greater arizona central
credentialing program
primary source and credential verification services

326 East Coronado Road • Phoenix, Arizona 85004-1576
Telephone: (602) 256-0705 • Fax: (602) 256-2763

Instructions for Completing the Initial Application

- Complete all areas on the application
- Do not leave any blanks
- Incomplete applications WILL be returned
- Print completed application, sign pages 15, 16, 17 and 14, if applicable
- Send with readable copies of:
  - Arizona professional license
  - All other current state licenses
  - DEA certificates
  - Malpractice insurance certificate
  - Degree(s) and post graduate training certificates
  - Military release certificate (DD214)
  - Board certification (certificate, status letter)
  - Continuing Medical Education certificates
  - TB attestation documentation
  - Current curriculum vitae
  - One current photo
  - Criminal background check forms, if applicable
- Non-Refundable check made payable to GACCP for $160.00 for each hospital (except St. Joseph's - see below) to which you are applying.

Facilities requiring criminal background checks:

- Maryvale (Medical Center) Hospital

If you are applying to any of the facilities listed above, please complete, sign and include pages 20 and 21

IMPORTANT NOTICE

St. Joseph's Hospital and Medical Center Applicants

As of January 1, 2002 fees connected with the verification process are to be paid directly to GACCP and included with completed application. Please remit $285.00, the total amount due for St. Joseph's.

If you are currently a member or become a member of the Maricopa County Medical Society within 30 days of our receipt of your GACCP application, you will receive a reduction in the form of a partial rebate of your GACCP application processing fee.

I AM APPLYING TO THE FOLLOWING HOSPITAL(S) AND HAVE ENCLOSED THE APPROPRIATE FEE

- ☐ Arizona Heart Hospital
- ☐ Arrowhead Hospital
- ☐ Kindred Hospital - Phoenix/Scottsdale
- ☐ Maryvale Hospital Medical Center
- ☐ Phoenix Baptist Hospital & Medical Center
- ☐ St. Joseph's Hospital Medical Center **
- ☐ St. Joseph's Westgate Medical Center
- ☐ Trillium Specialty Hospital - East Valley
- ☐ Trillium Specialty Hospital - West Valley
- ☐ Valley of the Sun Rehabilitation Hospital
- ☐ West Valley Hospital Medical Center

**AN ADDITIONAL FEE OF $125.00 MUST BE RETURNED WITH THE APPLICATION WHEN APPLYING TO ST. JOSEPH'S HOSPITAL MEDICAL CENTER

THE FOLLOWING HOSPITALS REQUIRE YOU TO COMPLETE A PRE-APPLICATION BEFORE WE CAN PROCESS YOUR APPLICATION. YOU MUST CONTACT THE FACILITY AND COMPLETE THEIR PRE-APPLICATION PROCESS

- ☐ Casa Grande Regional Medical Center (520) 381-6347
- ☐ Hualapai Mountain Medical Center

Printed Name _____ Date _____

Signature _____

GREATER ARIZONA CENTRAL CREDENTIALING PROGRAM

326 EAST CORONADO ROAD
PHOENIX, ARIZONA 85004-1576
TELEPHONE: 602-256-0705
FAX: 602-256-2763

INITIAL APPLICATION

FOR MEDICAL STAFF OR HEALTH CARE ENTITY

Date	
APPLICATION SENT:	_____
APPLICATION RECEIVED:	_____
VERIFICATION COMPLETED:	_____

Application will be returned if not complete.

Incomplete addresses will delay file.

DO NOT leave any blank spaces. "See CV" is not acceptable, if not applicable mark N/A.

Please PRINT (using black ink) or type. *If using a Highlighter, use yellow ONLY

DO NOT use white out. INITIAL ALL CHANGES.

Copies of all required attachments must be legible.

(PLEASE INDICATE SPECIALTY AREA(S) IN WHICH YOU ARE REQUESTING PRIVILEGES)

- ☐ **Addiction Medicine**
- ☐ **Allergy and Immunology**
- ☐ **Anesthesiology**
  - ☐ Pain Management
- ☐ **Dentistry**
  - ☐ Pediatric Dentistry
- ☐ **Dermatology**
- ☐ **Emergency Medicine**
  - ☐ Toxicology
- ☐ **Family Practice**
- ☐ **Internal Medicine**
  - ☐ Cardiovascular Disease
  - ☐ Endocrinology and Metabolism
  - ☐ Gastroenterology
  - ☐ Hematology
  - ☐ Infectious Disease
  - ☐ Medical Oncology
  - ☐ Nephrology
  - ☐ Pulmonary Disease
  - ☐ Rheumatology
- ☐ **Nuclear Medicine**
- ☐ **Obstetrics and Gynecology**
  - ☐ Gynecology Only
  - ☐ Gynecology Oncology
  - ☐ Maternal/Fetal Medicine
- ☐ **Pathology**
- ☐ **Pediatrics**
  - ☐ Neonatal-Perinatal
  - ☐ Sub Specialty_____
- ☐ **Physical Medicine and Rehab**
- ☐ **Podiatry**
- ☐ **Preventive Medicine**
- ☐ **Psychiatry and Neurology**
  - ☐ Child Psychiatry
  - ☐ Neurology and / or Child Neurology
  - ☐ Psychiatry
- ☐ **Psychology**
- ☐ **Radiology**
  - ☐ Interventional Radiology
- ☐ **Radiation Oncology**
- ☐ **Surgery**
  - ☐ Cardiothoracic Surgery
  - ☐ Colon & Rectal Surgery
  - ☐ General Surgery
  - ☐ Neurological Surgery
  - ☐ Ophthalmology
  - ☐ Oral & Maxillofacial Surgery
  - ☐ Orthopedic Surgery
  - ☐ Otolaryngology
  - ☐ Pediatric Surgery
  - ☐ Plastic Surgery
  - ☐ Surgical Assist
  - ☐ Urology
  - ☐ Vascular Surgery
- ☐ Other_____

I. PERSONAL DATA

Confidential and only used in the event of an emergency.

a) Name: _____ (Last) _____ (First) _____ (Middle) _____ (Title)

b) List other names you have used: _____ Sex: ☐ F ☐ M

c) Home: _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

d) Home Phone #: _____ e) Name of Spouse: _____

f) Date of Birth: _____ g) Place of Birth: _____ h) Citizenship: _____

i) Foreign Language(s): _____ ☐ Speak ☐ Write j) UPIN #: _____ (Assigned by Medicare)

k) NPI #: _____ l) SSN: _____ m) Tax ID#: _____

n) Primary Taxonomy Code: _____

II. CURRENT PRACTICE INFORMATION

a) **Primary Office**

Corporate/Group Name: _____ Office Manager: _____

_____ (Street Address)

_____ (City) _____ (State) _____ (Zip Code)

Phone: _____ Fax #: _____ Email: _____

Answering Service: _____ Pager: _____ Cell Phone: _____

b) **Other Locations**

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

☐ If additional space is needed - please attach a separate sheet

c) Address to which all correspondence should be sent (**IF DIFFERENT FROM** Primary Office Address):

_____ (Street Address / P.O. Box Number)

_____ (City) _____ (State) _____ (Zip Code)

Phone: _____ Fax #: _____ Email: _____

d) Associates (Name of Physicians): _____

e) Covering Physicians: _____

f) Do you sponsor / employ any Allied Health Practitioners? _____ (Yes/No) If yes, list names, category (i.e. NP, PA):

_____

III. FUTURE PRACTICE INFORMATION

Complete this section if you are in the process of moving from the location listed as your current primary office.

☐ **Not leaving Current Practice**

a) Corporate/Group Name: _____ b) Office Manager: _____

c) **Anticipated Start Date:** _____

d) Address: _____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

e) Phone: _____ f) Fax #: _____ g) Email: _____

h) Answering Service: _____ i) Pager: _____ j) Cell Phone: _____

k) Address to which all correspondence should be sent (**IF DIFFERENT FROM** Primary Office Address):

_____
(Street Address / P.O. Box Number)

_____ _____ _____
(City) (State) (Zip Code)

Phone: _____ Fax #: _____ Email: _____

l) Associates (Name of Physicians): _____

m) Covering Physicians: _____

n) Do you sponsor / employ any Allied Health Practitioners? _____
(Yes/No)

If yes, list names, category (i.e. NP, PA): _____

IV. LICENSE(S)

List in what states or provinces you have applied for or been granted license or registration.
If license not issued, so state. Attach legible copy of current license(s).
If additional space is needed, complete addendum page.

a) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
b) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
c) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
d) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
e) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

Explain any licenses not issued:

_____

_____

This completes my license information ☐ Yes ☐ No

V. EDUCATION

List all medical, osteopathic, dental or podiatric schools attended. Attach copy of Degree(s).
See Page 5 for Post Graduate education.

a) College or University: _____
(Name)

_____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? ☐ Yes ☐ No

b) College or University: _____
(Name)

_____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? ☐ Yes ☐ No

c) College or University: _____
(Name)

_____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? ☐ Yes ☐ No

d) College or University: _____
(Name)

_____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? ☐ Yes ☐ No

VI. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

Please attach copy of ECFMG Certificate (if applicable)

☐ **Does Not Apply**

ECFMG Certification #: _____ Date Issued: _____

VII. POSTGRADUATE TRAINING

List all facilities where you received training. Applicant must disclose every training program initiated, whether completed or not, and all completed programs. ATTACH COPIES OF CERTIFICATES.

a) Check one: ☐ Internship ☐ Residency ☐ Fellowship Specialty: _____

Facility: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? ☐ Yes ☐ No

b) Check one: ☐ Internship ☐ Residency ☐ Fellowship Specialty: _____

Facility: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? ☐ Yes ☐ No

c) Check one: ☐ Internship ☐ Residency ☐ Fellowship Specialty: _____

Facility: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? ☐ Yes ☐ No

d) Check one: ☐ Internship ☐ Residency ☐ Fellowship Specialty: _____

Facility: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? ☐ Yes ☐ No

VIII. MILITARY/PUBLIC HEALTH SERVICE

Please attach copy of DD214 / Statement of service U.S. Public Health

☐ **Does Not Apply**

In the previous 15 years, have you served or are you currently serving ☐ Yes ☐ No

☐ U.S. Military ☐ Reserves ☐ Public Health Service

If yes, which Branch: _____

From: _____ (Month Year) To: _____ (Month Year) Type of discharge: _____

IX. EMPLOYED FACULTY POSITION

Please list all positions held during previous 15 years.

☐ **Does Not Apply**

a) Institution: _____ (Name)

Department: _____

Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Phone: _____ Fax: _____

Position Held: _____ From: _____ (Month Year) To: _____ (Month Year)

Reason for Leaving: _____

Continue with additional employed faculty positions? ☐ Yes ☐ No

b) Institution: _____ (Name)

Department: _____

Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Phone: _____ Fax: _____

Position Held: _____ From: _____ (Month Year) To: _____ (Month Year)

Reason for Leaving: _____

Continue with additional employed faculty positions? ☐ Yes ☐ No

X. PRACTICE HISTORY

Please list all positions held during the previous 15 years, in chronological order. Leave no time period unaccounted.
Information should include private practice (solo, group) and any paid employment.
If additional space is needed please complete addendum page.

☐ **New physician, no previous practice**

a) Practice/Employer Name: _____

Address: _____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

b) Practice/Employer Name: _____

Address: _____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

c) Practice/Employer Name: _____

Address: _____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

XI. TIME GAPS

You must account for time gaps less than 90 days (3 months). Time gaps greater than 90 days (3 months) must be accounted for by you and verified in writing by someone other than yourself. You must account for all time gaps that occurred during the previous 15 years.

☐ **I have no time gaps**

a) From: _____ (Month Year) To: _____ (Month Year) Explain:

_____

_____

Name and address of person to contact for verification of time gap greater than 3 months.

_____ (Name) _____ (Phone) _____ (Fax)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Continue with additional time gap information? ☐ Yes ☐ No

b) From: _____ (Month Year) To: _____ (Month Year) Explain:

_____

_____

Name and address of person to contact for verification of time gap greater than 3 months.

_____ (Name) _____ (Phone) _____ (Fax)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Continue with additional time gap information? ☐ Yes ☐ No

c) From: _____ (Month Year) To: _____ (Month Year) Explain:

_____

_____

Name and address of person to contact for verification of time gap greater than 3 months.

_____ (Name) _____ (Phone) _____ (Fax)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Continue with additional time gap information? ☐ Yes ☐ No

d) From: _____ (Month Year) To: _____ (Month Year) Explain:

_____

_____

Name and address of person to contact for verification of time gap greater than 3 months.

_____ (Name) _____ (Phone) _____ (Fax)

_____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Continue with additional time gap information? ☐ Yes ☐ No

XII. STAFF MEMBERSHIPS

Please list ALL facilities to which you have applied during the previous 15 years.
If additional space is needed, please complete addendum page.

☐ **I have never applied or held staff membership in any healthcare facility during the previous 15 years**

a) **PRIMARY HOSPITAL AFFILIATION** _____
(Hospital Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

b) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

c) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

d) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

e) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

f) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

g) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

XIII. BOARD CERTIFICATION

List any and all Specialty Boards. Attach copy of certificate(s) or Documentation of Board Status.

a) Are you Board Certified? ☐ Yes ☐ No If yes, complete questions 1 through 3

1) Name of Board: _____
Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

b) Are you certified in a sub-specialty? ☐ Yes ☐ No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: _____
Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

c) Are you certified in an additional sub-specialty? ☐ Yes ☐ No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: _____
Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

d) If you are not Board certified, indicate current status: _____

Name of Board: _____
Board Name

Identify dates you sat for exam: Or will sit:

Date: _____ ☐ Passed Exam ☐ Failed Exam Date: _____

Date: _____ ☐ Passed Exam ☐ Failed Exam Date: _____

Date: _____ ☐ Passed Exam ☐ Failed Exam Date: _____

e) ☐ Not Pursuing

XIV. DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (DEA)

Please attach legible copy of current registration.

DEA Number: _____ Expiration Date: _____

☐ DEA Pending ☐ I do not have a DEA

XV. CONTINUING MEDICAL EDUCATION

Attach copies of CME certificates and/or provide a listing of all credits received.

Hospitals require documentation of CME hours related to privileges requested, except for practitioners who have completed training within the past year.

☐ **N/A, I completed training within the past year**

Number of continuing medical education hours awarded to you during the past calendar year: _____ hours.

XVI. PROFESSIONAL LIABILITY INSURANCE

Please list current professional liability insurance information. You must provide information on all professional policies under which you may be covered. List ALL policies under which you've been insured for the previous fifteen (15) years. Please attach a copy of current certificate of insurance

CURRENT CARRIERS

a) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____ (Street Address) _____ (City) ____ (State) ____ (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ (Month Year) To: _____ (Month Year) Retro Date: _____ (Month Year)

Amount of coverage currently in effect: $ _____ per occurrence/per aggregate.

Continue with additional insurance information? ☐ Yes ☐ No

b) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____ (Street Address) _____ (City) ____ (State) ____ (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ (Month Year) To: _____ (Month Year) Retro Date: _____ (Month Year)

Amount of coverage currently in effect: $ _____ per occurrence/per aggregate.

Continue with additional insurance information? ☐ Yes ☐ No

PRIOR CARRIERS

a) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____ (Street Address) _____ (City) ____ (State) ____ (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ (Month Year) To: _____ (Month Year)

Continue with additional insurance information? ☐ Yes ☐ No

b) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____ (Street Address) _____ (City) ____ (State) ____ (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ (Month Year) To: _____ (Month Year)

Continue with additional insurance information? ☐ Yes ☐ No

XVII. PEER REFERENCES

List four licensed, independent practitioners who can attest to your current clinical competency, ethical character, health status and ability to work cooperatively with others. **Two of the four must be in your specialty.** None of the practitioners should be related to you by family or current/ pending professional partnership/financial arrangement **(NOT AN ASSOCIATE)**. Practitioners listed as a reference must be local if you have been in Arizona for more than 6 months. Observations by peer reference must be within the last 2 years for current competency.

a) Name: _____ Specialty: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____ E-mail Address: _____

b) Name: _____ Specialty: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____ E-mail Address: _____

c) Name: _____ Specialty: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____ E-mail Address: _____

d) Name: _____ Specialty: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____ E-mail Address: _____

XVIII. OTHER PERTINENT INFORMATION

a) Are you currently under investigation or have you been subject to disciplinary or corrective action such as admonition, reprimand, probation, non-provisional supervision, suspension, termination, revocation or reduction of privileges by any healthcare facility or professional organization? ☐Yes ☐No IF YES, EXPLAIN:

b) Have you ever voluntarily withdrawn / terminated your healthcare facility application / membership? ☐Yes ☐No
Have you ever voluntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility? ☐Yes ☐No
IF YES, EXPLAIN:

c) Have you ever involuntarily withdrawn / terminated your healthcare facility application / membership? ☐Yes ☐No
Have you ever involuntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility? ☐Yes ☐No
IF YES, EXPLAIN:

d) Have you ever been or are you currently the subject of an investigation, suspension or sanction from participating in any private, federal or state health insurance program (e.g., Medicare, Blue Cross)? ☐Yes ☐No IF YES, EXPLAIN:

e) Have you ever been convicted of a felony? ☐Yes ☐No
Have you ever been convicted of a misdemeanor? ☐Yes ☐No IF YES TO EITHER QUESTION, EXPLAIN:

XIX. LICENSURE

a) Are you currently under investigation or has any license or registration entitling you to practice your profession in any jurisdiction been censured, challenged, investigated, denied, suspended, limited, placed under stipulation or probation, revoked or been voluntarily/involuntarily relinquished? ☐Yes ☐No IF YES, EXPLAIN:

b) Have you ever been issued an advisory letter or a letter of concern/reprimand? ☐Yes ☐No IF YES, EXPLAIN:

XX. DEA

a) Has your narcotics registration ever been limited, suspended, revoked, or voluntarily/involuntarily relinquished or is it currently being challenged/investigated? ☐Yes ☐No ☐N/A IF YES, EXPLAIN:

XXI. PROFESSIONAL LIABILITY INSURANCE

a) Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature or volume of claims against you? ☐Yes ☐No IF YES, EXPLAIN:

b) Does your malpractice coverage exclude you from providing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges? ☐Yes ☐No IF YES, EXPLAIN:

c) Have you ever practiced without professional liability insurance? ☐Yes ☐No IF YES, EXPLAIN:

d) In the previous 15 years, have there been or are there currently pending malpractice claims, suits, settlements, judgments, arbitration proceedings, or complaints filed involving your professional practice? ☐Yes ☐No
IF YES TO THIS QUESTION YOU MUST COMPLETE THE ATTACHED CONFIDENTIAL INFORMATION REPORT FOR EACH INCIDENT.

CONFIDENTIAL INFORMATION REPORT

☐ **Does not apply**

If you have answered "YES" to question (d) in Section XXI - Professional Liability Insurance (page 13), you must furnish the following information regarding each lawsuit or complaint. Attach a copy of the complaint and your response. **It is your responsibility to provide documentation verifying your response (i.e., statement from an attorney, court records, etc.).** You may choose to have your attorney complete this form, however, **your signature is required**.

Month / Year of Incident? _____ Where incident occurred? _____

Nature of Incident? (Complaint, Allegation)

_____

_____

_____

_____

Disposition of Claim ☐ Dropped ☐ Dismissed ☐ Pending ☐ Settled, Amount ? _____

☐ With Prejudice ☐ Without Prejudice

☐ Verdict for you, Amount? _____ ☐ Verdict for plaintiff, Amount? _____

Represented by Legal Counsel for this claim / malpractice lawsuit? ☐ Yes ☐ No

If yes, give the name and address of counsel. Name: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Insurance Company that provided coverage for this claim?

Company Name: _____

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Telephone Number: _____ Policy Number: _____ Claim Number: _____

Other comments:

_____

_____

_____

_____

Practitioner Signature: _____ Date: _____

Name: _____
(Please Print)

XXII. HEALTH STATUS

a) Do you have a chronic or recurring illness, mental or physical disability that might limit or affect your ability to perform privileges requested? ☐Yes ☐No IF YES, EXPLAIN:

_____

_____

b) Are you currently or have you in the past been dependent on or treated for alcohol or drugs? ☐Yes ☐No
IF YES, EXPLAIN:

_____

_____

c) Are you currently taking medication or undergoing treatment or therapy that is likely to affect your ability to perform privileges requested? ☐Yes ☐No IF YES, EXPLAIN:

_____

_____

TB ATTESTATION FORM

The Arizona Department of Health Services (DHS) requires each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis at least once every 24 months or more often as required by the hospital's infection control committee. This evidence of freedom from infectious pulmonary tuberculosis can be established by; (a) a report of a negative Mantoux skin test; (b) a report of a negative chest X-ray; or (c) if the medical staff member has had a positive Mantoux skin test, another physician's statement that he or she is free from infectious pulmonary tuberculosis.

DHS will accept a medical staff or allied health member's attestation that he or she is free from infectious pulmonary tuberculosis and can provide one of the types of evidence listed above upon request. If a medical staff or allied health member signs this attestation and cannot produce this evidence upon request, DHS has indicated that it will report the physician to AMB/OBEX or the appropriate licensing board.

I attest that I was evaluated for infectious pulmonary tuberculosis in _____ , 20 ___ .

I can provide the following evidence to demonstrate that I am free from infectious pulmonary tuberculosis:

- ☐ A report of a negative Mantoux skin test;
- ☐ A report of a negative chest X-ray; or
- ☐ Although I had a positive Mantoux skin test, I have another physician's statement that I am free from infectious pulmonary tuberculosis.

Practitioner Signature: _____ Date: _____

Print Name: _____

RELEASE AND STATEMENT OF APPLICANT

GACCP and all Healthcare Entities receiving this information will treat all information submitted in this application as confidential and protected under Arizona state statutes.

Please read carefully before signing

I understand and acknowledge that, as an applicant to those healthcare entities indicated in this application, it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications including my current licensure, relevant training and/or experience, current competence, health status, character and ethics can be based. I hereby pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for the care of my patients to any practitioner not qualified to undertake that responsibility. I further understand and acknowledge that the Maricopa County Medical Society's Greater Arizona Central Credentialing Program (GACCP), acting as agent for the healthcare entities, will verify the information in this application. I further understand that healthcare entities may also independently investigate my qualifications. By submitting this application, I agree to such verification and to the information exchange activities of GACCP and the healthcare entities. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations, and code of conduct of the healthcare entities and their medical staffs and agree to be bound by them. I understand and acknowledge that completing this application does not entitle me to membership or privileges at any of the healthcare entities and that GACCP shall have no responsibility or liability with respect to healthcare entities' membership decisions. I further understand and agree that GACCP is solely responsible for the information which it provides to healthcare entities and that healthcare entities shall have no responsibility or liability for the completeness or accuracy of this information insofar as it was provided by GACCP or verified by GACCP.

Verification of Application. I hereby authorize all individuals, institutions, and entities, (past, present, and future) including all professional liability insurers with whom I have had or currently have professional liability insurance (including past and present claims history), who have knowledge concerning my qualifications and other information requested in this application to consult with, and release relevant information and/or records to the healthcare entities, their medical staffs and agents, specifically including but not limited to GACCP.

I further authorize the use of the pictures provided by me for internal/ external purposes.

Authorization of Release. I understand and agree that the authorizations given by me herein shall be irrevocable for a period of twenty-four (24) months. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me in this application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial of appointment or for summary dismissal from the healthcare entities. I further release from liability and from any restrictions as to confidentiality and/or privacy, all representatives of GACCP, the hospitals, healthcare entities, their boards and medical staffs, and further release all medical schools, licensing boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in connection with the gathering and exchange of information as consented to above.

I agree to update this application while it is being processed, should there be any change in the information provided that could affect this application or its outcome.

I hereby agree that the exclusive remedy for any decision or recommendation made pertaining to this application for appointment or in any other peer review proceeding shall be to seek review of the correctness of the decision or recommendation, that no claim for alleged monetary damages will be brought on account thereof, and that no action at law or inequity will be brought until after all appeal rights available under the healthcare entities' medical staff bylaws/contracts have been exercised and completed.

I agree to notify GACCP and the healthcare entities within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me. I further agree to notify GACCP and the healthcare entities thirty (30) days prior to any change in malpractice insurance coverage.

Name: _____
(Please Print)

Date: _____ Signature: _____

MEDICARE ATTESTATION STATEMENT

NOTICE TO PRACTITIONERS

"Medicare, and/or other federally funded program payments to healthcare entities are based on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

I acknowledge that I have read the above statement.

Name: _____
(Please Print)

Date: _____ Signature: _____

ADDENDUM

LICENSES (continued from page 3)

f) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

g) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

h) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

i) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

j) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

Explain any licenses not issued:

_____

_____

PRACTICE HISTORY (continued from page 7)

d) Practice/Employer Name: _____

Address: _____ _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

e) Practice/Employer Name: _____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

f) Practice/Employer Name: _____

Address: _____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? ☐ Yes ☐ No

ADDENDUM

STAFF MEMBERSHIPS (continued from page 9)

h) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

i) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

j) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

k) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

l) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

m) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

n) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? ☐ Yes ☐ No

o) Healthcare Facility Name: _____
(Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Universal Background Screening™

Request for Background Check

Account #000774

Social Security Number

			—			–				

Date of Birth - used for identification purposes only

		—			—				
MONTH			DATE			YEAR			

First Name	**Middle Name**	**Last Name**

Other Names Used (maiden names, AKA names, etc.)

Current Residential Address

City	**State**	**Zip Code**

List each CITY, STATE and ZIP CODE (if known) where you have lived during the past seven years:

City	**State**	**Zip Code**	**From Date**	**To Date**	
					☐
					☐
					☐
					☐
					☐

Driver's License Number	**State of Issue**

FCRA NOTICE AND ACKNOWLEDGMENT

IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

NOTICE REGARDING BACKGROUND INVESTIGATION

Greater Arizona Central Credentialing Program (GACCP) ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include, but is not limited to: employment and education verifications; social security number verification; criminal and civil court records; personal interviews; driving records; and/or any other public records or any other information bearing on my character, general reputation, personal characteristics and trustworthiness. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report.

The report will be generated by Universal Background Screening (4000 North Central Avenue, Suite 1000, Phoenix, AZ 85012, 1-877-263-8033) or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION (above) and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT (separate document) and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. ☐

Signature _____ Date _____

Printed Name _____ Social Security Number (SSN) _____

maricopa county
medical society

326 East Coronado Road
Phoenix, Arizona 85004

P: 602-252-2015

F: 602-256-2749

E: mcms@mcmsonline.com

W: mcmsonline.com

Dear Healthcare Provider:

Thank you for using the Greater Arizona Central Credentialing Program (GACCP) to renew your license. The GACCP is a business service of the Maricopa County Medical Society (MCMS). The MCMS is a volunteer, professional association of physicians that provides advocacy, patient referrals, business and medical services programs and networking opportunities to its membership for the betterment of all physicians and healthcare in Arizona.

The MCMS provides many valuable services to its members, including:

- **Advocacy.** Working with the Arizona Medical Association (ArMA), the MCMS strives to protect the interests of physicians through legislative and lobbying efforts.
- **Physician Referral Line**. To aid the community and help attract patients to our physician members, The MCMS offers a free telephone and web-based physician referral service to connect the patient with a physician that best meets their medical needs. In 2013 the MCMS provided over 12,000 referrals to its members
- **Medical Collections**. In addition to GACCP, another MCMS sponsored business is the Bureau of Medical Economics (BME). BME provides specialized collection of delinquent medical accounts.
- **Engagement in the Medical Community**. The MCMS hosts annual and, beginning 2015, monthly events for physicians to network and learn from peers.
- **Community Outreach**. The MCMS is dedicated to supporting the community and has been a proud supporter of the ACT Kids Health Fair for fifteen years. This all-volunteer event addresses a full spectrum of health requirements for underprivileged children who otherwise do not have access to medical care.
- ***Round-up* Magazine**. This monthly publication from the MCMS focuses on topics that are important to physicians, and includes articles from experts in the medical field.

Please consider the following application to join the MCMS and become part of this physician community, and add your voice to ours, so that together we can effect change and promote excellence in the quality of care and the health of the community.

Sincerely,

Jay Conyers, PhD
CEO and Executive Director

MCMS Membership Application

STEP 1 - Choose a Membership Type

❒ **Active:** Physician in active practice - $250

❒ **Service:** Engaged in research or govt. position -$63

❒ **Affiliate:** Teaching, NP, PA, Missionaries - $36

❒ **Associate:** Medical Director, Retired, Disabled - $36

❒ **Educational:** Medical students, interns, residents, fellows - $0

Contact MCMS if you do not fit into one of these categories.

STEP 2 - Referral Information

Were you referred to MCMS by another member, staff or promotion? ❒ Yes ❒ No

Referred by: _____

Referral discount code: _____

STEP 3 - Method of Payment

Total due: $ _____

Credit card: ❒ Mastercard ❒ Visa ❒ AMEX

Card #: _____

Name on card: _____

Exp. Date: _____ CVV: _____

Date: _____

Signature: _____

❒ My check (payable to Maricopa County Medical Society) is enclosed.

STEP 4 - Tell Us a Little About You

Name: _____

Gender: ❒ M ❒ F Suffix: _____ Degree: _____

Home address: _____

City: _____ State: _____ Zip code: _____

Home or cell phone: _____ Fax: _____

Email: _____

Medical School: _____

Yr. Graduated: _____ State/Country: _____

Specialty: _____

Board certified?: ❒ Y ❒ N AZ License: _____

Date issued: _____

STEP 5 - Mailing Address

for MCMS Official Business and Communications

Practice or Facility Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

City: _____

State: _____ Zip code: _____

STEP 6 - Statement of Understanding

❒ I understand MCMS will share my contact information with preferred vendors (ONLY), which may periodically send industry related correspondence.

❒ I authorize all individuals, institutions, and entities (past, present, and future) including all professional liability insurers, who have knowledge concerning my qualifications and other information requested in this application to consult with and release relevant information and records to MCMS.

❒ I further agree, as evidenced by this signed application for membership, to furnish the Society with all information relative to any claim or action filed against me for malpractice, and I authorize and consent for the Society to obtain from my present and/or past liability insurance carrier any and all information regarding insurance coverage, premiums, claims and suits against me as well as settlements made on my behalf.

❒ I acknowledge that this is a pre-application only. MCMS membership will be effective upon vetting of this application and additional information provided by me to finalize the application process.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

MCMS USE ONLY

APP CODE: