

## ASM Test - 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:** 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.

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

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 0 of 1 Required

List home and office addresses.

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

New Address*	Delete
<b>Type</b>	
<input type="text"/>	
<b>Address1</b>	
<input type="text"/>	
Address 2	
<input type="text"/>	
<b>City</b>	
<input type="text"/>	
<b>State</b>	
<input type="text"/>	
Postal Code	
<input type="text"/>	
County	
<input type="text"/>	
Country	
<input type="text"/>	
<b>Telephone</b>	
<input type="text"/>	
Fax	
<input type="text"/>	
<b>Email</b>	
<input type="text"/>	

✕ Save

⊘ Cancel

New Addresses

+ Add

## 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.

New Alias\*

Delete

First Name

Middle Name

Last Name

✕ Save

⊘ Cancel

New Alias/Other Names Used

+ Add

## 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 the **Search** box. Click **Save** when finished.

New Education\*

Delete

**Education Type**

**Search**

**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.)

**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.

New Credential*	Delete
<p><b>Type</b></p> <input type="text" value=""/>	
<p><b>License Number</b></p> <input type="text" value=""/>	
<p><b>State</b></p> <input type="text" value=""/>	
<p><b>Expiration Date</b></p> <input type="text" value="MM/DD/YYYY"/>	
<p><b>Status</b></p> <input type="text" value=""/>	
<p><b>Comments</b></p> <input type="text" value=""/>	

New Licenses/Credentials

### 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.

New Board Certification*	Delete
Search	
<input type="text" value="Enter Name or City to search"/>	
<b>Name</b>	
<input type="text"/>	
Address	
<input type="text"/>	
Address 2	
<input type="text"/>	
City	
<input type="text"/>	
State	
<input type="text" value=""/>	
Postal Code	
<input type="text"/>	
Country	
<input type="text" value=""/>	
Specialty	



<input type="text"/>		▼
Certified In		
<input type="text"/>		▼
<b>Certificate Number</b>		
<input type="text"/>		
<b>Certification Status</b>		
<input type="text"/>		▼
Initial Certification		
<input type="text" value="MM/DD/YYYY"/>		
Expiration Date		
<input type="text" value="MM/DD/YYYY"/>		
Comments		
<input type="text"/>		
		<input type="button" value="✕ Save"/> <input type="button" value="⊘ Cancel"/>

  

New Board Certifications	<input type="button" value="+ Add"/>
--------------------------	--------------------------------------

## 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. Completed Statement of Understanding & Release Form (MUST be uploaded to submit application.)

### 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*	<input type="button" value="Delete"/>
-----------	---------------------------------------

## File Type

## File Description

## Upload File




New Files

## Attestation Questions

Please answer **\*\*ALL\*\*** attestation questions. For any "Yes" answers, please provide further explanation in the space provided.

 Yes

 No

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?

 Yes

 No

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)?

 Yes

 No

Have you ever been the subject of an informal or formal hearing process at any healthcare organization?

 Yes

 No

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?

<input type="radio"/> Yes	<input type="radio"/> 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?
<input type="radio"/> Yes	<input type="radio"/> No	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.
<input type="radio"/> Yes	<input type="radio"/> No	Have you ever had professional liability coverage denied, refused, or canceled by a professional liability insurance company?
<input type="radio"/> Yes	<input type="radio"/> 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?
<input type="radio"/> Yes	<input type="radio"/> No	Have you 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?
<input type="radio"/> Yes	<input type="radio"/> No	Do you have, or has it ever been suggested to you that you have, a diagnosed or undiagnosed chemical dependency (i.e. alcohol, illegal drugs, prescriptive drugs, etc), are engaged in illegal use of any legal or illegal substances, or are currently participating in a supervised rehabilitation program and/or professional assistance program, which monitor for alcohol and/or substance abuse?
<input type="radio"/> Yes	<input type="radio"/> No	Has it been more than 12 months since you have provided patient care in a professional setting?
<input type="radio"/> Yes	<input type="radio"/> No	Have you been charged with or convicted of a crime, other than a minor traffic offense, in any state or country?

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.

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