gracepoint

CREDENTIALING APPLICATION

IDENTIFYING INFORMATION	Last Name First Name Middle Initial		Date of Birth	
	Residence Address			Telephone
	Office Address			Telephone
	Language Spoken in Addition to English		Medicare No. (NPI)	
EDUCATION	College or University		Degree	Honors
	Address			Date of Graduation
MEDICAL EDUCATION	Medical School		Degree	Honors
	Address			Date of Graduation
INTERNSHIP	Name (Hospital, Clinic or Pharmacy) N/A			Dates
	Address City State Zip Code		Person Responsible For Performance:	
	Type of Internship	Special		
RESIDENCIES FELLOWSHIPS PRECEPTORSHIPS TEACHING APPOINTMENTS **LIST IN CHRONOLOGICAL ORDER. IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET.**	Facility (Full Name) N/A			
	Address			Dates
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairperson of Dept. etc.)		
	Facility (Full Name)			
	Address			Dates
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairperson of Dept. etc)		
	Facility (Full Name)			
	Address			Dates
	Type	Practitioner (s) Responsible for Performance (Chief of Staff, Chairperson of Dept. etc)		
CONTINUING MEDICAL EDUCATION	On separate sheet, list all post graduate activities that you have attended or for which you have received credit in the past twenty-four months.			
	Furnish a list of scientific papers or essays you have written and a list of scientific meetings you have attended during the previous three years (Include reprints). N/A			
AFFILIATIONS	List all present and previous affiliations with healthcare facilities and medical staff memberships for the past 10 years, in chronological order (Including Assistantships, Appointments, and Military Experience). Specify all departments in which privileges were exercised and nature and extent of such privileges.			
	Present Affiliation N/A			Dates
	Facility (Full Name)		Capacity	No. of Beds
	Street			Dates
	Facility (Full Name)		Capacity	No. of Beds
	Street			Dates

MEMBERSHIP IN PROFESSIONAL SOCIETIES

Are You A Member of the _____State Medical Association? ☐ Yes ☐ No
Do You Have an Application Pending? ☐ Yes ☐ No
Do You Intend to Apply? N/A ☐ Yes ☐ No

If A Member, Past or Present or Applicant to Other County, State or National Society, Give Name

FELLOWSHIP

American College of N/A	Date
American College of	Date
Member of American Academy of Family Practice? ☐ Yes ☐ No	Date
Fellowship in Other Specialty Colleges	

CERTIFICATION

Certified by American Board of (Name of Board) N/A		Date
Board Qualified (Name of Board)		Date
Specialty Board Status (Name of Board)	Are You Certified? ☐ Yes ☐ No	Date
If Not Certified, Give Present Status		

LICENSING

Medical License (Name of State)		Date Issued	Date Expired	License No.
Drug Enforcement Administration Renewal Date: ____/____/_____	License No.	Controlled Substance Administration(State specific) Renewal Date:		License No.
Other (Name of License, County and State)		Date Issued	Date Expired	License No.

LIABILITY INSURANCE

Enclose Certificate of Professional Liability Insurance Documenting Amount of Coverage and Expiration Date
N/A

Amount of Coverage	Insurance Carrier	Expiration Date
Policy No.	Agent (Name and Full Address)	
Prior Carriers		

If Either of the Following is Answered in the Affirmative, Provide Full Explanation on a Separate Sheet.
During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? Yes X No
Have you ever been denied Professional Liability Insurance? Yes X No

DISCIPLINARY ACTIONS

Have Any of the Following Ever Been or are Any Currently in the Process of Being Investigated, Denied, Revoked, Suspended, Reduced, Limited, Placed on Probation, Restricted, Not Renewed, or Relinquished, Either Voluntarily or Involuntarily? If Yes, Please Provide Full Explanation on a Separate Sheet.

1.	Professional License to practice in any State or County	Yes	X No
2.	License to prescribe in any State or County	Yes	X No
3.	DEA Registration	Yes	X No
4.	Other Professional Registration/License	Yes	X No
5.	Academic Appointment	Yes	X No
6.	Managed Care Organization, i.e., HMO, PPO, IPA, etc.	Yes	X No
7.	Membership on any hospital Medical Staff	Yes	X No
8.	Rights or prerogatives on any Medical Staff	Yes	X No
9.	Clinical Privileges	Yes	X No
10.	Other institutional affiliation or status	Yes	X No
11.	Professional Office	Yes	X No
12.	Professional society membership or fellowship/Board Certification	Yes	X No
13.	Are you presently taking medications or other substances that could impair your ability to provide patient care services for which you are seeking clinical privileges?	Yes	X No
14.	Have you ever discontinued practice for any reason (other than for routine vacation, formal education/training) for 30 days or more?	Yes	X No
15.	Have you now or ever been excluded, debarred or otherwise ineligible to participate in the Medicare, Medicaid or other State or Federal programs?	Yes	X No
16.	Have you ever been charged, arrested, or convicted of a criminal offense, other than traffic infractions? If yes, please provide full explanation on separate sheet, including resolution of charges.	Yes	X No
17.	Any other type of professional sanction, investigation, hearing, etc. If yes, please provide full explanation on separate sheet, including resolution of charges.	Yes	X No
18.	If circumstances change prior to your reappointment, such that your answers to questions in paragraph 15 and 16 above are no longer completely accurate, do you agree to notify Gracepoint immediately?	X Yes	No

DESCRIPTION OF PRACTICE	On a Separate Sheet, Give Narrative Summary of All Past And Present Medical Practice, Including Office, Clinic, Hospital and Military. (**Curriculum Vitae Acceptable**)	
PROFESSIONAL REFERENCES	Name two individuals who have personal knowledge of your current ability, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. None of the individuals should be related to you by family or professional partnership or financial association. (Requested source: Chief of Residency training program, department/service chief, practitioner in same specialty, administrators of prior hospitals.)	
	Name	Telephone 1
	Address	Telephone 2
	Name	Telephone 1
	Address	Telephone 2
CONSENT TO RELEASE EDUCATIONAL RECORDS	I, _____, hereby consent to the release by the institutions listed above and or National Student Clearing House the information concerning my educational records. I understand that such records may not be released without written authorization from me. I understand that by signing this form gives my permission to Gracepoint to the access to my records. Information released will only contain educational records; I understand that this policy will be explained to those persons requesting any educational information. I also understand at any time I have the right to terminate my consent to release information to Gracepoint. X _____ Date _____/_____/_____ (Employee Signature)	