Saturday	____ AM to ____ PM		
Sunday	____ AM to ____ PM	Sunday	____ AM to ____ PM		

Are you new patients at this office site? Y N Is this office wheelchair or handicap accessible? Y N

Third Office Address _____
Street

City State Zip Code

Third Office Phone # (____) _____ Third Office Fax # (____) _____

Direct Phone Line # (____) _____ Beeper/Pager # (____) _____

Answering Service Phone # (____) _____ Cellular Phone # (____) _____

Last Name First Initial

Work E-mail _____ Tax ID# _____

Name of Group/Corporate Name (as it appears on your W-9), if applicable _____

Office Manager/Contact Person Name _____ Phone # (____) _____

Third Office Hours	Your On-Site Hours	Languages Spoken On-Site	By Whom
Monday ____AM to ____PM	Monday ____AM to ____PM		
Tuesday ____AM to ____PM	Tuesday ____AM to ____PM		
Wednesday ____AM to ____PM	Wednesday ____AM to ____PM		
Thursday ____AM to ____PM	Thursday ____AM to ____PM		
Friday ____AM to ____PM	Friday ____AM to ____PM		
Saturday ____AM to ____PM	Saturday ____AM to ____PM		
Sunday ____AM to ____PM	Sunday ____AM to ____PM		

Are you new patients at this office site? __Y __N Is this office wheelchair or handicap accessible? __Y __N

Education/Training

Please provide all of the information requested, below and **attach copies of diplomas, certification and other proofs of attendance.** If any gaps in chronology of your academic and/or professional history exist, provide a brief summary of details, as well as an explanation for any "No" responses. Please also **attach** a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

College Undergraduate Education

School _____

Address _____

Street _____

City _____

State _____

Zip Code _____

Phone () _____ Fax () _____

Dates Attended _____ to _____ Degree _____

School _____

Address _____

Street _____

City _____

State _____

Zip Code _____

Phone () _____ Fax () _____

Dates Attended _____ to _____ Degree _____

Medical/Dental/Professional Education

School _____

Address _____

Street _____

City _____

State _____

Zip Code _____

Phone () _____ Fax () _____

Dates Attended _____ to _____ Degree _____

Honors or Recognition _____

School _____

Address _____

Street

City

State

Zip Code

Phone () _____ Fax () _____

Dates Attended _____ to _____ Degree _____

Honors or Recognition _____

Internship

Hospital _____

Address _____

Street

City

State

Zip Code

Phone () _____ Fax () _____

Dates of Service _____ to _____ Specialty _____

Internship Completed? Yes **No*** Name of Director/Department Chair _____

Residency

Hospital _____

Address _____

Street

City

State

Zip Code

()

Phone#

()

Fax #

Dates of Service _____ to _____ Specialty _____

Residency? Yes **No*** Name of Director/Department Chair _____

Hospital _____

Address _____

Street

City

State

Zip Code

()

Phone#

()

Fax #

Dates of Service _____ to _____ Specialty _____

Residency? Yes **No*** Name of Director/Department Chair _____

Formal Post Graduate/Fellowship Education

Hospital _____

Address _____

Street

City

State

Zip Code

()

Phone#

()

Fax #

Dates of Service _____ to _____ Specialty _____

Fellowship? Yes **No*** Name of Director/Department Chair _____

Last Name

First Initial

Other Training

Institution _____

Address _____

Street

City

State

Zip Code

(____)_____
Phone#

(____)_____
Fax #

Fax #

Dates of Service _____ to _____ Specialty _____

Completed? ___Yes ___No* Name of Director/Department Chair _____

***Full explanation required on a separate sheet of paper**

Any additional Training must be documented on a separate sheet of paper

Hospital Affiliations/Work Experience/Professional History _____

List in chronological order, beginning with the most recent, all institutional affiliations or places of employment. This includes all hospitals, teaching institutions, managed care organizations, private practices, corporations, military assignments and government agencies and all other licensed health care organizations. Exclude residency and fellowship training. If more space is needed, please use another sheet. Please also attach a current copy of a signed and dated CV. However, *it will not be considered a replacement for any part of this application.*

Institution _____

Address _____

Street

City

State

Zip Code

(____)_____
Phone #

(____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(____)_____
Phone #

(____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(____)_____
Phone #

(____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Last Name

First Initial

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(_____)_____
Phone #

(_____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(_____)_____
Phone #

(_____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(_____)_____
Phone #

(_____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Institution _____

Address _____

Street

City

State

Zip Code

(_____)_____
Phone #

(_____)_____
Fax #

Department or Service _____ Dates of Service _____ to _____

Department Director/Immediate Supervisor _____

Status _____ Reason for Discontinuation of Service _____

Last Name

First Initial

Board Certification/Recertification _____

Attach copies of Board specialty and subspecialty certifications and recertifications, or a copy of qualifying letter(s).

Certifying Board _____ Date of Original Certification _____

Certifying Board _____ Date of Original Certification _____

Certifying Board _____ Date of Original Certification _____

Emergency Care Training, Infection Control Certification, Special Credentials and CME Courses

Submit with your Uniform Application Form a list of all major training (excluding residency and fellowship) and continuing education courses you have completed within the past two years. Attach copies of each certificate you hold for emergency care training (i.e. CPR, ACLS, ATLS, and PALS). Please indicate any special credentials you possess related to OB ultrasound and neuropsychology testing for HMO's. If you have trained in additional procedures, submit certificates of training or other documentation.

Identification Numbers _____

Please list identification numbers assigned to you by for the following entities:

Blue Cross Blue Shield – Rochester # _____ Preferred Care # _____

Medicare UPIN # _____ Medicaid/MMIS # _____

NPI # _____ Taxonomy # _____

Workers' Compensation # _____

Other # _____

Professional Associations _____

List memberships in professional societies, colleges, academies, etc.:

<u>Organization</u>	<u>Initial Date of Membership</u>	<u>Status</u> <u>Please Circle</u>
_____	_____	Active Inactive
_____	_____	Active Inactive
_____	_____	Active Inactive

Professional Licensing Information _____

Attach copies of each item listed below, including state licenses, DEA, ECFMG/USMLE and infection control certificates:

<u>State</u>	<u>License Type</u> <u>(i.e. Limited)</u>	<u>License #</u>	<u>Date Received</u>	<u>Expiration Date</u>	<u>Status</u> <u>Please Circle</u>
_____	_____	_____	_____	_____	Current Pending
_____	_____	_____	_____	_____	Active Inactive*
_____	_____	_____	_____	_____	Active Inactive*

Last Name

First Initial

* For those licenses, which are no longer active, please provide an explanation regarding the reason for disassociation on a separate sheet of paper.

Federal Narcotics Registration /DEA # _____ Expiration Date _____

Federal Narcotics Registration /DEA # _____ Expiration Date _____

Federal Narcotics Registration /DEA # _____ Expiration Date _____

ECFMG # _____ USMLE # (formerly NBME) _____

Professional References

List four professional references that have had direct clinical observation of your work for at least one year. Please identify those individuals you have listed that are/were your partners. For MCOs and POs, be sure to refer to each organization's criteria as requirements may vary.

Name _____

First

Middle Initial

Last

Degree

Title/Position _____

Address _____

Street

City _____ State _____ Zip Code _____

Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Name _____

First

Middle Initial

Last

Degree

Title/Position _____

Address _____

Street

City _____ State _____ Zip Code _____

Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Name _____

First

Middle Initial

Last

Degree

Title/Position _____

Address _____

Street

City _____ State _____ Zip Code _____

Phone # (____) _____ Fax # (____) _____ E-Mail Address _____

Last Name

First Initial

Name

First

Middle Initial

Last

Degree

Title/Position

Address

Street

City

State

Zip Code

Phone # (____) _____

Fax # (____) _____

E-Mail Address _____

Professional Liability Insurance

You must provide an answer for each question in this category and attach a copy of your policy face sheet(s), which name(s) you and show(s) policy limits, coverage, limitations and expiration dates.

Current Carrier

Policy #

Type of Insurance

Claims Made

Occurrence

Retroactive Date

Name of Hospital Providing Secondary Layer of Insurance

List insurance carriers which provided you with coverage during the last ten years, including those carriers that may have covered you while serving as a locum tenens:

Carrier Name

Complete Address

Street

City

State

Zip

Dates of Coverage

to _____

Carrier Name

Complete Address

Street

City

State

Zip

Dates of Coverage

to _____

Carrier Name

Complete Address

Street

City

State

Zip

Dates of Coverage

to _____

Last Name

First Initial

You must provide an answer for each of the following questions and provide a full explanation to any "Yes" responses on a separate sheet of paper. Also list the name of the carrier and the date of the company's action.

1. ___Yes ___No has your professional liability insurance coverage ever been surcharged, suspended or terminated by action of any insurance company?
2. ___Yes ___No has your professional liability insurance coverage ever been denied or not renewed by action of any insurance company?
3. ___Yes ___No Has your present professional liability insurance carrier excluded any specific procedures from your coverage? **If yes, list the procedure(s), the date(s) the exclusion(s) commenced**
4. ___Yes ___No Have any professional liability suits been filed against you which are currently pending in this or any other state?
- 5 ___Yes ___No Have any professional liability judgments and/or settlements ever been made against you or on your behalf?

If the answer to question four or five is "Yes," provide a full explanation on a separate sheet. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney defending you and any other relevant details, including the clinical background of the suit, as well as the sum and substance of the findings in such actions or proceedings.

Corrective or Disciplinary Action _____

If the answer to any of the questions above is "Yes," provide a full explanation on a separate sheet. The explanation must include all relevant details, including the name and address of the attorney defending you, the name and address of any insurance company/companies providing professional liability coverage when the action occurred, the clinical background of the action, and the sum and substance of the findings in such actions or proceedings.

1. ___Yes ___No Have you ever been reported to the National Practitioner Data Bank, Healthcare Integrity and/or Protection Data Bank?
2. ___Yes ___No Has your employment, medical staff appointment, panel participation, affiliation or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused or limited in any hospital, health care facility or managed care organization, IPA or PPO including to avoid disciplinary action for reasons related to professional competence or conduct?
3. ___Yes ___No Have you ever involuntarily relinquished your license to practice your profession in any state?
4. ___Yes ___No Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (including Medicare, Medicaid or a managed care organization)?
5. ___Yes ___No Has your narcotics registration certificate ever been voluntarily or involuntarily limited, restricted, denied renewal, suspended or revoked?
6. ___Yes ___No Have you ever been denied membership, membership renewal or been subject to any professional review, censure or reprimand in any medical organization or professional society -- local, state or national?
7. ___Yes ___No Have you ever been subject to disciplinary action by a state agency or professional body (i.e. Medical Society, IPRO, OPMC)?
8. ___Yes ___No Has your specialty board certification or qualification ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended or reduced?
- 9 ___Yes ___No Do you have any pending misconduct changes against you in this state or any other state?

10. Yes No Have you ever been convicted of a misdemeanor or felony in any jurisdiction?
11. Yes No Are you presently subject to any suspension, revocation, discontinuance, limitation, restriction or monitoring proceedings?
12. Yes No Have you ever been cited for violation of patient rights as set forth by the Federal Law and/or NYS Department of Health or any other state department of health?

Attestation

1. True False I attest that the information provided in this application is complete, true and accurate.
2. True False I agree to update this Uniform Application Form while it is being processed, should there be any change in the information provided.
3. True False I understand that any misrepresentation, misstatement or omission from this application could result in the immediate rejection of this application or subsequent revocation of any privileges/membership granted and subject to reporting according to NYS regulations.
4. True False I am currently able to perform the clinical privileges that I have requested from each specific hospital, health care facility and/or managed care organization to which I direct this Uniform Application Form.
5. True False I am not currently using any illegal drug, nor have I during the past two years.

Signature

- Before signing this Uniform Application Form**, please make enough copies for each hospital, managed care organization or other health care entity with which you seek affiliation. Each entity requires an **original signature**. Therefore, it is ***vital*** that you make your copies prior to signing this form. Forms without original signatures will not be processed.
- You are responsible for mailing** a copy of the Uniform Application Form to each entity with which you seek affiliation.
- Be sure to attach all requested documents** to each copy of the Uniform Application Form before mailing.
- Please retain the unsigned original application once it is completed** in the event you would like to apply to another entity at a future date.

I hereby waive any confidentiality provision concerning the information provided in this application, pursuant to New York State Public Health Law section 2805-k.

Signature

Date

A checklist is provided on the next page for your assistance when preparing this application.

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Checklist

Please provide an explanation on a separate sheet for any missing items and attach copies of all requested items. Your Application will not be considered complete and cannot be processed without all of the following documentation:

- ___ Completed Uniform Application Form.
- ___ Individual NPI Number (page 13)
- ___ Group NPI Number(s) if applicable (page 13)
- ___ Taxonomy Code
- ___ Copy of Photo ID
- ___ Signed and dated Release Statement for each entity to which you are applying for privileges, employment, panel participation or membership.
- ___ Copy of current board certifications/qualifying letters.
- ___ Dated Curriculum Vitae.
- ___ Copies of professional diplomas.
- ___ Applicable training certificates.
- ___ CME documentation.
- ___ Copy of current NYS license registration certificate.
- ___ Other current state licenses and registration certificates.
- ___ Copy of current DEA registration certificate.
- ___ ECFMG/USMLE certificate.
- ___ Copy of current infection control training certificate.
- ___ Current malpractice insurance face sheet(s).
- ___ Explanations for Yes/No answers on a separate sheet.
- ___ Current Health Assessment Form, completed, dated and signed by your personal physician.
- ___ Original signature and date on each copy of the Uniform Application Form for each of your affiliations.
- ___ Original, unsigned copy for your files and future use.