Reappointment 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 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 Files. 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.

- 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 [####-####]. 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 (citing authority)]. 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

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

Suffix
Degree

Degree 2
Degree 3
Birth Date

SSN

NPI
Preferred
Name Gender

Birth Place
Lookout
Citizenship
Marital Status
Spouse Name
Pager
Answering Service

Cell

E-Mail
Preferred Contact
Method Language 1
Language 2

Addresses

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.

Office Address

Address1

Address 2

City

State

Postal Code

Country

Telephone Fax

E-Mail

Alias/Other Names

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.

Maiden

AliasType

FamilyName

GivenName

OtherGivenName

Education/Training

Review the current entries below and update any new education or training (including new college degrees, residencies, fellowships, etc.), as applicable, since last appointment 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.

MedicalEducation

Type
Medical Education
Name

Address

Address 2
City

State

Postal Code

Country

Telephone

Fax
Email
Website
Start Date

End Date

Degree Earned

Subject

Comments
None
Contact

Hospital Affiliations

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

Include all current and new healthcare organizations where medical staff membership and/or privileges are granted (including employment, self-employment, or service as an independent contractor) since last appointment.

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

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

Hospitals

Name

Address

Address 2
City

State

Postal Code

Country
United States

Telephone

Fax
Email
Websit
e

Start Date

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

Supervisor

Relationship
Reason For
Leaving

Comments

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.

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.

Work History

Type

Name

Address
Address 2
City

State
Postal
Code
Country
Telephone

Fax
Email
Websit
e
Start Date

End Date
Subject

Relationship

Relationshi
p Contact3
Comments

Peer Professional References

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 more or less peer references depending on the facility’s peer review processes for reappointment.

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

Peer References

First Name

Last Name

Degree

Address

Address2

City

State

Postal Code

Years Known

Relationship

Telephone

Fax

Email

Licenses/Credentials

Review the current entries below and ensure current and new credentials are listed, 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 active professional state licenses, and state licenses that have become inactive since last appointment.
2. ALL active DEA, CDS, or other licenses or registrations, as well as those that have become inactive since last appointment.
3. Current life support certifications (Example: BLS, ACLS, ATLS, NRP, PALS, ALSO, etc.)
4. Signed Practitioner Conditions of Application and 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 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.

Licenses/Credentials

Type

Name

Address
Address 2
City
State
Postal Code
Country

Telephone
Fax
Email
Website

License Number

Issue Date

Expiration Date

State

Limitations
Status
Comments

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

Board Certifications

Name

Address

Address 2

City
State

Postal Code

Country
Telephone

Fax
Email

Website
Specialty

Certified In
Certificate Number

Certification Status
Exam Date
Initial Certification
Recertification
Expiration Date

Comments

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.

Medical Societies

Name

Address

Address 2

City
State

Postal Code

Telephone

Fax

Email
Website
Start Date
End Date
Title

Malpractice Coverage

Review the current entries below and update or add any new malpractice coverage since last appointment, as applicable, including name, policy number, and dates held.

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

Malpractice Coverage

Name

Address

Address 2

City

State

Postal Code

Country

Telephone

Fax

Email

Website

12345615

Policy Number

Issued Date

Expiration Date

Retroactive Date

Coverage

Terms

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, as applicable. External verification (i.e., statement from an attorney, court records, etc.) may be requested.

since last appointment

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.

Malpractice Claims

Incident Date

Type

Status
Action
Date Filed

Date Closed
Amount
History

Allegation
Status Comments

Notes
Hospital Name

Hospital Address
Hospital Address 2
Hospital City

Hospital State

Hospital Postal Code
Hospital Country
Hospital Telephone

Hospital Fax
Insurance Name

Insurance Address
Insurance Address 2
Insurance City
Insurance State
Insurance Postal
Code Insurance
Country

Insurance Telephone

Insurance Fax

Files 1 of 4 Required

Upload the following required documents. If you do not upload two documents you will be unable to submit your application. 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. Signed IHS Conditions of Application & Release 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. Any other documents in the download section or provided to you by email

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

Add
File Type
Description
Click To Upload
Save

1. Select
2. Select a
3. Enter a (Optional)
4. Click on to browse for the file
5. 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.

Files
File Type

File Description
Expiration Date

Attestation Questions

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

false

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?

false

Has your license to practice ever been subject to probation, either voluntarily or involuntarily?

false

Has any disciplinary actions or investigations ever been initiated against you by any state licensure board?

false

Have you ever been reprimanded and/or fined, by any local, state, or federal agency that licenses providers?

False

Have you ever been subject to informal or formal proceedings (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

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?

false

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?

false

Have you ever been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society, regulatory agency, or place of employment?

false

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?

false

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?

false

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?

false

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?

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

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?

false

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?

false

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.

false

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.

false

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

false

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?

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 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?

False
Are you aware of any impairment, including but not limited to a medical impairment, that you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership? (If a reasonable accommodation would allow you to exercise your clinical privileges and clinical staff duties completely and safely, please refer to the Indian Health Manual, Part 1, Chapter 14, for additional information on requesting an accommodation.)

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

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

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

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
Were you ever the subject of any disciplinary action at any educational (college) or training (residency, fellowship, internship, etc.) programs?

Certification of Professional Licenses

true
I certify that I have listed all active and inactive state medical licenses and controlled substance registrations/licenses on this application.

true
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.

true
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.

Privileges

Privileges are facility specific, listed here.

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.