

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	<input type="text"/>	Birth Place	<input type="text"/>
First Name	<input type="text"/>	Citizenship	<input type="text"/>
Middle Name	<input type="text"/>	Ethnicity	<input type="text"/>
Suffix	<input type="text"/>	Emergency Contact Name	<input type="text"/>
Degree	<input type="text"/>	Emergency Contact Phone	<input type="text"/>
Salutation	<input type="text"/>	Pager	<input type="text"/>
Preferred Name	<input type="text"/>	Answering Service	<input type="text"/>
Birth Date	<input type="text" value="MM/DD/YYYY"/>	Cell	<input type="text"/>
SSN	<input type="text"/>	E-Mail	<input type="text"/>
Gender	<input type="text"/>	NPI	<input type="text"/>
Specialty 1	<input type="text"/>	Medicare	<input type="text"/>
Specialty 2	<input type="text"/>	Medicaid	<input type="text"/>
Language 1	<input type="text"/>	Preferred Contact Method	<input type="text"/>
Language 2	<input type="text"/>		

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	<input type="text" value="Home"/>	Country	<input type="text"/>
Address1	<input type="text"/>	Telephone	<input type="text"/>
Address 2	<input type="text"/>	Fax	<input type="text"/>
City	<input type="text"/>	E-Mail	<input type="text"/>
State	<input type="text"/>		
Postal Code	<input type="text"/>		
County	<input type="text"/>		

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	<input type="text"/>
Last Name	<input type="text"/>
First Name	<input type="text"/>
Middle Name	<input type="text"/>

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

Hospital Affiliations

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

Mandatory fields are in **Red**.

New Hospital*

Search	<input type="text" value="Enter Name or City to search"/>	Start Date	<input type="text" value="MM/DD/YYYY"/>
Name	<input type="text"/>	End Date	<input type="text" value="MM/DD/YYYY"/>
Address	<input type="text"/>	Specialty	<input type="text" value=""/>
Address 2	<input type="text"/>	Relationship	<input type="text"/>
City	<input type="text"/>	Supervisor	<input type="text"/>
State	<input type="text" value=""/>	Reason For Leaving	<input type="text"/>
Postal Code	<input type="text"/>	Were you the subject of any disciplinary action during your attendance at this institution?	<input type="text" value=""/>
County	<input type="text"/>	If yes, please explain	<input type="text"/>
Telephone	<input type="text"/>	Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)	<input type="text"/>
Fax	<input type="text"/>		
Email	<input type="text"/>		
Website	<input type="text"/>		

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	<input type="text"/>	Start Date	<input type="text" value="MM/DD/YYYY"/>
Search	<input type="text" value="Enter Name or City to search"/>	End Date	<input type="text" value="MM/DD/YYYY"/>
Name	<input type="text"/>	Position	<input type="text"/>
Address	<input type="text"/>	Relationship	<input type="text"/>
Address 2	<input type="text"/>	Supervisor	<input type="text"/>
City	<input type="text"/>	Reason for leaving	<input type="text"/>
State	<input type="text"/>	Were you the subject of any disciplinary action during your attendance at this institution?	<input type="text"/>
Postal Code	<input type="text"/>	If yes, please explain	<input type="text"/>
County	<input type="text"/>	Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)	<input type="text"/>
Country	<input type="text"/>		
Telephone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		
Website	<input type="text"/>		

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	<input type="text" value="MM/DD/YYYY"/>	Explanation	<input type="text"/>
End Date	<input type="text" value="MM/DD/YYYY"/>		

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	<input type="text"/>	YearsKnow	<input type="text"/>
Last Name	<input type="text"/>	Telephone	<input type="text"/>
Degree	<input type="text" value="▼"/>	Fax	<input type="text"/>
Address	<input type="text"/>	E-Mail	<input type="text"/>
Address 2	<input type="text"/>	Relationship	<input type="text"/>
City	<input type="text"/>	Specialty	<input type="text"/>
State	<input type="text" value="▼"/>		
Postal Code	<input type="text"/>		

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	<input type="text"/>	License Number	<input type="text"/>
Name	<input type="text"/>	Issue Date	<input type="text" value="MM/DD/YYYY"/>
Address	<input type="text"/>	Expiration Date	<input type="text" value="MM/DD/YYYY"/>
Address 2	<input type="text"/>	State	<input type="text"/>
Address 3	<input type="text"/>	Limitations	<input type="checkbox"/>
City	<input type="text"/>	Comments	<input type="text"/>
State	<input type="text"/>		
Postal Code	<input type="text"/>		
County	<input type="text"/>		
Country	<input type="text"/>		
Telephone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		
Website	<input type="text"/>		

Board Certifications

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

Mandatory fields are in **Red**.

New Board Certification*

Search	<input type="text" value="Enter Name or City to search"/>	Certification Status	<input type="text"/>
Name	<input type="text"/>	Status	<input type="text"/>
Address	<input type="text"/>	Certificate Number	<input type="text"/>
Address 2	<input type="text"/>	InitialCertification	<input type="text" value="MM/DD/YYYY"/>
Address 3	<input type="text"/>	Recertification	<input type="text" value="MM/DD/YYYY"/>
City	<input type="text"/>	Certification Expires	<input type="text" value="MM/DD/YYYY"/>
State	<input type="text"/>	Exam Date	<input type="text" value="MM/DD/YYYY"/>
Postal Code	<input type="text"/>	Specialty	<input type="text"/>
County	<input type="text"/>	Specialization	<input type="text"/>
Country	<input type="text"/>	Explanation	<input type="text"/>
Telephone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		
Website	<input type="text"/>		

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

Start Date

Name

End Date

Address

Title

Address 2

City

State

Postal Code

County

Country

Telephone

Fax

Email

Website

Malpractice Coverage

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

Malpractice Coverage

Search	<input type="text" value="Enter Name or City to search"/>	Policy Number	<input type="text"/>
Name	<input type="text"/>	Issued Date	<input type="text" value="MM/DD/YYYY"/>
Address	<input type="text"/>	Expiration Date	<input type="text" value="MM/DD/YYYY"/>
Address 2	<input type="text"/>	Retroactive Date	<input type="text" value="MM/DD/YYYY"/>
City	<input type="text"/>	Coverage	<input type="text"/>
State	<input type="text" value="▼"/>	Terms	<input type="text"/>
Postal Code	<input type="text"/>		
County	<input type="text"/>		
Country	<input type="text"/>		
Telephone	<input type="text"/>		
Fax	<input type="text"/>		
Email	<input type="text"/>		
Website	<input type="text"/>		

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*

IncidentDate

DateFiled

DateClosed

Amount

Type

Status

Notes

History

Allegation

Status Comments

Search

Insurance Name

Policy Number

InsuranceAddress

InsuranceAddress2

InsuranceCity

InsuranceState

InsurancePostalCode

InsuranceCountry

InsuranceTelephone

InsuranceFax

Search

Hospital Name

HospitalAddress

HospitalAddress2

HospitalCity

HospitalState

HospitalPostalCode

HospitalCountry

HospitalTelephone

HospitalFax

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 by 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	<input type="text"/>	FileDescription	<input type="text"/>
Expiration Date	<input type="text" value="MM/DD/YYYY"/>	Upload File	<input type="button" value="Click to Upload"/>
		<input type="button" value="Save"/> <input type="button" value="Cancel"/>	

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.

- | | | |
|---------------------------|--------------------------|--|
| <input type="radio"/> Yes | <input type="radio"/> No | Has any disciplinary actions or investigations been initiated against you by any state licensure board? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you been reprimanded and/or fined, by any local, state, or federal agency that licenses providers? |
| <input type="radio"/> Yes | <input type="radio"/> 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? |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society or regulatory agency? |
| <input type="radio"/> Yes | <input type="radio"/> 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? |
| <input type="radio"/> Yes | <input type="radio"/> No | Has your federal DEA number and/or state controlled substance license been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily? |
| <input type="radio"/> Yes | <input type="radio"/> 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? |
| <input type="radio"/> Yes | <input type="radio"/> 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.) |
| <input type="radio"/> Yes | <input type="radio"/> 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)? |
| <input type="radio"/> Yes | <input type="radio"/> 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.) |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you currently engaged in illegal use of any legal or illegal substances? |
| <input type="radio"/> Yes | <input type="radio"/> No | Are you currently participating in a supervised rehabilitation program and/or professional assistance program, which monitor you for alcohol and/or substance abuse. |
| <input type="radio"/> Yes | <input type="radio"/> No | Has it been more than 12 months since you have provided patient care? (in a professional setting) |
| <input type="radio"/> Yes | <input type="radio"/> No | Have you been charged with or convicted of a crime (other than a minor traffic offense) in any state or country? |
| <input type="radio"/> Yes | <input type="radio"/> No | Has your license to practice in any jurisdiction been, or attempted to have been, denied, restricted, limited, suspended, revoked, or canceled? |
| <input type="radio"/> Yes | <input type="radio"/> No | Has your license been subjected to probation either voluntarily or involuntarily? |
| <input type="radio"/> Yes | <input type="radio"/> No | Has your license been withdrawn either voluntarily or involuntarily? |
| <input type="radio"/> Yes | <input type="radio"/> 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 graduate 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.

 Submit Application