Introduction

Form Approved
OMB No. 0917-0009
Exp. Date 02/29/2020

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 Indian 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 Your Application

*Items in **Red** are mandatory fields and must be completed to finish the application. At any point in the application, you may click **Save** and return to the application at a later time. The blue toolbar at the top right provides additional help.*

- **Packet Documents** included on the previous screen before starting this application are **MANDATORY** and need to be viewed and/or filled out and uploaded into the **Files** section on this application.
- **The Head Icon** at the top right allows you to change/reset your password and authorize account access to your chosen delegate.
- **Help Icon** provides support if you encounter difficulties with the application.
- **Return To Your Application** after completion where you will have the opportunity to download, view and print your completed application and supporting documents at the main page after logging in.

INSTRUCTIONS: Please fill out all **REQUIRED** fields marked in Red and fill out all other information where applicable.

UPLOADING DOCUMENTS: Completed documents and forms may be uploaded to the application in the **Files** section. If you are unable to upload the documents and forms, please contact the Medical Staff Credentialing Coordinator for other delivery methods.

LENGTHY RESPONSES: Each comment/note field in this application has a limit of two lines of text data. If you need to submit a lengthy response that is more than two lines, please type your response in Word or PDF format and upload that document in the files section within the application.

ATTENTION: Misrepresentations, inaccuracies, or falsification of information can be grounds for termination of Medical Staff appointment and associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank.

REMINDERS: Incomplete submissions will not be accepted and will delay the processing of your application. To accelerate the processing of your submission, please ensure you provide a completed application with all requested documents and forms.

Personal Information 0 of 1 Required

Application for Initial Appointment Please enter the requested information and select the most appropriate specialties. Mandatory fields are in **Red**. Click **Edit** to modify this section and **Save** to save the information entered and navigate forward or backward in the application.

Last Name		Birth Place	
First Name		Citizenship	
Middle Name		Ethnicity	
Suffix		Emergency Contact Name	
Degree	▾	Emergency Contact Phone	
Salutation		Pager	
Preferred Name		Answering Service	
Birth Date	MM/DD/YYYY	Cell	
SSN		E-Mail	
Gender	▾	NPI	
Specialty 1	▾	Medicare	
Specialty 2	▾	Medicaid	
Language 1	▾	Preferred Contact Method	
Language 2	▾		

✖ Save ⊘ Cancel

Addresses 0 of 1 Required

Please list your home and office address.

Mandatory fields are in Red.

Additional office addresses may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Address*

Type	Home	Country	
Address1		Telephone	
Address 2		Fax	
City		E-Mail	
State			
Postal Code			
County			

Save Cancel

Add New

Alias/Other Names Used

Please list ALL your aliases or other names used.

Additional aliases may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Alias*

Alias Type	
Last Name	
First Name	
Middle Name	

Save Cancel

Add New

Education / Training 0 of 1 Required

Please list all institutions where you received education and/or training.

Mandatory fields are in **Red**. If you do not know the exact day please ensure that month and year are correct.

If you are a Foreign Graduate you **MUST** enter your ECFMG number in the **Licenses/Credentials section** of this application.

Begin by selecting the type of training you received (Medical Education, Internship, Residency, Fellowship), then typing the Name or City in the "Search" box.

If you are entering an Internship, please enter if it was "Rotating" or "Straight" in the "Subject" box. If entering "Straight" please also include discipline.

If you are entering a Residency or Fellowship, please enter your program in the "Subject" box.

Additional Education may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Education*

Type		Telephone	
Search	Enter Name or City to search	Fax	
Name		Email	
Address		Website	
Address 2		Start Date	MM/DD/YYYY
City		End Date	MM/DD/YYYY
State		Degree Earned	
Postal Code		Subject	
		Did you successfully complete this program? If no, please explain in the explanation section	
		Were you the subject of any disciplinary action during your attendance at this institution?	
		If yes, please explain	

✖ Save ⊘ Cancel

Add New

Hospital Affiliations

Please list all hospital practice history (past/present) where you have ever had an affiliation or where you have an application in process (including employment, self-employment, or service as an independent contractor), that has occurred since completion of medical or professional school.

DO NOT duplicate fellowship, internship and/or residency previously reported under Education and Training. If there is a gap greater than 60 days, explain that in the Gaps section.

Mandatory fields are in **Red**.

Additional healthcare affiliations may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Hospital*

Search	Enter Name or City to search	Start Date	MM/DD/YYYY
Name		End Date	MM/DD/YYYY
Address		Specialty	
Address 2		Relationship	
City		Supervisor	
State		Reason For Leaving	
Postal Code		Were you the subject of any disciplinary action during your attendance at this institution?	
County			
Telephone		If yes, please explain	
Fax		Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)	
Email			
Website			

✖ Save ⊘ Cancel

Add New

Work History

Please list all practice history (past/present) that has occurred since completion of medical or professional school. List all work engagements (including employment, self-employment, service as an independent contractor, ambluatory centers, surgery centers, assistantships, corporations, medical offices, universities, teaching, military assignments and government agencies) where you have ever had an affiliation or where you have an application in process.

DO NOT duplicate affiliations listed in the Hospital Affiliations Section and/or do not duplicate fellowship, internship, and/or residency previously reported under Education and Training Section. If there is a gap greater than 60 days, explain that in the Gaps section.

Enter current information first, then previous.

Mandatory fields are in Red.

Additional Work History may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Work History*

Type		Start Date	MM/DD/YYYY
Search	Enter Name or City to search	End Date	MM/DD/YYYY
Name		Position	
Address		Relationship	
Address 2		Supervisor	
City		Reason for leaving	
State		Were you the subject of any disciplinary action during your attendance at this institution?	
Postal Code			
County		If yes, please explain	
Country		Please indicate your Staff Status (active, courtesy, provisional, temporary, etc)	
Telephone			
Fax			
Email			
Website			

Save Cancel

Add New

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.

Additional Gaps may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

Mandatory fields are in Red.

New Gap*

Start Date MM/DD/YYYY

End Date MM/DD/YYYY

Explanation

Save Cancel

Add New

Peer Professional References 0 of 3 Required

Please list names and contact information of at least three (3) individuals who are of the same discipline or profession who have personal knowledge (within the last 12 months) of your current clinical abilities, ethical character, and interpersonal skills.

For those in training, one reference must be from the Director of the training program.

For all other applicants, one must be from a supervisor, Chief of Staff or Departmental Chairperson from each hospital, where the applicant is on the active clinical staff.

Please note that some facilities may require additional peer references, and although the minimum listed above may allow for the application to be submitted, we may be reaching out to you to obtain additional peer references.

Mandatory fields are in Red.

Additional Peer References may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Peer Reference*

First Name

Last Name

Degree

Address

Address 2

City

State

Postal Code

YearsKnow

Telephone

Fax

E-Mail

Relationship

Specialty

Save Cancel

Add New

Licenses / Credentials

Please note that other credentials may be required by the facility in which you are applying.

Please note if there are any limitations or restrictions.

**Begin by selecting the type. Please NOTE all the following credentials listed below are required:

1. ALL Inactive and Active licenses (Medical/Nursing/Pharmacy, DEA, CDS, etc...)
2. Life Support Certifications (BLS, ACLS, ATLS, NRP, PALS, ALSO, etc...)
3. ECFMG (if applicable)
4. National Provider Identification (NPI) Number

Mandatory fields are in **Red**.

If the Credential you are listing does not have a State and/or License number associated with it please add N/A to the License Number field and use a state that you are licensed and/or reside in since these are required fields. Please include any additional information in the Comments field.

Additional Licenses and Certifications may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Credential*

Type		License Number	
Name		Issue Date	MM/DD/YYYY
Address		Expiration Date	MM/DD/YYYY
Address 2		State	
Address 3		Limitations	☐
City		Comments	
State			
Postal Code			
County			
Country			
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

Add New

Board Certifications

Please list all board certifications currently or previously held. List your primary board certification first. Begin by typing the board acronym and/or name in the Search box, once selected it will pre-populate fields. Under Certification Status: E = Board Eligible, N = Not Certified, Y = Yes, Certified.

If not certified, please provide in the Explanation Box if you have applied, or intend to apply, for certification examination, and include anticipated exam date.

Mandatory fields are in Red.

Additional Board Certifications may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Board Certification*

Search	Enter Name or City to search	Certification Status	
Name		Status	
Address		Certificate Number	
Address 2		InitialCertification	MM/DD/YYYY
Address 3		Recertification	MM/DD/YYYY
City		Certification Expires	MM/DD/YYYY
State		Exam Date	MM/DD/YYYY
Postal Code		Specialty	
County		Specialization	
Country		Explanation	
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

Add New

Medical Societies

Please list any current or previous medical society affiliations. Begin by typing the acronym and/or name in the Search box, once selected it will pre-populate fields.

Mandatory fields are in Red.

Additional Medical Societies may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Society*

Search	Enter Name or City to search	Start Date	MM/DD/YYYY
Name		End Date	MM/DD/YYYY
Address		Title	
Address 2			
City			
State			
Postal Code			
County			
Country			
Telephone			
Fax			
Email			
Website			

✖ Save ⊘ Cancel

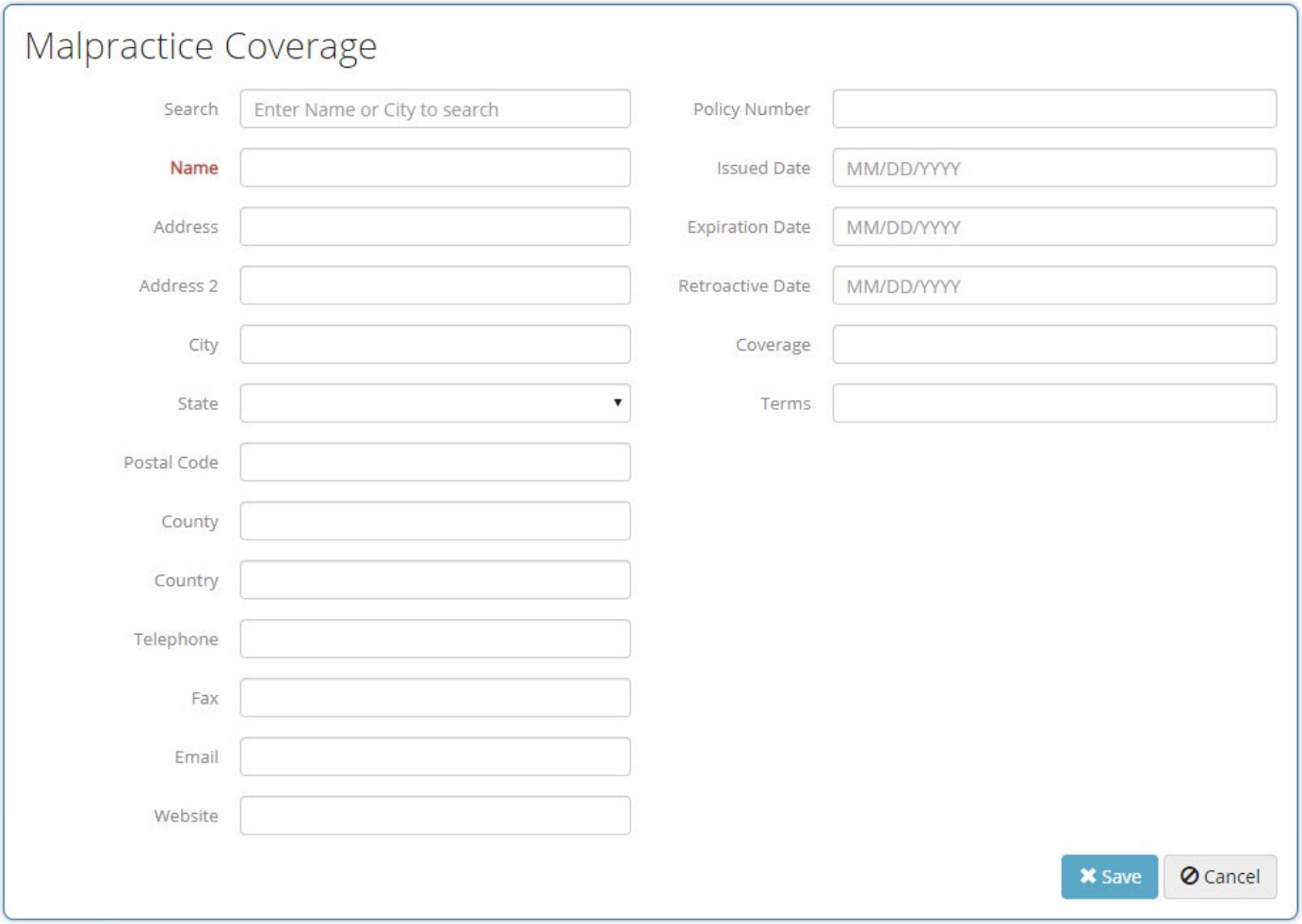
Add New

Malpractice Coverage

Please list all current, previous or future malpractice insurance carriers for the past 5 years, including name, policy number, and dates held. Begin by typing the insurance carrier's name in the Search box, once selected it will pre-populate fields.

Mandatory fields are in Red.

Additional Malpractice Insurance Carriers may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.



Add New

Malpractice Claims

Please provide the following information regarding any current (open/pending) and/or previous lawsuits or complaints against you and/or against a hospital, corporation, or the United States Government based on a case with which you were professionally associated. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response if requested.

The Search Boxes for Insurance and Hospital names will prepopulate fields once selected. Under Hospital you should list where the incident occurred. If the Status of the malpractice claim is not available under Status, please use Status Comments box to provide information.

Please note that the Notes section is limited to 300 characters; if your response is more than 300 characters please upload the information as a MS Word or PDF document in the Files section. If status is "Judgement for Plaintiff" or "Settled," please put the amount in the amount field.

Mandatory fields are in Red.

Additional Malpractice Claims may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Malpractice Claim*

IncidentDate MM/DD/YYYY

DateFiled MM/DD/YYYY

DateClosed MM/DD/YYYY

Amount

Type

Status

Notes

History

Allegation

Status Comments

Search Enter Name or City to search

Insurance Name

Policy Number

InsuranceAddress

InsuranceAddress2

InsuranceCity

InsuranceState

InsurancePostalCode

InsuranceCountry

InsuranceTelephone

InsuranceFax

Search Enter Name or City to search

Hospital Name

HospitalAddress

HospitalAddress2

HospitalCity

HospitalState

HospitalPostalCode

HospitalCountry

HospitalTelephone

HospitalFax

✖ Save ⊘ Cancel

Add New

Health Screen/Immunizations

Immunizations that met current CDC vaccination recommendations for healthcare workers must be provided to the Employee Health Nurse prior to seeing patients.

Must list and/or add MMR, PPD (within the past year), and Hep B. In addition, upload documentation of these in the Files Section of this application. List and/or add Influenza, Varicella, Tdap and Meningococcal if you have these readily available.

Rubella and Measles Immunity

Applicants requesting hospital/clinic privileges are required to submit evidence of rubella and measles 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 rubella and measles vaccine. Please submit documentation in the Files Section of this application that your rubella and measles immunity was positive or that that you have received the vaccine .

TB Skin Test

Applicants requesting hospital/clinic privileges are required to submit documentation of a current (within the past 12 months) TB 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 indiciates prior exposure, please note that in the Result Section.

By selecting that you decline the Hepatits B, 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 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 received 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 **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.

New Medical History*

MedicalHistory

Result

Date Administered — MM/DD/YYYY

Comments

Date Expired — MM/DD/YYYY

✖ Save ⊘ Cancel

Add New

Files

Please upload the following required documents:

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. Signed and confirmed health statement by applicant and personal physician
5. Current Curriculum Vitae or Resume
6. Application Approval Signature Page
7. Delineation of Privileges Signature Page
8. Bylaws Attestation
9. Confidentiality - General Statement
10. Medicare Statement
11. CMEs (including IHS Opioid Prescriber Training Certificate)

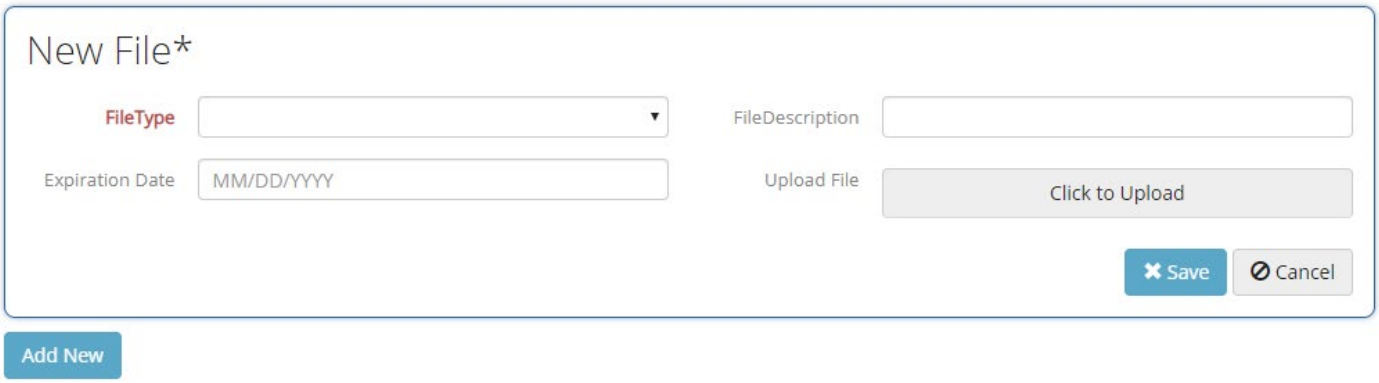
In order to upload an item, it must be saved in a digital format on your computer (pdf, jpg, etc.). If unable to perform this function, please contact MD-App Support at 1-800-736-7276 or the Medical Staff Office.

Mandatory fields are in Red.

To upload:

1. Select *Add New**.
2. Select a **File Type**
3. Enter a **Description** (Optional)
4. Enter an **Expiration Date** (Optional)
5. Click **"Click To Upload"** and Browse To Your File.
6. Click Save to complete the upload

Additional Files may be added by clicking the **Add New** button. Click **Save** when finished. You can add as many as you would like by clicking **Add New**.



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, or canceled?
○ Yes	○ No	Has your license ever been subjected to probation either voluntarily or involuntarily?
○ Yes	○ No	Has your license ever been withdrawn either voluntarily or involuntarily?
○ Yes	○ No	Has any disciplinary actions or investigations been initiated against you by any state licensure board?
○ Yes	○ No	Have you 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 been the subject of a complaint or have you been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal 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 been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society or regulatory agency?
○ 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 been reprimanded, censured, excluded, suspended, and/or disqualified from participating in voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, Tri-Care, and/or any other governmental health related programs?
○ Yes	○ No	Have Medicare, Medicaid, Tri-Care, PRO authorities, and/or any other third party payers brought charges against you for alleged inappropriate fees, and/or quality of care issues?
○ Yes	○ No	Has any information pertained to you, including malpractice judgements and/or disciplinary action ever been reported to the National Practitioner Data bank or any other practitioner data bank?
○ Yes	○ No	Has your federal DEA number and/or state controlled substance license been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily?
○ Yes	○ No	Have you been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?
○ Yes	○ No	Have you had a claim for professional negligence asserted against you in the past 10 years? (if yes you are required to note the final judgement and settlements involving yourself as a practitioner in the Malpractice Claims section of this application.
○ Yes	○ No	Have liability claims, judgements or settlements 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?

○ 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 been the subject of a civil or criminal complain 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, or elder abuse?
○ Yes	○ No	Do you have, or has it been suggested to you that you have, a history including that the present, of any physical, mental, or emotional impairment either 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 been charged with or convicted of a crime (other than a minor traffic offense) in any state or country?
○ Yes	○ No	Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges before a hospital or health facility's governing board made a decision?

Certification of Professional Licenses

○ Yes	○ No	I certify that I have listed all active and inactive state medical 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, the District of Columbia, or Puerto Rico.
○ Yes	○ No	I also 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

Please review and request any privileges that you may be requesting by clicking on the check-box that is next to the appropriate privilege. If you have cases to provide, please include them. You may also include more details in the **Comments** section.

Review Application

Please select **Submit Application** to submit your application ensuring all areas have been completed and all requested documents and forms have been included. Your application and documents may be saved to your computer and/or printed from the ***Main Login Screen*** After you submit your application. **Press Summary or View On Main Page**

Final Steps:

1. Check the Applicant's Acknowledgement below
2. Enter your complete and legal name below indicating you have read and agree to be bound by the statements below
3. Click Submit Application below to notify the Medical Staff Office that your application is complete ** Note: Once your application has been submitted, you may go back to edit your data by pressing **Unsubmit** on the main login page. You can return to this site to print your application and documents. If you have any questions, please contact the Medical Staff Credentialing Coordinator. Their information is located in your ***Welcome Letter*** located in the Application Packet. We look forward to receiving your completed application.

Please enter your complete and legal name to indicate that you certify that to the best of your knowledge, that all information provided on this application are true, accurate, and you have not omitted any material or facts which would render the statement false, fictitious, or fraudulent as a result of omission

⚠ Submit Application