STATE OF ILLINOIS

Section 965.APPENDIX A Uniform Health Care and Hospital Credentials Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans that desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: General and Practice Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments that contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

Any credentials data collected or obtained by the health care entity, health care plan, or hospital shall be confidential, as provided by law, and otherwise may not be redisclosed without written consent of the health care professional, except that in any proceeding to challenge credentialing or recredentialing, or in any judicial review, the claim of confidentiality shall not be invoked to deny a health care professional, health care entity, health care plan, or hospital access to or use of credentials data. Nothing in this subsection *prevents a health care entity, health care plan, or hospital from disclosing any credentials data to its officers, directors, employees, agents, subcontractors, medical staff members, any committee of the health care entity, health care plan, or hospital involved in the credentialing process, or accreditation bodies or licensing agencies. However, any redisclosure of credentials data contrary to this* subsection *is prohibited.* (Section 15(h) of the Act)

ATTACHMENTS

Attach Forms A-F as needed to support "yes" responses in the Professional History section and copies of the following:

- ☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed Per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certificates, as Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Uniform Health Care and Hospital Credentials Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature (or electronic signature)	Type or Print Name	Date

*****PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND** **HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION** **AND RELEASE OF INFORMATION.*****

PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree MD/DO/DC/PhD/MSW/DPM/DDS/DMD/Other

List other names by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

_____

Birth Date: _____ (mm/dd/yy) Place of Birth: _____
City State Country

Sex: Male ☐ Female ☐ Language Fluency of Applicant: English ☐ Other ☐ _____ Spanish ☐

U.S. Citizen? Yes ☐ No ☐

If "no", do you have a legal right to reside permanently and work in the U.S.? Ye ☐ No ☐

CONFIDENTIAL INFORMATION

Resident Visa No: _____
Medical Education Number: _____
Emergency Contact Person: _____
Last *First* *MI*
Telephone Number: ( ) _____

Mailing Address: _____ *Daytime Phone: ( )* _____

EMAIL Address: _____ *Fax Number: ( )* _____

Check here if you have appended additional information for this Section. ☐

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: _____ Unrestricted License? Yes ☐ N o ☐

If "no", please explain restriction(s) _____

Current and Previous Professional Licenses in Other States

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License? Yes ☐ No ☐

If "no", please explain restriction(s) _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License? Yes ☐ No ☐

If "no", please explain restriction(s) _____

State: _____ License # _____ Exp. Date: _____ (mm/dd/yy)

Unrestricted License? Yes ☐ No ☐

If "no", please explain restriction(s) _____

Check here if you have appended additional information for this section. ☐

Current Federal DEA License Number: _____ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: _____ (mm/dd/yy)

Unrestricted License? Yes ☐ No ☐

If "no", please explain restriction(s) _____

Check here if you have appended additional information for this section. ☐

Current and Previous State Controlled Substance Numbers:

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

Please identify all limitations related to the above Controlled Substances Numbers and explain limitations:

_____

_____

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification:

State: _____ Certificate #: _____ Expiration Date: _____ (mm/dd/yy)

Check here if you have appended additional information for this section. ☐

COMPLETE FOR EACH SPECIALTY

Specialty/Subspecialty I: _____

Are you Board Certified in Specialty I: Yes ☐ No ☐

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled to take the Specialty Boards Certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy)

Certification Expiration Date, If Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty II? Yes ☐ No ☐

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled to take the Specialty Boards Certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy)

Certification Expiration Date, If Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty III: _____

Are you Board Certified in Specialty III? Yes ☐ No ☐

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled to take the Specialty Boards Certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy)

Certification Expiration Date, If Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty IV: _____

Are you Board Certified in Specialty IV? Yes ☐ No ☐

If "yes", name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If "no", have you taken or are you scheduled to take the Specialty Boards Certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy)

Certification Expiration Date, If Any: _____

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Check here if you have appended additional information for this section. ☐

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? Claims Made ☐ Occurrence ☐

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

Yes ☐ No ☐

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? Claims Made ☐ Occurrence ☐

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

Yes ☐ No ☐

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? Claims Made ☐ Occurrence ☐

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

Yes ☐ No ☐

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number (last 4 digits): _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? Claims Made ☐ Occurrence ☐

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

Yes ☐ No ☐

Check here if you have appended additional information for this section. ☐

PROFESSIONAL LIABILITY ACTIONS

If you answer "yes" to any questions in this section, please complete FORM B. Please make copies of FORM B, if needed, and complete one for each "yes" answer.

1. Have any professional liability judgements ever been entered against you? Yes ☐ No ☐
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? Yes ☐ No ☐
3. Are there any currently pending professional liability suits, actions, and/or claims filed against you? Yes ☐ No ☐

LIABILITY INSURANCE

If you answer "yes" to this question, please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, had your professional liability insurance coverage canceled or non- renewed, or had limits reduced? Yes ☐ No ☐

SECTION D. EDUCATION AND TRAINING

If you have separated from a clinical training program prior to its conclusion, explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: _____

Address 1: _____
Street City State Zip

Address 2: _____
Region Country

Telephone Number: ( ) _____ Email: _____

Degree: _____ Year Graduated: _____

Dates attended: From: _____ (mm/yy) To: _____ (mm/yy)

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? Yes ☐ No ☐

Date Issued: _____ Serial Number for ECFMG: _____

Were you the subject of any disciplinary action during your time at this institution? Yes ☐ No ☐
(Attach an explanation of a "yes" answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐

INTERNSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Dates attended: From: _____ (mm/yy) To: _____ (mm/yy)

Type of internship: Rotating ☐ Straight ☐

If straight, please list specialty: _____

Did you successfully complete this program? Yes ☐ No ☐ If "no", please attach an explanation.

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

Were you the subject of any disciplinary action during your time at this institution? Yes ☐ No ☐
(Attach an explanation of a "yes" answer.)

FIRST RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: (____) _____ Email: _____

Dates Attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of residency: _____

Did you successfully complete this program? Yes ☐ No ☐ If "no", please attach an explanation

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

SECOND RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: (____) _____ Email: _____

Dates attended: From _____ To: _____
(mm/yy) (mm/yy)

Type of residency: _____

Did you successfully complete this program? Yes ☐ No ☐ If "no", please attach an explanation

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

FIRST FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of fellowship: _____

Did you successfully complete this program? Yes ☐ No ☐ If "no", please attach an explanation

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

SECOND FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Dates attended: From: _____ To: _____
(mm/yy) (mm/yy)

Type of fellowship: _____

Did you successfully complete this program? Yes ☐ No ☐ If "no", please attach an explanation

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Dates: From: _____ (mm/yy) To: _____ (mm/yy) Rank/Position, if applicable: _____

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: _____

Department Chair or Program Director: _____
Last First MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Dates: From: _____ (mm/yy) To: _____ (mm/yy) Rank/Position, if applicable: _____

Were you the subject of any disciplinary action during your time at this institution?
Yes ☐ No ☐ (Attach an explanation of a "yes" answer.)

If more than two teaching experiences/faculty appointments, check here and attach additional information that duplicates the information above: ☐

MEMBERSHIP STATUS – USE FOR SECTIONS E, F AND G

Please use the following key to indicate Membership Status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgical Treatment Center Practice) below:

A. Active	E. Suspended/Terminated/Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct E	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP – CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: From: _____ To Present
(mm/yy)

Department/Division: _____

Department Telephone #: (___) _____

Medical Staff Office Email: _____

Any limitations in your area of specialty at this hospital?

_____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: From: _____ To Present
(mm/yy)

Department/Division: _____

Department Telephone #: (___) _____

Medical Staff Office Email: _____

Any limitations in your area of specialty at this hospital?

_____

C. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: From: _____ To Present
(mm/yy)

Department/Division: _____

Department Telephone #: ( ) _____

Medical Staff Office Email: _____

Any limitations in your area of specialty at this hospital?

_____

Check here if you have appended additional information for this section. ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

1. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____

Department Telephone #: ( ) _____

Medical Staff Office Email: _____

2. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____

Department Telephone #: ( ) _____

Medical Staff Office Email: _____

3. Hospital Name _____

Address: _____
Street City State Zip

Membership Status (see above): _____ Dates: _____
From (mm/yy) To (mm/yy)

Department/Division: _____

Department Telephone #: ( ) _____

Medical Staff Office Email: _____

Check here if you have appended additional information for this section: ☐

SECTION G. AMBULATORY SURGICAL TREATMENT CENTER PRACTICE

Please list all ambulatory surgical treatment centers where you currently have clinical privileges. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three ASTCs.)

A. Primary Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email: _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email: _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgical Treatment Center

ASTC Name: _____

Address: _____
Street City State Zip

Email: _____ Telephone #: ( ) _____

Membership Status (see above): _____ Dates: _____ _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section: ☐

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self- employment, service as an independent contractor, and military service) in the past 4 years. Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current workplace: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Title or Professional Occupation: _____

Time in this employment: From: _____ **To Present**
(mm/yy)

Previous workplace: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Previous workplace: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: (   ) ______________ Email: ______________

Title or Professional Occupation: ______________________________

Time in this employment: From: ______________ To: ______________
(mm/yy) (mm/yy)

Previous workplace: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: (   ) ______________ Email: ______________

Title or Professional Occupation: ______________________________

Time in this employment: From: ______________ To: ______________
(mm/yy) (mm/yy)

Previous workplace: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: (   ) ______________ Email: ______________

Title or Professional Occupation: ______________________________

Time in this employment: From: ______________ To: ______________
(mm/yy) (mm/yy)

Previous workplace: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: (   ) ______________ Email: ______________

Title or Professional Occupation: ______________________________

Time in this employment: From: ______________ To: ______________
(mm/yy) (mm/yy)

Previous workplace: _____

Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Title or Professional Occupation: _____

Time in this employment: From: _____ To: _____
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section. ☐

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge of your current clinical abilities, ethical character, and interpersonal skills, preferably including at least one person with whom you have worked in the last 12 months, and who would be willing to provide this information upon request. If you list partners, relatives, or department chairpersons, please identify their relationship to you.

CONFIDENTIAL INFORMATION

1. Name _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Relationship: _____ Years Known: _____

2. Name _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Relationship: _____ Years Known: _____

3. Name _____ Title: _____
Last First MI Degree

Specialty: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Email: _____

Relationship: _____ Years Known: _____

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no". If you answer "yes" to any questions, please complete FORM A. Please make copies of FORM A as needed and complete one form for each "yes" answer.

ADVERSE OR OTHER ACTIONS

1.	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation, either voluntarily or involuntarily, or has your application for a license ever been withdrawn?	Yes ☐	No ☐
2.	Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency that licenses providers?	Yes ☐	No ☐
3.	Have you ever had your board certification rescinded or elected not to recertify, and/or failed to recertify?	Yes ☐	No ☐
4.	Have you ever been examined by a Certifying Board but failed to pass?	Yes ☐	No ☐
5.	Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	Yes ☐	No ☐
6.	Has your federal DEA number and/or state associated Controlled Substances License been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	Yes ☐	No ☐
7.	Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied, or has probation ever been imposed?	Yes ☐	No ☐
8.	Has your membership at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, not renewed, denied, or has probation even been imposed?	Yes ☐	No ☐
9.	Has your medical staff membership at any hospital or healthcare institution ever been voluntarily or involuntarily terminated?	Yes ☐	No ☐
10.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ASTC privileges and/or your license?	Yes ☐	No ☐

11.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating in Medicare, Medicaid, CHAMPUS and/or any other governmental health- related programs, or voluntarily withdrawn to avoid an investigation relating to those programs?	Yes ☐	No ☐
12.	Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-party payors, brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	Yes ☐	No ☐
13.	Have you ever withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	Yes ☐	No ☐
14.	Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation order, not renewed, denied renewal, or has probation ever been imposed?	Yes ☐	No ☐
15.	Were you the subject of any disciplinary action(s) during your attendance at any academic or training institution, either during any formal education, training, or faculty appointments?	Yes ☐	No ☐

CRIMINAL ACTIONS

If you answer "yes" to any questions in this section, please complete FORM D. Please make copies of FORM D, if needed, and complete one for each "yes" answer.

1.	Have you ever been charged with or convicted of a felony or misdemeanor (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this State or any other state or country?	Yes ☐	No ☐
2.	Have you ever been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	Yes ☐	No ☐

MEDICAL CONDITION

If you answer "yes" to this question, please complete FORM E.

	Do you currently have a physical illness or mental illness or disability that results in your inability to practice medicine with reasonable judgement, skill, and safety? (See Medical Practice Act – 225 ILCS 60/22(a))	Yes ☐	No ☐

CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER

If you answer "yes" to any questions in this section, please complete FORM F. Please make copies of FORM F, if needed, and complete one for each "yes" answer.

1.	Do you currently overuse and/or abuse alcohol or any controlled substances?	Yes ☐	No ☐
2.	If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?	Yes ☐	No ☐
3.	Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance use disorder?	Yes ☐	No ☐

INVESTMENTS

Apart from employment, in the last 5 years have you and/or a member of your family ever purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgical center, and/or other business dealing with the provision of ancillary health services, equipment or supplies?

Yes ☐ No ☐

If "yes", please provide explanation: _____

_____

_____

_____

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site Group/Business Name _____

Building Name _____

Office Address _____
Number Street Suite / Apt.

_____
City County State Zip

Office Administrator _____
Last First MI

E-Mail _____

( ) _____ ( ) _____
Main Telephone Number Fax Number

( ) _____ ( ) _____
Emergency Number Answering Service

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)?
Yes ☐ No ☐ **If "yes"**, describe the restrictions: _____

_____

Briefly describe your practice at this location, including any special practice focus or equipment: _____

_____

Are you currently accepting new patients at this location? Yes ☐ No ☐

If "yes", describe any restrictions (e.g., appointment type, patient type):

_____

_____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year: _____

Please provide the business hours, including days of the week and hours of operation:

_____

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventative Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour:	
Average Waiting Time in Office: (from scheduled appointment time to actual examination)	
Average Response Time for Returning Patient Calls:	
Acute or Urgent Situation	
Emergency Situation	
Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic/chiropractic manipulation	☐ IV hydration/ treatment	☐ Physical therapy
☐ Acupuncture	☐ Pathology	

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible? (check all that apply)

Building ☐ Parking ☐ Wheelchair ☐ Restroom ☐

Does this site employ paraprofessionals for direct patient care? Yes ☐ No ☐

If "yes", is supervision always provided on premises during paraprofessional's direct patient care?

Yes ☐ No ☐

Do the paraprofessionals bill under any of your Tax ID Numbers? Yes ☐ No ☐

CONFIDENTIAL INFORMATION: If "yes", list Tax ID Numbers used:

_____ _____ _____ _____

Lab service at this site Yes ☐ No ☐

If "yes", check whether: Primary ☐ Secondary ☐ Tertiary ☐

CLIA Waiver: Yes ☐ No ☐

If "yes", CLIA Expiration Date: _____

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Please provide the following information about physicians/practitioners who practice in this office:

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #2

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #3

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #4

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice. If there is more than one additional site, copy and complete this section for each additional site.

Site

Group/Business Name _____

Building Name _____

_____
Office Address – Number and Street – Suite

_____
City County State Zip

Office Administrator _____
Last First MI

E-Mail _____

( ) _____ ( ) _____
Main Telephone Number Fax Number

( ) _____ ( ) _____
Emergency Number Answering Service

Specialty practiced at this site: _____

Is your practice restricted within your specialty (e.g., by age or type of patient)?

Yes ☐ No ☐ **If "yes"**, describe the restrictions:_____

_____

Briefly describe your practice at this location, including any special practice focus or equipment:

_____

_____

Are you currently accepting new patients at this location? Yes ☐ No ☐

If "yes", describe any restrictions (e.g., appointment type, patient type):

_____

_____

Please provide the number of active patients enrolled with you at this site: _____

Please provide the number of patient visits you have at this site per year? _____

Please provide the business hours, including days of the week and hours of operation:

_____

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventative Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour:	
Average Waiting Time in Office: (from scheduled appointment time to actual examination)	
Average Response Time for Returning Patient Calls:	
Acute or Urgent Situation	
Emergency Situation	
Routine Call:	

Please check all procedures you perform at this site:

- ☐ Age-appropriate immunizations
- ☐ Tympanometry/audiometry screening
- ☐ Pulmonary function studies
- ☐ Office gynecology (routine pelvic/PAP)
- ☐ Osteopathic/chiropractic manipulation
- ☐ Acupuncture
- ☐ EKG
- ☐ X-rays
- ☐ Flexible sigmoidoscopy
- ☐ Asthma treatment
- ☐ IV hydration/ treatment
- ☐ Pathology
- ☐ Drawing blood
- ☐ Minor surgery
- ☐ Laceration repair
- ☐ Allergy skin testing
- ☐ Physical therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible? (check all that apply)

- ☐ Building
- ☐ Parking
- ☐ Wheelchair
- ☐ Restroom

Does this site employ paraprofessionals for direct patient care? Yes ☐ No ☐

If "yes", is supervision always provided on premises during paraprofessional's direct patient care?
Yes ☐ No ☐

Do the paraprofessionals bill under any of your Tax ID Numbers? Yes ☐ No ☐

CONFIDENTIAL INFORMATION: If "yes", list Tax ID Numbers used:

_____ _____ _____ _____

Lab service at this site: Yes ☐ No ☐

If "yes", check whether:

- ☐ Primary
- ☐ Secondary
- ☐ Tetiary

CLIA Waiver: Yes ☐ No ☐

If "yes", CLIA Expiration Date: _____

Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ______________________________ Telephone: (   ) ________
Street City State Zip

Availability: Days ☐ Nights ☐ Weekends ☐ Holidays ☐

CONFIDENTIAL INFORMATION: Tax ID#: ____________________

Please provide the following information about physicians/practitioners who practice in this office:

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

Name: _____ Specialty: _____
Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site or more than 5 business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1 **Site #:** _____

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #2 **Site #:** _____

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #3 **Site #:** _____

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

Business Arrangement #4 **Site #:** _____

Name of Business Arrangement on SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: ( ) _____

End Uniform Health Care and Hospital Credentials Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name:

_____

Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes":

Question Number: _____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

_____

_____

_____

_____

_____

B. Provide an explanation of any actions taken. Please include the date the action was taken.

_____

_____

_____

_____

_____

C. Provide the current status of the issue.

_____

_____

_____

_____

_____

D. If known: Contact: _____

Department/Committee: _____

Address: _____

Street City State Zip

Telephone Number: ( ) _____

Signature: _____ **Date:** _____

(or electronic signature)

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, State/jurisdiction, Case Name & Case Number: _____

_____

B. Your Involvement in the Care (Attending, Consulting, Etc.): _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Named in Suit, Etc.)

_____

D. Allegations, including Patient Outcome, If Available:

_____

_____

_____

E. Date of Incident (mm/yy) _____ F. Date Filed (mm/yy) _____

G. Date Case Closed (mm/yy): _____

Case Resolution:

☐ Dismissed ☐ Judgement ☐ Arbitration ☐ Other

☐ Settlement Out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $ _____

I. Professional Liability Insurer Name (if one was involved): _____

J. Insurer Telephone Number: ( ) _____

K. Policy Number: _____

L. Insurer Address: _____
Street City State Zip Code

Signature: _____ **Date:** _____
(or electronic signature)

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. **History of Professional Liability Insurance (Please Check One)**

☐ Cancelled Voluntarily ☐ Non-Renewed
☐ Cancelled Involuntarily ☐ Application Denied

B. Carrier Name: _____

C. Carrier Telephone Number: (____) _____

D. Policy Number (last 4 digits): _____

E. Carrier Address: _____
Street City State Zip

F. Dates of Coverage: From (mm/yy): _____ To (mm/yy): _____

G. Circumstances Involved: _____

_____

Signature (or electronic signature)**:** _____ **Date:** _____

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

_____

E. Allegations: _____

_____

_____

_____

F. Details of Incident: _____

_____

_____

_____

G. Actions Taken Against You: _____

_____

_____

_____

H. Current Status of Situation: _____

_____

_____

_____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

_____

_____

_____

Signature (or electronic signature)**:** _____ **Date:** _____

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

_____

_____

_____

_____

B. To what extent does this current condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

_____

C. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name **Telephone Number**

_____ (____) _____
Last First MI Degree

_____ (____) _____
Last First MI Degree

Signature (or electronic signature)**:** _____ **Date:** _____

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER

DUPLICATE this from as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Describe the substance(s) you use: _____

A. To what extent does, or could, your use of this (these) substance(s) affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

B. Monitored by State Board Mandate (Name and Address)

_____

_____

C. Monitored Voluntarily (Name and Address)

_____

_____

D. Other information about the current status of your use of substances:

_____

E. Abstinent since (mm/yy): _____

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance(s) use and can comment on what impact (if any) it has on your current/future professional practice. Please attach additional pages if more than one provider needs to be listed.

Name: _____
Last First MI Degree

Address: _____
Street City State Zip

Telephone Number: (_____) _____

Signature (or electronic signature)**:** _____ **Date:** _____

(Source: Amended at 48 Ill. Reg. 12398, effective August 1, 2024)