ASM Test - Reappointment 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 Reappointment 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

Review the current entries below and update information, as applicable.

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

Prefix

First Name

Middle Name

Last Name

Test

Suffix

Degree

Degree2

Degree3

Specialty 1

Specialty 2

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

Review the current entries below and update information, as applicable.

Mandatory fields are in **Red**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

New Address* Delete

Type

Address1

Address 2

City

State

Postal Code

County

Country

Telephone

Fax

E-Mail

✖ Save ⊘ Cancel

New Addresses ✚ Add

Alias/Other Names Used

Review the current entries below and update information, as applicable.

Mandatory fields are in **Red**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

New Alias* Delete

AliasType

FamilyName

GivenName

OtherGivenName

✖ Save ⊘ Cancel

New Alias/Other Names Used ✚ Add

Education / Training

Review the current entries below and update any new education or training (including new college degrees, residencies, fellowships, etc.) **since last appointment**, as applicable. **State in the Comments field if you completed the education/training. If you did not, please explain why.**

If the exact start or end date is unknown, please ensure that the month and year are correct.

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**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

New Education* Delete

Type

SourceID

Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

Reason for leaving

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

Review the current entries below and add any new healthcare organization information where medical staff membership and/or privileges were granted (including employment, self-employment, or service as an independent contractor) since **since last appointment**, as applicable.

DO NOT include fellowships, internships and/or residencies previously reported under Education/Training.

Mandatory fields are in **Red**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

New Hospital* Delete

SourceID

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

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

Reason for leaving

Comments

✖ Save ⊘ Cancel

New Hospital Affiliations

+ Add

Work History

Review the current entries below and add any current or past work history **since last appointment**, as applicable.

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**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

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

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.

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

Specialty

✖ Save ⊘ Cancel

New Peer Professional References ✚ Add

Licenses / Credentials

Review the current entries below and update or add any new credentials **since last appointment**, as applicable.

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**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

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

Review the current entries below and update or add any new board certification **since last appointment**, as applicable. (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

Review the current entries below and update or add any new medical society memberships **since last appointment**, as applicable.

Mandatory fields are in **Red**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

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

Review the current entries below and update or add any new malpractice coverage **since last appointment**, as applicable.

Mandatory fields are in **Red**. Click **Edit** to modify an existing entry, **Delete** to delete an entry, and **Add** to add a new entry. Click **Save** to save the information entered.

New Insurance* Delete

SourceID

Enter Name or City to search

Name

Address

Address 2

City

State

Postal Code

County

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 **since last appointment**, as applicable. 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

IncidentDate

MM/DD/YYYY

DateFiled

MM/DD/YYYY

DateClosed

MM/DD/YYYY

Amount

Type

Status

Notes

Allegation

Status Comments

InsuranceID

Enter Name or City to search

Insurance Name

InsuranceAddress

InsuranceAddress2

InsuranceCity

InsuranceState

InsurancePostalCode

InsuranceCountry

InsuranceTelephone

InsuranceFax

HospitalID

Enter Name or City to search

Hospital Name

HospitalAddress

HospitalAddress2

HospitalCity

HospitalState

HospitalPostalCode

HospitalCountry

HospitalTelephone

HospitalFax

Save Cancel

New Malpractice Claims 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. CMEs since last appointment
2. Completed Statement of Understanding & Release Form
3. Completed Health Statement Form (MUST be uploaded to submit application.)

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 malpractice 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 (electronic signature of this application will suffice)
6. Delineation of Privileges Signature Page (electronic signature of this application will suffice)

7. Any other documents in the download section or provided to you by email

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?
○ Yes	○ No	Do any health problems exist that could affect your ability to perform the privileges requested?
○ Yes	○ No	I have an impairment that affects my ability to perform the clinical privileges requested and for which I require accommodation.

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

Request privileges below by checking the blue Request check box on the left side of the screen. Currently approved privileges are denoted as "Granted" below the blue box. If you do NOT want to renew a specific privilege, please do NOT check the blue Request box.

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