



Please complete each section thoroughly.
 Attach additional sheets where necessary.
 (Indicate clearly the practitioner name and section on each attachment.)
 Type or print clearly in black ink.

Practitioners Name		Date
Social Security Number		Date of Birth
		NPI Number

YOU MUST INCLUDE THE FOLLOWING WITH ATTACHED COMPLETED APPLICATION

- Copy of ALL current State License(s): For purposes of this application, State License shall include licensure from all 50 states, the District of Columbia, and U.S. Territories.
- Copy of current DEA Registration (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and Practitioner's name
- Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- Copy of certificate(s) or letter(s) certifying formal post-graduate training (Degree, Internship, Residency, and/or Fellowship)
- Copy of Curriculum Vitae/Resume (Include work history) (Not accepted as a substitute for completion of application.)
- Copy of ECFMG Certificate (if applicable)
- Copy of IRS Assignment of Tax ID Number Notification and W-9 for verification of each Tax ID number used (required for payers only)
- Copy of Visa or work permit (if not a U.S. citizen)
- Copy of NPI Assignment Notification (letter or e-mail)
- Copy of CMS1500 with bottom section completed (typed or computer generated)

CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.



1. APPLICANT INFORMATION:

Last Name		First Name		Middle Name	Maiden Name	S.S.#
Degree:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Birth Date:	Birthplace:	Languages Spoken other than English:	
Current Home Address:			City:	State:	Zip Code:	Home Phone:

2. AREA(S) OF SPECIALTY (please be specific and list any primary focus):

Specialty:	Sub-specialty:	
Certifying Board Name & Specialty (Submit copies of all certifications)	Initial Certification Date:	Most Recent Certification Date
Has fulfilled academic requirements to sit for _____ Board Examination (Board Specialty)		

3. CITIZENSHIP:

Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, what is your citizenship?	If no, what is status of your Visa?	If no, do you hold a permanent work permit?
Type of Visa:	Expiration of Visa:	
ECFMG # (if applicable, attach copy)		

4. STATE LICENSE(S): List all current and past professional licenses:

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the scope of your practice require the supervision of another practitioner?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Practitioner Name:		

5. CERTIFICATIONS/REGISTRATIONS:

Federal DEA Certificate#	Expiration Date	Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No
State DEA Certificate #	Expiration Date	Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No

6. OFFICE PRACTICE INFORMATION:

VERY IMPORTANT: PLEASE COMPLETE WITH MAIN OFFICE LOCATION AND ATTACH **ALL OTHER OFFICE LOCATIONS** ON A SEPARATE SHEET!

UPIN Number	Medicare Number	Medicaid Number	Individual NPI Number	Group NPI Number
Group/Practice Name				
Address (Building, Street, Suite #)			City	
State	Zip Code	County	E-Mail Address	
Office Telephone Number () -		Office Fax Number () -		Office Back Line Number () -
Office Manager:			Credentialing Contact:	
Are you currently accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA			Have you closed your practice to any plans or programs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Patient Age Range:			If Yes, please list:	

IDENTIFY HOURS OF OPERATION:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM

Group/Practice Name (Check Payable To - as it appears on the W-9):				Tax ID#		
Billing Address (Building, Street, Suite #)			City		State	Zip
Billing Office Phone Number				Billing Manager's Name		

7. MEDICAL/PROFESSIONAL EDUCATION:

List all, completed or not. (Attach copies of all diplomas.) If additional space is needed, please photocopy this page and attach. All time gaps must be accounted for in Section 11.

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)			
Street Address	City	State, Zip	Graduation Date		
If Foreign Graduate, provide ECFMG Certificate Number and attach certificate:				Date Issued:	

8. PROFESSIONAL TRAINING - Internship/Residency/Fellowship/Preceptorship/Other:

List all, completed or not. (Attach copies of all program certificates.) If additional space is needed, please photocopy this page and attach. All time gaps must be accounted for.

Training Institution:		Program:			
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other:			
City	State	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of Training/Specialty	Dates of Training From: (Month/Year) To: (Month/Year)		Your Program Director's Name:		

Training Institution:		Program:	
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other:	
City	State	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Training/Specialty	Dates of Training From: (Month/Year) To: (Month/Year)	Your Program Director's Name:	
Training Institution:		Program:	
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other:	
City	State	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Training/Specialty	Dates of Training From: (Month/Year) To: (Month/Year)	Your Program Director's Name:	
Training Institution:		Program:	
		<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other:	
City	State	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Training/Specialty	Dates of Training From: (Month/Year) To: (Month/Year)	Your Program Director's Name:	

9. PROFESSIONAL LIABILITY INSURANCE COVERAGE:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last five (5) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier		Telephone Number	
		() -	
Address		City	State Zip
Coverage Effective Date	Coverage Termination Date	Amount of Coverage \$ million/occurrence \$ million/aggregate	If Umbrella/Excess coverage, amount of coverage \$
Policy Number	Type of Coverage <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Do you have prior acts coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Second Current Insurance Carrier		Telephone Number	
		() -	
Address		City	State Zip
Coverage Effective Date	Coverage Termination Date	Amount of Coverage \$ million/occurrence \$ million/aggregate	If Umbrella/Excess coverage, amount of coverage \$
Policy Number	Type of Coverage <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Do you have prior acts coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Previous Insurance Carrier		Telephone Number	
		() -	
Address		City	State Zip
Coverage Effective Date	Coverage Termination Date	Amount of Coverage \$ million/occurrence \$ million/aggregate	If Umbrella/Excess coverage, amount of coverage \$
Policy Number	Type of Coverage <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Do you have prior acts coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	

12. WORK HISTORY/EXPERIENCE:

List in chronological order (beginning with current) all current and previous professional work history, including Military Service. You must explain all gaps in time since Medical School. (If additional space is needed, please photocopy this page and attach.)

Practice/Employer:

Street Address				City	State	Zip
Dates of Employment (Month/Year)			Reason for leaving, if applicable			

Practice/Employer:

Street Address				City	State	Zip
Dates of Employment (Month/Year)			Reason for leaving, if applicable			

Practice/Employer:

Street Address				City	State	Zip
Dates of Employment (Month/Year)			Reason for leaving, if applicable			

Practice/Employer:

Street Address				City	State	Zip
Dates of Employment (Month/Year)			Reason for leaving, if applicable			

13. PROFESSIONAL PEER REFERENCES:

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. If your training was completed within the past three (3) years, you may list your Program Director(s) as a professional reference.

1 - Name	Title					
Street Address	City			State	Zip	
Telephone Number () -	Fax Number (if known) () -					
Relationship: (instructor, department chair, chief of staff, colleague, etc.)						
2 - Name	Title					
Street Address	City			State	Zip	
Telephone Number () -	Fax Number (if known) () -					
Relationship: (instructor, department chair, chief of staff, colleague, etc.)						
3 - Name	Title					
Street Address	City			State	Zip	
Telephone Number () -	Fax Number (if known) () -					
Relationship: (instructor, department chair, chief of staff, colleague, etc.)						

14. HOSPITAL/HEALTHCARE ENTITY AFFILIATIONS (list current affiliation first):

Check here if entire section is not applicable to applicant.

List ALL health care facilities at which you currently have, or have had, privileges. Explain gaps in Section 11.

Name of Affiliation/Hospital/Healthcare Entity ----- PRIMARY HOSPITAL -----

Street Address	City	State	Zip
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Name of Affiliation/Hospital/Healthcare Entity:

Street Address	City	State	Zip
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Name of Affiliation/Hospital/Healthcare Entity:

Street Address	City	State	Zip
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Name of Affiliation/Hospital/Healthcare Entity:

Street Address	City	State	Zip
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Name of Affiliation/Hospital/Healthcare Entity:

Street Address	City	State	Zip
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15. PRACTICE DISCLOSURE INFORMATION

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA

H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
J. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
P. Have you had any charges of unprofessional conduct brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Q. Have you had any charges of fraud brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
S. To the best of your knowledge, do you have any mental or physical conditions that would adversely affect my ability to carry out the contractual duties that I have requested?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
T. <u>PCP ONLY, NOT APPLICABLE TO OTHERS</u> : The total active patient load (patients who access my services three or more times in a twelve month period) for which I have personal responsibility does not exceed 3,000 patients.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> NA
U. Are you currently engaged in the illegal use of drugs ("Currently" means sufficient recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of the application, rather than it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances). If yes, please provide an explanation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

<p>V. Do you use any chemical substances that could in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? If yes, please provide an explanation</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>W. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients? If yes, please provide an explanation</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>X. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? If yes, please provide an explanation</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

I hereby attest that all information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Renaissance Health Systems of Florida, Inc. (Renaissance) of any changes thereto. I understand that this application does not entitle me to participate in Renaissance’s Health Systems in Florida. By applying for appointment as a Renaissance Participating Provider, I authorize its Medical Director, and appropriate representatives to consult with administrators and members of medical staffs of hospitals and/or other institutions where I currently have or have had admitting privileges and others with which I have been associated with, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Renaissance Health its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Renaissance at other hospitals, that may be material to an evaluation of any professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for Participating Provider status with Renaissance. I hereby release Renaissance Health Systems of Florida, Inc. and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individual and organizations from any liability who provided information to Renaissance or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Primary Care Provider Agreement or Specialty Care Provider Agreement, as such terms may be applicable to me.

I understand that as an applicant for participation in Renaissance Health System of Florida, Inc., I have the right to review information obtained from primary verification sources during the credentialing process and I also have the right to request the status of my application at anytime either in writing or by phone. I further understand that upon notification from Renaissance, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee’s decision either in writing or by appearance before the Credentialing Committee, if they so request.

Practitioner Signature (REQUIRED)	Date (REQUIRED)



16. RELEASE OF INFORMATION

In order for Renaissance Health Systems of Florida, Inc. (RHS) to access and verify my education, professional qualifications and suitability for contract, I hereby authorize RHS to make inquiries and consult with all persons, places of employment and education, malpractice carriers, State licensing Boards and all other agencies who may have information bearing on my moral, ethical and professional qualifications and competence to carry out the contracted duties I have requested. I authorize release of all such information and copies of related records and/or documents to RHS.

I authorize RHS to disclose to such persons, employers, institutions, boards or other agencies any identifying information about me to efficiently enable RHS to make such appropriate inquiries.

I release from liability all those who provide information to RHS in good faith and without malice in response to such inquiries.

Signature

Date

Printed Name

Title

Phone Number



17. VERIFICATION OF PROFESSIONAL LIABILITY

By completing and signing this form, the undersigned physician agrees to authorize his current Professional Insurance Carrier to release verification and renewal of professional liability insurance to *Renaissance Health Systems*.

Renaissance Health Systems, is to hereinafter, as Certificate Holder, to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from coverage.

I will notify *Renaissance Health Systems* of any changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

Practitioner's Signature

Date

Printed Name

Enter Current Professional Liability Insurance Carrier Name

Policy Number

Enter Street Address

City

State & Zip