asm test test - Initial Application

Introduction

Form Approved
OMB No. 0917-0009
Exp. Date 08/31/2023

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 Indians 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 the Initial Application

INSTRUCTIONS: Enter all pertinent information, as applicable. Fill out all required sections and fields that are marked in Red; these are mandatory and must be completed to submit the application. At any point, the application may be saved by clicking Save and completed at a later time. The blue toolbar at the top right provides additional help. The definition of "applicant" within this application is the individual requesting medical staff membership and/or clinical privileges.

- Packet Documents included on the previous home screen are MANDATORY. These must be viewed and/or filled out and uploaded into the Files section on this application. Please note

that any documents that require electronic signature are found at the end of the application.
- **The Head Icon** at the top right allows the applicant to change or reset the password and authorize account access to a delegate.
- **Help Icon** provides support if technical difficulties are encountered.
- **Return To Application** after submitting the application, where the completed application and supporting documents may be viewed, downloaded, or printed.

UPLOADING DOCUMENTS: Completed documents and forms must be uploaded in the **Files** section of this application. Please contact the Medical Staff Credentialing Coordinator for other delivery methods if technical difficulties are encountered.

LENGTHY RESPONSES: Each text field in this application has a limit of two lines. If a response exceeds two lines of text, please upload the response as a Word or PDF document in the Files section of this application.

ATTENTION: Misrepresentations, inaccuracies, or falsification of any information may be grounds for denial or termination of medical staff appointment and/or associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank (NPDB), and state and federal licensing boards.

INCOMPLETE APPLICATIONS & MISSING DOCUMENTS: Applications with incomplete information or missing documents will be returned to the applicant and delay the processing of the application. If the applicant does not respond within 30 days of the request and/or the time specified in the local medical staff bylaws, the applications (initial or reappointment) will be deemed incomplete and ineligible for processing. The applicant has the responsibility for furnishing information that will help resolve any questions concerning these qualifications.

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

Enter the requested information and select the most appropriate medical specialties.

Mandatory fields are in **Red**. Click **Edit** to modify this section and **Save** to save the information entered.

Prefix

First Name

asm test

Middle Name

Last Name

test

Suffix

Degree

Degree2

Degree3

Preferred Name

Birth Date

MM/DD/YYYY

SSN

Gender

Birth Place

Citizenship

Marital Status

Spouse Name

Pager

Answering Service

Cell

E-Mail

NPI

Preferred Contact Method

Language 1

Language 2

✖ Save ⊘ Cancel

Addresses 0 of 1 Required

List home and office addresses.

Mandatory fields are in **Red**. Additional addresses may be added by clicking the **Add** button. Click **Save** when finished.

New Address* Delete

Address1

Address 2

City

State

Postal Code

County

Country

Telephone

Fax

E-Mail

✖ Save ⊘ Cancel

New Addresses ✚ Add

Alias/Other Names Used

List ALL aliases or other names used.

Additional aliases may be added by clicking the **Add** button. Click **Save** when finished.

New Alias* Delete

Last Name

First Name

Middle Name

✖ Save ⊘ Cancel

New Alias/Other Names Used ✚ Add

Education / Training 0 of 1 Required

List all institutions and colleges where education and training was received. **This includes all undergraduate education, graduate education, residencies, and fellowships. Also list all colleges where a degree was transferred from or not obtained.** If the exact start or end date is unknown, please ensure that the month and year are correct. **State in the Comments field if you completed the education/training. If you did not, please explain why.**

If applicable, **ECFMG** information MUST be entered in this section.

If a residency or fellowship was completed, please indicate the specialty and program name in the Subject field. If internship information is submitted, please add if the internship was rotating, mixed, or straight in the Subject box. If a straight residency was complete, please also include the discipline.

Mandatory fields are in **Red**. Education may be added by clicking the **Add** button. Select the appropriate **Education Type**, then search the name or city in the **Search** box. Click **Save** when finished.

New Education* Delete

Type

Source ID

Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

Telephone

Fax

Email

Website

Start Date

MM/DD/YYYY

End Date

MM/DD/YYYY

Degree Earned

Subject

Comments

✖ Save ⊘ Cancel

New Education / Training ✚ Add

Hospital Affiliations

List all current and historical healthcare organizations where medical staff membership and/or privileges were granted (including employment, self-employment, or service as an independent contractor) since completion of medical or professional school.

DO NOT include fellowships, internships and/or residencies previously reported under Education/Training. If a time gap greater than 60 days exists between organizations, please add and explain in the Gaps section.

Mandatory fields are in **Red**. Additional healthcare organizations may be added by clicking the **Add** button. Click **Save** when finished.

New Hospital* Delete

Source ID

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

Relationship

Supervisor

What is or was your medical staff status (active, temporary, provisional, etc.)?

Reason for leaving

Comments

✖ Save ⊘ Cancel

New Hospital Affiliations ✚ Add

Work History

List all current and past work history since completion of medical or professional school. Add engagements not already listed in the Hospital Affiliations section, including employment, self-employment, service as an independent contractor, assistantships, corporations, medical offices, universities, teaching, military assignments, and government agencies.

DO NOT include organizations already listed in the Hospital Affiliations and Education/Training sections. If a gap greater than 60 days exists between organizations, please add and explain in the Gaps section.

Mandatory fields are in **Red**. Additional work history may be added by clicking the **Add** button. Click **Save** when finished.

New Work History* Delete

Type

SourceID

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

Comments

✖ Save ⊘ Cancel

New Work History ✚ Add

Gaps

Please explain any time periods or gaps longer than sixty (60) days in duration since graduation from professional school. If the application is found to have any unexplained time period or gaps, the application will not be processed and will be returned to the applicant as incomplete.

Mandatory fields are in **Red**. Additional gaps may be added by clicking the **Add** button. Click **Save** when finished.

New Gap* Delete

Start Date

MM/DD/YYYY

End Date

MM/DD/YYYY

Explanation

✖ Save ⊘ Cancel

New Gaps

+ Add

Peer Professional References 0 of 3 Required

List names and contact information of at least three (3) individuals who have equal or greater credentials, who are unrelated by blood or marriage, and have personal knowledge of the applicant's current clinical abilities, ethical character, and interpersonal skills, within the last 24 months.

For applicants currently in training, one reference must be from the training program director.

Please note that some facilities may require and request additional peer references.

Mandatory fields are in **Red**. Additional peer references may be added by clicking the **Add** button. Click **Save** when finished.

New Peer Reference* Delete

First Name

Last Name

Degree

Address

Address 2

City

State

Postal Code

Years Known

Telephone

Fax

E-Mail

Relationship

✖ Save ⊘ Cancel

New Peer Professional References ✚ Add

Licenses / Credentials

All the following credentials listed below are required (please note that other credentials may be required by the facility in which you are applying.):

1. **ALL** inactive and active professional state licenses
2. **ALL** inactive and active DEA, CDS, or other licenses or registrations
3. Current life support certifications (Example: BLS, ACLS, ATLS, NRP, PALS, ALSO, etc.)

Please document any limitations or restrictions in the Status section.

The License Number and State fields are required to submit the application. If a license or credential does not have a license number associated with it, please add N/A to the License Number field. If a license or credential does not have a state associated with it, add a state that you are licensed in or reside in. Please include any additional information in the Comments field.

Mandatory fields are in **Red**. Begin by clicking **Add**, then selecting the **Type**. Click **Save** when finished.

New Credential* Delete

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

Status

Comments

Save Cancel

New Licenses / Credentials Add

Board Certifications

List all board certifications currently and previously held. (Note that state licenses granted by state licensing boards should be added in the Licenses/Credentials section.)

If not certified, please provide an explanation in the Comments section. Also document if an application was submitted for board certification and the examination date, if applicable.

Mandatory fields are in **Red**. List your primary board certification first. Begin by clicking the **ADD** button, and type the board acronym and/or name in the **Search** box. Once selected, it will pre-populate fields.

New Board Certification* Delete

SourceID

Enter Name or City to search

Name

Address

Address 2

Address 3

City

State

Postal Code

County

Country

Telephone

Fax

Email

Website

Certification Status

Certificate Number

Initial Certification

MM/DD/YYYY

Recertification

MM/DD/YYYY

Expiration Date

MM/DD/YYYY

Exam Date

MM/DD/YYYY

Specialty

Certified In

Comments

Save Cancel

New Board Certifications Add

Medical Societies

List any current or previous professional medical society memberships. Begin by clicking on **Add**, then type the acronym and/or name in the **Search** box. Once selected, it will pre-populate the application fields.

Mandatory fields are in **Red**. Additional medical societies may be added by clicking the **Add** button. Click **Save** when finished.

New Society* Delete

SourceID

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

Title

✖ Save ⊘ Cancel

New Medical Societies ✚ Add

Malpractice Coverage

List all current, previous (within the last 5 years), and any future malpractice insurance carriers **including name, policy number, and dates held.** Begin by clicking on **Add**, then type the insurance carrier's name in the **Search box**. Once selected, it will pre-populate the application fields.

Mandatory fields are in **Red**. Additional malpractice insurance carriers may be added by clicking the **Add** button. Click **Save** when finished.

New Insurance* Delete

SourceID

Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

Country

Telephone

Fax

Email

Website

Policy Number

Issued Date

MM/DD/YYYY

Expiration Date

MM/DD/YYYY

Retroactive Date

MM/DD/YYYY

Coverage

Terms

✖ Save ⊘ Cancel

New Malpractice Coverage ✚ Add

Malpractice Claims

Provide information regarding any current (open or pending) and previous lawsuits or complaints against the applicant or a hospital, corporation, or the United States Government based on a case with which the applicant is or was professionally associated. External verification (i.e., statement from an attorney, court records, etc.) may be requested.

Begin by clicking **Add**, then type in the insurance company name associated with the incident in the **Insurance ID** box, and the healthcare organization where the incident occurred in the **Healthcare Organization ID** box. Once selected, the fields will prepopulate. If the status of the malpractice claim is not available under **Status**, please provide the information in the **Status Comments** box. If the Status selected is "Settled," please place the settlement amount in the **Amount** field. Click **Save** when finished.

The **Notes** section is limited to 300 characters. If a response is more than 300 characters, upload the information as a Word or PDF document in the Files section.

New Malpractice Claim* Delete

Incident Date

MM/DD/YYYY

Date Filed

MM/DD/YYYY

Date Closed

MM/DD/YYYY

Amount

Type

Status

Notes

Allegation

Status Comments

Insurance ID

Enter Name or City to search

Insurance Name

Insurance Address

Insurance Address 2

Insurance City

Insurance State

Insurance Postal Code

Insurance Country

Insurance Telephone

Insurance Fax

Healthcare Organization ID

Enter Name or City to search

Healthcare Organization Name

Healthcare Organization Address

Healthcare Organization Address 2

Healthcare Organization City

Healthcare Organization State

Healthcare Organization Postal Code

Healthcare Organization Country

Healthcare Organization Telephone

Healthcare Organization Fax

✖ Save ⊘ Cancel

New Malpractice Claims ✚ Add

Health Screen/Immunizations

Proof of receipt of immunizations administered that meet current CDC Healthcare Worker vaccination recommendations, and agency and facility vaccination requirements must be provided.

List MMR (measles, mumps, rubella), PPD, and Hep B. In addition, upload documentation of these in the Files section of this application.

MMR Immunity

Applicants requesting hospital/clinic privileges are required to submit evidence of MMR immunity **prior** to being granted privileges. **Individuals born before 1957 do not need to submit proof of immunity to measles.** If the titer is negative, the applicant must receive the MMR vaccine. Please submit documentation in the Files section.

PPD

Applicants requesting hospital/clinic privileges are required to submit documentation of a PPD skin test or chest x-ray if the skin test was previously positive. Please submit documentation in the Files section of this application.

Hepatitis B Immunity

Health care professionals are at risk of acquiring Hepatitis B virus (HBV) infection due to occupational exposure to blood and other potentially infectious materials. The Indian Health Service strongly encourages applicant to obtain the Hepatitis B vaccination series. However, this is not required as a condition of employment.

If you have received the Hepatitis B vaccine or you have had a Hepatitis B antibody test result that indicates prior exposure, please note that in the Result Section.

By selecting that you decline the Hepatitis B vaccine, you are acknowledging "I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself; however I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B virus (HBV) infection, a serious disease, due to my occupational exposure to blood or other potentially infectious materials. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at the service unit where I am employed or contracted at no charge to me. **If you decline you must select "Declined Hep B Vaccination" under the Result section.**

Mandatory fields are in **Red**. Select immunization/vaccination type from the drop down menu and provide the required information at a minimum for MMR, PPD and Hep B. Additional Medical History may be added by clicking the **New** button. Click **Save** when finished. You can add as many as you would like by clicking **New**.

New Medical History* Delete

Type

Date Administered

MM/DD/YYYY

Date Expired

MM/DD/YYYY

Result

Comments

✖ Save ⊘ Cancel

New Health Screen/Immunizations ✚ Add

Files

Upload the following required documents. Note that some forms may not be required by some facilities. Forms that require signature are either housed on the login screen, at the end of the application for electronic signature, or will be emailed to you.

1. Government-issued photo identification (for example, a driver's license, passport, or military ID)
2. Copies of life support certifications
3. Copy of immunization record to include MMR, PPD, Hep B, Influenza, Varicella (Chickenpox), Tetanus, diphtheria, pertussis and Meningococcal
4. Last 2 years of CMEs (including IHS Opioid Prescriber Training Certificate)
5. Current curriculum vitae or resume
6. Application Approval Signature Page (electronic signature of this application will suffice)
7. Delineation of Privileges Signature Page (electronic signature of this application will suffice)
8. Bylaws Attestation
9. Completed Confidentiality Statement Form
10. Completed Medicare Statement Form
11. Completed Health Statement Form
12. Completed Statement of Understanding & Release Form (MUST be uploaded to submit application.)
13. Any other documents with information that supports this application

To upload a digital document (pdf, jpg, etc):

1. Select **Add**
2. Select a **File Type**
3. Enter a **Description** (Optional)
4. Click on **Click To Upload** to browse for the file
5. Click **Save** to complete the upload

If unable to perform a document upload, please contact MD-App Support at 1-800-736-7276 or the Medical Staff Office.

New File* Delete

FileType

Expiration Date

MM/DD/YYYY

FileDescription

Upload File

Click to Upload

✖ Save ⊘ Cancel

New Files ✚ Add

Attestation Questions

Please answer **ALL** attestation questions. For any "Yes" answers , please explain in the space provided.

○ Yes	○ No	Has your license to practice in any jurisdiction ever been or ever attempted to have been denied, restricted, limited, suspended, revoked, canceled, reprimanded, or censured, and/or have you ever practiced without a license?
○ Yes	○ No	Has your license to practice ever been subject to probation, either voluntarily or involuntarily?
○ Yes	○ No	Has your license ever been voluntarily or involuntarily withdrawn?
○ Yes	○ No	Has any disciplinary actions or investigations ever been initiated against you by any state licensure board?
○ Yes	○ No	Have you ever been reprimanded and/or fined, by any local, state, or federal agency that licenses providers?
○ Yes	○ No	Have you ever been the subject of an informal or formal hearing process at any healthcare organization?
○ Yes	○ No	Have you ever been the subject of a complaint, or have you ever been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal agency that licenses providers?
○ Yes	○ No	Have you ever 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	

Have you ever been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society, regulatory agency, or place of employment?		
○ Yes	○ No	Has your employment and or clinical privileges at any hospital, clinic, or other health care setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?
○ Yes	○ No	Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges prior to a hospital or health facility's governing board's final decision?
○ Yes	○ No	Have you ever been reprimanded, censured, excluded, suspended, disqualified and/or participation voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, TRICARE, and/or any other governmental health related programs?
○ Yes	○ No	Have Medicare, Medicaid, TRICARE, PRO authorities, and/or any other third party payers ever brought charges against you for alleged inappropriate fees, and/or quality of care issues?
○ Yes	○ No	Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank or any other practitioner data bank, or any other federal or state board oversight authority?
○ Yes	○ No	Has your federal DEA number, state controlled substance license, or other controlled substance license ever been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily?
○ Yes	○ No	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 a DEA or other controlled substance registration or license?
○ Yes	○ No	Have you ever had a claim for professional negligence asserted against you? If yes, you are required to note your final judgement and settlements in the Malpractice Claims section of this application.
○ Yes	○ No	Have liability claims, judgements or settlements ever 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 Section of this application.

○ Yes	○ No	Have you ever had professional liability coverage denied, refused, or canceled by a professional liability insurance company?
○ Yes	○ No	Have you ever withdrawn from or been suspended, dismissed or expelled from a professional school or postgraduate training program, or has any third party ever attempted to have you withdrawn, suspended, dismissed, or expelled from a professional school or postgraduate training program?
○ Yes	○ No	Have you ever been placed on probation or taken a leave of absence from medical, dental, or other graduate school or postgraduate training program?
○ Yes	○ No	Have you ever 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, elder abuse, or any other violent crimes?
○ Yes	○ No	Do you currently have, or has it ever been suggested to you that you have any physical, mental, or emotional impairment that 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.
○ 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	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 ever been charged with or convicted of a crime, other than a minor traffic offense, in any state or country?

○ Yes	○ No	Were you ever the subject of any disciplinary action at any educational (college) or training (residency, fellowship, internship, etc.) programs?

Certification of Professional Licenses

○ Yes	○ No	I certify that I have listed all active and inactive state medical licenses and controlled substance registrations/licenses on this application.
○ 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 or a territory of the United States.
○ Yes	○ No	I 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.

Privileges

Review and request any privileges by clicking on the checkbox. If you have cases to provide, please include them. You may also include more details in the **Comments** section. If applicable, please review the core privileges and uncheck any core privileges for which you do not have current competency to perform.

Review Application

Final Steps:

1. Read the Applicant's Certification Statement:

   By signing this application, I certify that all the information submitted by me in this application is true and complete to the best of my knowledge. I agree to immediately disclose to the governing body if any answer to a question above becomes "Yes" while or staff membership and/or privileges are pending or have been granted. I agree to abide by all lawful standards, policies, rules, regulations, and bylaws of the facility, the Area, the Indian Health Service, the U.S. Public Health Service, and the Department of Health and Human Services, as they apply to my responsibilities and practice as a member of the clinical staff. I further agree to answer any questions concerning the contents of this application either during the application process or

subsequent to having been granted privileges. I agree that inquiries may be made to any federal or private sector facility with which I have been affiliated. I pledge to maintain an ethical practice and to provide for the continuous care of all my patients.

2. Click Submit Application. (Once the application has been submitted, you may go back to edit your data by clicking **Unsubmit** on the main login page. You may also print the application by clicking **View Application**.)
3. On the Electronic Signature page enter your complete and legal name, check the box indicating that you have read and agree to be bound by the Applicant's Certification Statement, and that to the best of your knowledge, all information provided on the application is true and accurate, and that no material or facts which would render the statement false, fictitious, or fraudulent is omitted.

The application is incomplete

Submit Application