Pre-Application

# Introduction



Form Approved OMB No. XXXX-XXXX

Exp. Date XX/XX/XXXX

The Federal Health Program for American Indians/Alaska Natives

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.

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

The pre-application is used to identify individuals who meet the minimum qualiﬁcations to receive a full application for medical staﬀ membership and/or privileges. Once the pre-application is reviewed, the applicant will be notiﬁed if the minimum qualiﬁcations are met to receive a full application.

Enter all pertinent information, as applicable. Fill out all required sections and ﬁelds that are marked in ; these are mandatory and must be completed to submit the

application. At any point, the application may be saved by clicking 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.



included on the previous home screen are . These must be viewed and/or ﬁlled out and uploaded into the section on this application.

Please note that any documents that require electronic signature are found at the end of the application.

at the top right allows the applicant to change or reset the password and authorize account access to a delegate.

provides support if technical diﬃculties are encountered.

after submitting the application, where the completed application and supporting documents may be viewed, downloaded, or printed.

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

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.

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.

Applications with incomplete information or missing documents will be returned to the applicant and delay the processing of the application.

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 [####-####]. This information collection is to be used in verifying an applicant’s credentials to meet agency policy, Centers for Medicare Conditions of Participation requirements, and accrediting body standards. The time required to complete this information collection is estimated to average less than 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required to determine an applicant’s credentials to provide healthcare (IHS IHM 3-1.4 C. (1-2), CMS CoP §482.12(a)(6) and

§482.22(c)(4) and [the nature and extent of conﬁdentiality to be provided, if any (5 U.S.C. 552a and 25 U.S.C. 1675)]. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, 5600 Fishers Lane, mailstop: 09E07, Rockville, MD 20857, Attention: Information Collections Clearance Oﬃcer



Personal Information

Enter the requested information.

Mandatory ﬁelds are in

. Click

to modify this section and

to save the information entered.

Middle Name

Degree 2

Degree 3



Addresses

List home and oﬃce addresses.

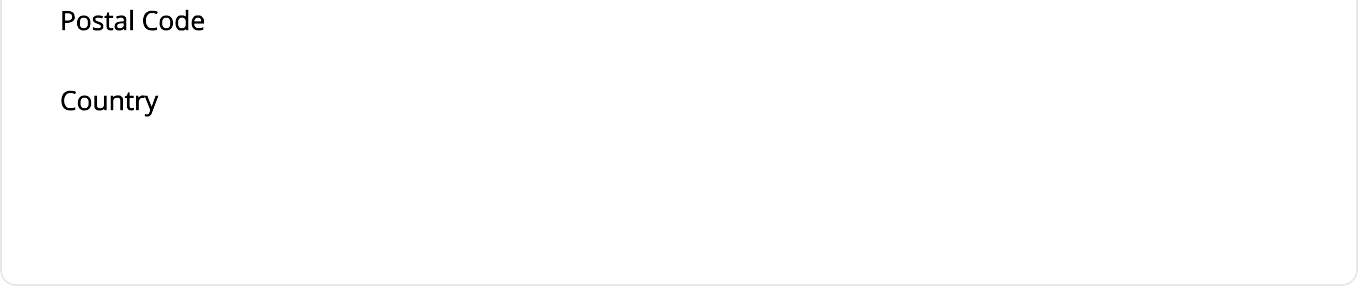
Mandatory ﬁelds are in

ﬁnished.

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

Oﬃce Address

Address 2



Alias/Other Names Used

List ALL aliases or other names ever used. Additional aliases may be added by clicking the

button. Click

when ﬁnished.

OtherGivenName

Education/Training

List all institutions and colleges where education and training was received.

If the exact start or end date is unknown, please ensure

that the month and year are correct.

If applicable,

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

. Education may be added by clicking the

, then search the name or city in the box. Click

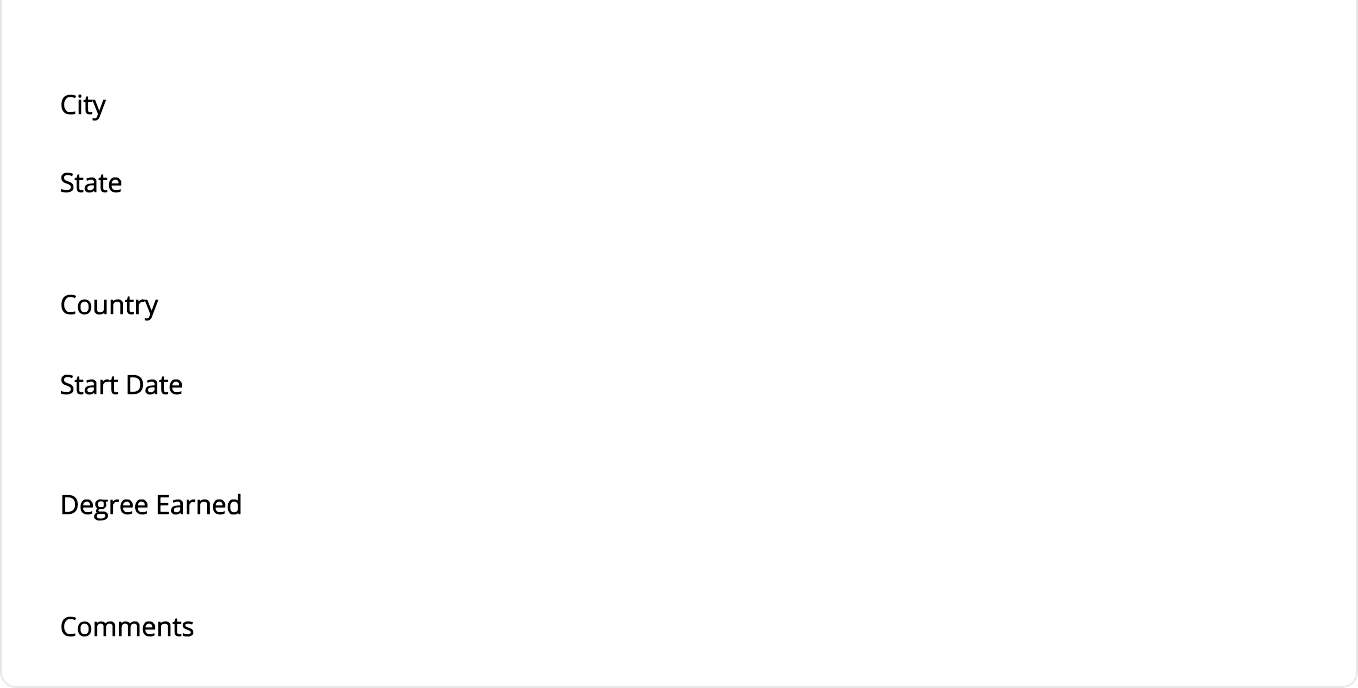
button. Select the appropriate when ﬁnished.

MedicalEducation

United States Telephone Fax

E-Mail

Maiden



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.

2.

inactive and active professional state licenses

inactive and active DEA, CDS, or other licenses or registrations

3. Current life support certiﬁcations (Example: BLS, ACLS, ATLS, NRP, PALS, ALSO, etc.)

4) Signed Practitioner Acknowledgement & Release Form

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 in 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

. Begin by clicking

, then selecting the Type. Click

when ﬁnished.

Comments

Address Address 2

Postal Code

End Date

l

Subject

# 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.)

Also document if an application was submitted for board certiﬁcation and the examination date, if applicable.

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

Rehabilitation

Address Address 2 City

State

Postal Code Country

Rehabilitation

Certiﬁed In

Comments



Files

Upload the following required documents. 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. Current curriculum vitae or resume

2. Signed Practitioner Acknowledgement & Release Form

1. Select
2. Select a



1. Enter a (Optional)
2. Click on to browse for the ﬁle
3. Click 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.

File Description

File Type Name

# Attestation Questions

Please answer \*\*ALL\*\* attestation questions. For any "Yes" answers, please provide further explanation in the space provided. Answering yes to questions will not necessarily disqualify an applicant.

false

Have any licenses (state license, DEA, and/or state controlled substance license) 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?

false

Have you ever been cautioned, reprimanded, ﬁned, disciplined, investigated, excluded, subject of a complaint, or notiﬁed of any criminal, civil, or disciplinary action by local, state, or federal licensing board (state, DEA, CDS, etc.), certiﬁcation board, professional organization/agency, accrediting or professional standards review organization, or governmental health related program (Medicare, Medicaid, TriCare, etc.)?

false

Have you ever been the subject of an informal or formal hearing process (including hearing processes) by the federal government or any branch of the military, licensing board, hospital, healthcare organization, agency or professional association to revoke, suspend, restrict or limit a professional license/registration/permit?

false

Has your employment, medical staﬀ membership, 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?

false

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?

false

Have any professional liability claims, judgements or settlements ever been made against you, a healthcare organization, or the United States Government, based on a case with which you were professionally associated? If yes, please explain. Include the ﬁnal judgement and settlements.

false

Have you ever had professional liability coverage denied, refused, or canceled by a professional liability insurance company?

false

Have you ever been placed on probation or taken a leave of absence from medical, dental, or other graduate school or postgraduate training program?

false

Have you ever been arrested, cited, charged with or convicted of a felony or misdemeanor other than minor traffic violations, regardless of the outcome? This includes withheld judgements and matters that have been expunged.

false

Are you currently engaged in illegal use of any legal or illegal substances?”

false

Has it been more than 12 months since you have provided patient care in a professional setting?

false

Do you have any reason to believe that you could pose a risk to the safety or well-being of patients?



Submit Application

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 on 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.

1. Click Submit Application. (Once the application has been submitted, you may go back to edit your data by clicking on the main login page. You may also print the application by clicking

.)

1. 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.