Introduction

Form Approved
OMB No. 0917-0009
Exp. Date 02/29/2020

Welcome to Indian Health Service

The Federal Health Program for American Indians/Alaska Natives

Our Mission: The overall mission of the Indian Health Service is to raise the physical, mental, and social and spiritual health of American Indian and Alaska Natives (AI/AN) to the highest level.

Our Goal: To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians & Alaska Native people.

Information and Tips For Completing Your Application

*Items in Red are mandatory fields and must be completed to finish the application. At any point in the application, you may click **Save** and return to the application at a later time. The blue toolbar at the top right provides additional help.*

- **Packet Documents** included on the previous screen before starting this application are **MANDATORY** and need to be viewed and/or filled out and uploaded into the **Files** section on this application.
- **The Head Icon** at the top right allows you to change/reset your password and authorize account access to your chosen delegate.
- **Help Icon** provides support if you encounter difficulties with the application.
- **Return To Your Application** after completion where you will have the opportunity to download, view and print your completed application and supporting documents at the main page after logging in.

INSTRUCTIONS: Please fill out all **REQUIRED** fields marked in **Red** and fill out all other information where applicable.

UPLOADING DOCUMENTS: Completed documents and forms may be uploaded to the application in the **Files** section. If you are unable to upload the documents and forms, please contact the Medical Staff Credentialing Coordinator for other delivery methods.

LENGTHY RESPONSES: Each comment/note field in this application has a limit of two lines of text data. If you need to submit a lengthy response that is more than two lines, please type your response in Word or PDF format and upload that document in the files section within the application.

ATTENTION: Misrepresentations, inaccuracies, or falsification of information can be grounds for termination of Medical Staff appointment and associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank.

REMINDERS: Incomplete submissions will not be accepted and will delay the processing of your application. To accelerate the processing of your submission, please ensure you provide a completed application with all requested documents and forms.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0009. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Services, OMS/DRPC, 5600 Fishers Lane, 09E70, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

Personal Information 0 of 1 Required

Provider's Application for Reappointment. Please review your information to ensure accuracy. Please make changes to anything that needs to be updated.

Mandatory fields are in **Red**.

Click **Edit** to modify this section and **Save** to save the information entered and navigate forward or backward in the application.

Last Name		Birth Place	
First Name		Citizenship	
Middle Name		Ethnicity	
Suffix		Emergency Contact Name	
Degree	▾	Emergency Contact Phone	
Salutation		Pager	
Preferred Name		Answering Service	
Birth Date	MM/DD/YYYY	Cell	
SSN		E-Mail	
Gender	▾	NPI	
Specialty 1	▾	Medicare	
Specialty 2	▾	Medicaid	
Language 1	▾	Preferred Contact Method	
Language 2	▾		

✖ Save ⊘ Cancel

Addresses 0 of 1 Required

Please review your home and office address, make any updates as necessary.

Mandatory fields are in Red.

Additional office addresses may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Address*

Type: Home

Address1

Address 2

City

State

Postal Code

County

Country

Telephone

Fax

E-Mail

Save | Cancel

Add New

Alias/Other Names Used

Since your LAST appointment, list any new aliases or other names used.

Additional aliases may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Alias*

AliasType

Last Name

First Name

Middle Name

Save | Cancel

Add New

Education / Training

Since LAST appointment, please list any NEW education and/or training.

Begin by selecting the type of training you received (Medical Education, Internship, Residency, Fellowship).

Mandatory fields are in **Red**. If you do not know the exact day please ensure that month and year are correct.

If you are entering an Internship, please enter if it was "Rotating" or "Straight" in the "Subject" box. If entering "Straight" please also include discipline.

If you are entering a Residency or Fellowship, please enter your program in the "Subject" box.

Additional Education may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Education*

Type	▾	Telephone	
Search	Enter Name or City to search	Fax	
Name		Email	
Address		Website	
Address 2		Start Date	MM/DD/YYYY
City		End Date	MM/DD/YYYY
State	▾	Degree Earned	▾
Postal Code		Subject	
		Did you successfully complete this program? If no, please explain in the explanation section	
		Were you the subject of any disciplinary action during your attendance at this institution?	▾
		If yes, please explain	

✖ Save | ⊘ Cancel

Add New

Hospital Affiliations

Please list all NEW/UPDATED hospital practice history that has occurred since LAST appointment.

Mandatory fields are in Red.

New Hospital*

Search: Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

County

Telephone

Fax

Email

Website

Start Date: MM/DD/YYYY

End Date: MM/DD/YYYY

Specialty

Relationship

Supervisor

Reason For Leaving

Were you the subject of any disciplinary action during your attendance at this institution?

If yes, please explain

Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)

Save | Cancel

Add New

Work History

Please list all NEW/UPDATED practice history that has occurred since LAST appointment, including employment, teaching, military assignments and government agencies.

DO NOT duplicate affiliations listed in the Hospital Affiliations Section.

Mandatory fields are in Red.

Additional Work History may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Work History*

Type

Search: Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

County

Country

Telephone

Fax

Email

Website

Start Date: MM/DD/YYYY

End Date: MM/DD/YYYY

Position

Relationship

Supervisor

Reason for leaving

Were you the subject of any disciplinary action during your attendance at this institution?

If yes, please explain

Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)

Save | Cancel

Add New

Gaps

Since last appointment, please explain any periods or gaps longer than sixty (60) days in duration.

Additional Gaps may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

Mandatory fields are in Red.

New Gap*

Start Date MM/DD/YYYY

End Date MM/DD/YYYY

Explanation

✖ Save ⊘ Cancel

Add New

Peer Professional References 0 of 3 Required

Please list names and contact information of at least three (3) individuals who are of the same discipline or profession who have personal knowledge (within the last 12 months) of your current clinical abilities, ethical character, and interpersonal skills.

For those in training, one reference must be from the Director of the training program.

For all other applicants, one must be from the Chief of Staff or Departmental Chairperson from each hospital, where the applicant is on the active clinical staff.

Please note that some facilities may require additional peer references, although it is not set to required, we may be reaching out to you to obtain additional peer references.

Mandatory fields are in Red.

Additional Peer References may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Peer Reference*

First Name

Last Name

Degree

Address

Address 2

City

State

Postal Code

YearsKnow

Telephone

Fax

E-Mail

Relationship

Specialty

✖ Save ⊘ Cancel

Add New

Licenses / Credentials

Since your **last appointment**, please provide any updates to your licenses and credentials. Begin by selecting the type. Please NOTE that all the follow credentials listed below are required to be current at the time of reappointment.

Please note that other credentials may be required by the facility in which you are applying.

1. All active and inactive licenses
2. DEA license
3. CMEs (including the IHS Opioid Prescriber Training)
4. Life Support Certifications (BLS, ACLS, ATLS, NRP, PALS, etc...)
5. Current CV
6. ECFMG (if applicable)
7. State CDS license (if applicable)

Mandatory fields are in **Red**.

New Credential*

Type

Name

Address

Address 2

Address 3

City

State

Postal Code

County

Country

Telephone

Fax

Email

Website

License Number

Issue Date MM/DD/YYYY

Expiration Date MM/DD/YYYY

State

Limitations ☐

Comments

✖ Save ⊘ Cancel

Add New

Board Certifications

Since last appointment, please list any new Board Certifications and/or renewals.

Mandatory fields are in Red.

New Board Certification*

Field	Value	Field	Value
Search	Enter Name or City to search	Certification Status	▾
Name		Status	
Address		Certificate Number	
Address 2		InitialCertification	MM/DD/YYYY
Address 3		Recertification	MM/DD/YYYY
City		Certification Expires	MM/DD/YYYY
State	▾	Exam Date	MM/DD/YYYY
Postal Code		Specialty	▾
County		Specialization	▾
Country		Explanation	
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

Add New

Medical Societies

Please list any current or previous medical society affiliations.

Mandatory fields are in Red.

Additional Medical Societies may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Society*

Search	Enter Name or City to search	Start Date	MM/DD/YYYY
Name		End Date	MM/DD/YYYY
Address		Title	
Address 2			
City			
State	▾		
Postal Code			
County			
Country			
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

Add New

Malpractice Coverage

Since last appointment, please list any new medical malpractice coverage.

Malpractice Coverage

Field		Field	
Search	Enter Name or City to search	Policy Number	
Name		Issued Date	MM/DD/YYYY
Address		Expiration Date	MM/DD/YYYY
Address 2		Retroactive Date	MM/DD/YYYY
City		Coverage	
State	▾	Terms	
Postal Code			
County			
Country			
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

Add New

Malpractice Claims

Since last appointment, please list any current or previous lawsuits or complaints against you. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response if requested. Please note that the Notes section is limited to 300 characters; if your response is more than 300 characters please upload the information as a MS Word or PDF document in the Files section. If status is "Judgement for Plaintiff" or "Settled," please put the amount in the amount field.

Mandatory fields are in Red.

Additional Malpractice Claims may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Malpractice Claim*

Field	Value
IncidentDate	MM/DD/YYYY
DateFiled	MM/DD/YYYY
DateClosed	MM/DD/YYYY
Amount	
Type	
Status	
Notes	
History	
Allegation	
Status Comments	

Field	Value
Search	Enter Name or City to search
Insurance Name	
Policy Number	
InsuranceAddress	
InsuranceAddress2	
InsuranceCity	
InsuranceState	
InsurancePostalCode	
InsuranceCountry	
InsuranceTelephone	
InsuranceFax	
Search	Enter Name or City to search
Hospital Name	
HospitalAddress	
HospitalAddress2	
HospitalCity	
HospitalState	
HospitalPostalCode	
HospitalCountry	
HospitalTelephone	
HospitalFax	

✖ Save ⊘ Cancel

Add New

Files

Please upload the following required documents for your reappointment:

1. Current CMEs
2. Signed and dated Statement of Understanding & Release
3. Signed, dated and confirmed Health Statement by applicant and personal physician

Please upload the following, if applicable:

1. IHS Opioid Prescriber Training Certificate (if renewed since your last appointment)
2. Copies of Life Support Certifications (if renewed since your last appointment)
3. Any new claims information since your last appointment (if applicable)
4. Current Curriculum Vitae or Resume (if any new affiliations since your last appointment)
5. Application Approval Signature Page (if in the download section or provided to you by email)
6. Delineation of Privileges and Privilege Signature Page (if in the download section or provided to you be email)
7. Any other documents in the download section or provided to you by email.

If you answered "yes" to any questions, please upload an explanation.

In order to upload an item, it must be saved in a digital format on your computer (pdf, jpg, etc.). If unable to perform this function, please contact the MD-Staff Support at 1-800-736-7276 or the Medical Staff Office.

Mandatory fields are in Red.

To upload:

1. Select *Add New**.
2. Select a **File Type**
3. Enter a **Description** (Optional)
4. Enter an **Expiration Date** (Optional)
5. Click **"Click To Upload"** and Browse To Your File.
6. Click Save to complete the upload

Additional Files may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New File*

FileType		FileDescription	
Expiration Date	MM/DD/YYYY	Upload File	Click to Upload

Save Cancel

Add New

Attestation Questions

Since your last appointment, please answer **ALL** attestation questions. IF you answer "yes" to any questions, please upload an explanation in the Files section of this application.

Yes	No	Question
○ Yes	○ No	Has any disciplinary actions or investigations been initiated against you by any state licensure board?
○ Yes	○ No	Have you been reprimanded and/or fined, by any local, state, or federal agency that licenses providers?
○ Yes	○ No	Have you been the subject of a complaint or have you been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal that licenses providers?
○ Yes	○ No	Have you been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society or regulatory agency?
○ Yes	○ No	Have Medicare, Medicaid, Tri-Care, PRO authorities, and/or any other third party payers brought charges against you for alleged inappropriate fees, and/or quality of care issues?
○ Yes	○ No	Has your federal DEA number and/or state controlled substance license been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily?
○ Yes	○ No	Have you 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	Have liability claims, judgements or settlements been made against a hospital, corporation, or the United States Government in professional liability suits based on a case with which you were professionally associated? (if yes, you are required to note the final judgement and settlements involving yourself as a practitioner in the malpractice claims section of this application.)
○ Yes	○ No	Do you have, or has it been suggested to you that you have, a diagnosed or undiagnosed chemical dependency (i.e. alcohol, illegal drugs, prescriptive drugs, etc)?
○ Yes	○ No	Do you have, or has it been suggested to you that you have, a history including that the present, of any physical, mental, or emotional impairment either you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership and which could require an accommodation for you to exercise your clinical privileges and clinical staff duties completely and safely? (if yes, please describe the accommodation needed on the Health Statement.)
○ Yes	○ No	Are you currently engaged in illegal use of any legal or illegal substances?
○ Yes	○ No	Are you currently participating in a supervised rehabilitation program and/or professional assistance program, which monitor you for alcohol and/or substance abuse.
○ Yes	○ No	Has it been more than 12 months since you have provided patient care? (in a professional setting)
○ Yes	○ No	Have you been charged with or convicted of a crime (other than a minor traffic offense) in any state or country?
○ Yes	○ No	Has your license to practice in any jurisdiction been, or attempted to have been, denied, restricted, limited, suspended, revoked, or canceled?
○ Yes	○ No	Has your license been subjected to probation either voluntarily or involuntarily?
○ Yes	○ No	Has your license been withdrawn either voluntarily or involuntarily?
○ Yes	○ No	Have you been the subject of an informal or formal hearing process at any healthcare organization?

○ Yes	○ No	Have you been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization (e.g., hospital, HMO, PPA, IPA), professional group or society, licensing board, certification board, PSRO or PRO?
○ Yes	○ No	Has your employment and or clinical privileges at any hospital, clinic, or other health care setting been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?
○ Yes	○ No	Have you voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges before a hospital or health facility's governing board made a decision?
○ Yes	○ No	Have you been reprimanded, censured, excluded, suspended, and/or disqualified from participating in voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, Tri-Care, and/or any other governmental health related programs?
○ Yes	○ No	Have you had any claims for professional negligence asserted against you? (if yes you are required to note the final judgement and settlements involving yourself as a practitioner. Include date, amount of settlement in the malpractice claims section of this application.)
○ Yes	○ No	Have you been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse?
○ Yes	○ No	Have you withdrawn from or been suspended, dismissed or expelled from a professional school or postgraduate training program, or has any third party attempted to have you withdrawn, suspended, dismissed, or expelled from a professional school or postgraduate training program?
○ Yes	○ No	Has any information pertained to you, including malpractice judgments and/or disciplinary action been reported to the National Practitioner Data bank or any other practitioner data bank?
○ Yes	○ No	Have you been placed on probation or taken a leave of absence from a medical, dental, or graduate school or post gradate training program?
○ Yes	○ No	Have you had professional liability coverage denied, refused or canceled?

Certification of Professional Licenses

○ Yes	○ No	I also certify, as required by the false statements provisions of the Program Fraud Civil Remedies Act of 1986, 45 Code of Federal Regulations (CFR) 79, that to the best of my knowledge, each of the above statements are true, accurate, and do not omit any material or facts which would render the statement false, fictitious, or fraudulent as a result of omission.
○ Yes	○ No	I certify that my professional licenses and certifications (nurse, medical, dental, or other health profession) have not been terminated, suspended, or revoked in any state, the District of Columbia, or Puerto Rico.
○ Yes	○ No	I certify that I have listed all active and inactive state medical licenses on this application.

Privileges

Please review and request any privileges that you may be requesting by clicking on the check-box that is next to the appropriate privilege. If you have cases to provide, please include them. You may also include more details in the **Comments** section.

Review Application

Please enter your complete and legal name to indicate that you certify that to the best of your knowledge, that all information provided on this application are true, accurate, and you have not omitted any material or facts which would render the statement false, fictitious, or fraudulent as a result of omission.