Pre-Application

Introduction

Form
Approved OMB
No. XXXX-XXXX
Exp. Date XX/XX/XXXX

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 Pre-Application

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.

INSTRUCTIONS:

Red

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 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:

Files

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.

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.

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 Red. Click Edit to modify this section and Save to save the information entered.

First Name

Middle Name

Last Name

Degree

Degree 2

Degree 3

E-Mail

Cell

Citizenship

Birth Date

SSN

NPI

Addresses

List home and office addresses.

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

Office Address

Address1

Address 2

City

State

Postal Code

Country

United States

Telephone

Fax

E-Mail

Alias/Other Names Used

List ALL aliases or other names ever used. Additional aliases may be added by clicking the Add button. Click Save when finished.

Maiden

AliasType

FamilyName

GivenName

OtherGivenName

Education/Training

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 thebox. Click Search Save when finished.

MedicalEducation

Type

Name

Address
Address 2
City
State
Postal Code
Country
Start Date
End Date
Degree Earned
Subject
Comments

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.)
4) Signed Practitioner Acknowledgement & Release Form

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 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 Red. Begin by clicking Add, then selecting the Type. Click Save when finished.

Type
License Number
State
Expiration Date
Status
Comments

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.

Rehabilitation

Name

Address
Address 2
City
State
Postal Code
Country
Specialty
Rehabilitation
Certified In
Certificate Number

Certification Status

Initial Certification

Expiration Date

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.

Current curriculum vitae or resume
2. Signed Practitioner Acknowledgement & Release Form (MUST be uploaded to submit application.)

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

Select a File Type Add

Enter a(Optional) Description
Click onto browse for a file Click To Upload
Clickto complete the upload Save

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

File Type Name

File Description File Type

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

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 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.

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

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.