

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

☐ Check if there are any changes and update below.

Last Name:

First Name:

Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City:

State:

Zip Code:

Telephone Number:

Fax Number:

Cell Number:

Pager Number:

Practitioner Email:

Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date:

Birth Place:

Race (optional):

Ethnicity (optional):

Language(s) (optional):

The credentialing entity will not discriminate or base credentialing decisions on the applicant's race, ethnicity and language and providing this information is optional.

Driver's License State/Number:

Social Security Number:

Gender: ☐ Male ☐ Female

Your intent is to serve as a(n):

☐ Primary Care Provider

☐ Specialist

☐ Urgent Care

☐ Hospitalist

☐ Hospital Based

Specialty:

Subspecialties:

III. Practice Information

☐ Check if there are any changes and update below.

Practice Name (if applicable):

Department Name (if hospital based):

Primary Office Address:

City:

State:

Zip Code:

Telephone Number:

Fax Number:

Website (if applicable):

Office Administrator/Manager:

Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email:

Office Administrator/Manager Fax Number:

Federal Tax ID Number:	Name Associated with Tax ID:
Please identify the physical accessibility of this office: <input type="checkbox"/> Basic <input type="checkbox"/> Limited <input type="checkbox"/> None	

III. Practice Information (Continued) <input type="checkbox"/> Check if there are any changes and update below.	
Type of practice (check all that apply):	
<input type="checkbox"/> Solo Practice	
<input type="checkbox"/> Group Practice	
<input type="checkbox"/> Single Specialty Group	
<input type="checkbox"/> Multi Specialty Group	
<input type="checkbox"/> Urgent Care	
Primary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Secondary Practice Information

Practice Name (if applicable):	Department Name (if hospital based):	
Secondary Office Address:		
City:	State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Office Administrator/Manager:	Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:	Office Administrator/Manager Fax Number:	
Federal Tax ID Number:	Name Associated with Tax ID:	
Please identify the physical accessibility of this office: <input type="checkbox"/> Basic <input type="checkbox"/> Limited <input type="checkbox"/> None		
Type of practice (check all that apply):		
<input type="checkbox"/> Solo Practice		
<input type="checkbox"/> Group Practice		
<input type="checkbox"/> Single Specialty Group		
<input type="checkbox"/> Multi Specialty Group		
<input type="checkbox"/> Urgent Care		

Secondary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Tertiary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):	
Tertiary Office Address:			
City:		Zip Code:	
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	
Please identify the physical accessibility of this office: <input type="checkbox"/> Basic <input type="checkbox"/> Limited <input type="checkbox"/> None			
Type of practice (check all that apply): <input type="checkbox"/> Solo Practice <input type="checkbox"/> Group Practice <input type="checkbox"/> Single Specialty Group <input type="checkbox"/> Multi Specialty Group <input type="checkbox"/> Urgent Care			
Tertiary Office Hours of Operation:	Languages spoken by Staff:		
	Languages spoken by Provider:		
Group Medicare PTAN/UPIN #:	Group NPI #:		

Mailing Address

Which of your practices is your primary mailing address? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Other
If your mailing address is different from your practice address, please provide it:

IV. Billing Information

☐ Check if there are any changes and update below.

Which of your practices handles your billing? <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary, if none, please provide billing info:
Billing Company:
Billing Company Mailing Address:

City:	State:	Zip Code:
Contact Person:	Telephone Number:	
Federal Tax ID Number:	Name Associated with Tax ID:	

V. Practice Description		<input type="checkbox"/> Check if there are any changes and update below.
Do you employ any allied health professionals (e.g., nurse practitioners, physician assistants, psychologist, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list:		
Name	License Number	
Physician Assistant Supervisor Name:	License Number:	

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list:
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Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary
		<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:
Which offices does this apply to: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary
Please list any clinical services you do not perform that are typically associated with your specialty:
Which offices does this apply to: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary
Is your practice limited to certain ages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify limitation:
Which offices does this apply to: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company:			
Answering Service Company Address:			
City:	State:	Zip Code:	Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training, and Experience below.

☐ Check if there are any changes and update

Medical/Professional Education

Medical School/Professional:	Degree Received:	Graduation Date:
Mailing Address:	Website (if applicable):	
City:	State: Zip Code:	Registrar's Phone Number:

Internship/PGY-1

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Type of Internship:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain on a separate sheet.)		

Residencies/Fellowships Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:

Telephone Number:	Fax Number:	Website (if applicable):	
Type of Training:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, please explain on a separate sheet.)			

VII. Medical Licensure & Certifications	<input type="checkbox"/> Check if there are any changes and update below.
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California State Medical License: Number	Issue Date:	Expiration Date:
Drug Enforcement Agency (DEA) Registration Number:	Schedules:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Issue Date	
Individual National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	Individual Medicare PTAN Number:

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by: • a member board of the American Board of Medical Specialties • a member board of the American Osteopathic Association • a board or association with equivalent requirements approved by the Medical Board of California • a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:	Describe here:
Board Name:	
Exam Date:	

VIII. Current Hospital and Other Institutional Affiliations ☐ Check if there are any changes and update below.

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:	Zip Code:	
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:	Zip Code:	
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:	Zip Code:	
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:	Department Name:
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Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):	
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B. Previous Hospital and Other Institutional Affiliations

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
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	From (mm/yy):
	To (mm/yy):
Reason for leaving:	

IX. Peer References ☐ Check if there are any changes and update below.

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility where you currently hold privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:		Specialty:	
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:	Email Address:	

Name of Reference:		Specialty:	
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:	Email Address:	

Name of Reference:		Specialty:	
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:	Email Address:	

X. Work History ☐ Check if there are any changes and update below.

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice:		Contact Name:	
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:	From (mm/yyyy):	To (mm/yyyy):

Current Practice:		Contact Name:	
Address:	City:	State:	Zip:
Telephone Number:	Fax Number:	From (mm/yyyy):	To (mm/yyyy):

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

XI. Professional Liability

☐ Check if there are any changes and update below.

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website (if applicable):
Email Address:	Tail Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website (if applicable):
Email Address:	Tail Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website (if applicable):
Email Address:	Tail Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

XII. Professional and Practice Services

☐ Check if there are any changes and update below.

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID:	Type of Service Provided:	Do you have a CLIA certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Billing Name:		Do you have a waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No

CLIA Certificate Number:

CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued) ☐ Check if there are any changes and update below.

Have you or your office received any of the following accreditations, certificates, or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAHC)
- ☐ Medicare Certification ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP) ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS) ☐ Family Planning
- ☐ Other:

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ☐ Yes ☐ No If so, which Network?

Do you use a practice management system/software? ☐ Yes ☐ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

- ☐ No, I do not wish to be designated as an HIV/AIDS specialist.
- ☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:
 - ☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine, OR
 - ☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; OR
 - ☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
 - ☐ 1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND
 - ☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; OR
 - ☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV, AND
 - ☐ 1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; OR
 - ☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; OR
 - ☐ 3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions “Yes” or “No”. If your answer to any of the following questions is “Yes”, please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending?

☐ Yes ☐ No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending?

☐ Yes ☐ No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

☐ Yes ☐ No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

☐ Yes ☐ No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No
6. Have you ever been denied certification/recertification by a specialty board?

☐ Yes ☐ No
7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?

☐ Yes ☐ No
8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense?

☐ Yes ☐ No
8. b. Are any such actions pending?

☐ Yes ☐ No
9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If YES, please complete Addendum B.

☐ Yes ☐ No
10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending?
If YES, please complete Addendum B.

☐ Yes ☐ No
11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

☐ Yes ☐ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ☐Yes ☐No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ☐Yes ☐No
14. Are you currently engaged in the illegal use of drugs, or have a chemical or substance abuse dependency? ☐Yes ☐No
15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ☐Yes ☐No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment, or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable): _____

PRINTED NAME: _____

DATE: _____

Continue to the Next Page for Information Release/Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)

PRINTED NAME

DATE

Addenda Submitting;

☐ Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:

- California Association of Health Plans (916) 552-2910

- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages before submission.