

**PERSONAL INFORMATION**

|  |                        |                               |                                 |
|--|------------------------|-------------------------------|---------------------------------|
| Last Name  | First Name             | M.I.                          | Degree                          |
| Date of Birth  | Social Security Number | Male <input type="checkbox"/> | Female <input type="checkbox"/> |
| List any other name under which you have been known:   |                        |                               |                                 |
| List Languages (Other than English):<br>Sign Language <input type="checkbox"/> Yes <input type="checkbox"/> No |                        |                               |                                 |

**PROFESSIONAL LICENSE/CERTIFICATE INFORMATION (Please complete the following when applicable)**

|  |                               |
|--|-------------------------------|
| Connecticut License Number: _____                | Expiration: _____/_____/_____ |
| Other State License Number: _____ State: _____   | Expiration: _____/_____/_____ |
| Other State License Number: _____ State: _____   | Expiration: _____/_____/_____ |
| Federal DEA Number: _____                        | Expiration: _____/_____/_____ |
| CT Controlled Substance Number: _____            | Expiration: _____/_____/_____ |
| ECFMG Number: _____                              | Expiration: _____/_____/_____ |
| Laboratory Registration Number (CLIA ID#): _____ | Expiration: _____/_____/_____ |
| Medicare Number: _____                           |                               |
| Medicaid Number: _____                           |                               |
| UPIN Number: _____                               |                               |

**DIRECTORY LISTING AND BOARD CERTIFICATION INFORMATION**

|   |  |                              |                        |
|---|--|------------------------------|------------------------|
| Are you applying for affiliation as:    Primary Care Physician <input type="checkbox"/> Specialist <input type="checkbox"/> Both <input type="checkbox"/> |  |                              |                        |
| <b>Specialty Listing Requested</b>  | <b>Board Certified</b>                                   | <b>Date of Certification</b> | <b>Expiration Date</b> |
| Primary: _____  | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____/_____/_____            | _____/_____/_____      |
| Secondary: _____  | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____/_____/_____            | _____/_____/_____      |
| Additional: _____   | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____/_____/_____            | _____/_____/_____      |

## PRACTICE INFORMATION

Type of Practice? (Check all that apply) Solo  Partnership  Corporation  Institution  Other  \_\_\_\_\_  
 Single Specialty  MultiSpecialty  \_\_\_\_\_

Do you limit your practice by age?  YES  NO If yes, please define:

Other Practice Limitations?  YES  NO If yes, Please define:

Do you accept new patients into your practice?  YES  NO  
 Do you accept new patients by physician referral only?  YES  NO  
 Do you accept Medicare assignment?  YES  NO  
 Are you willing to accept Medicaid patients?  YES  NO

Give a narrative description of your practice, including the type of medicine that comprises the majority of your practice, special interests, and procedures performed in your office.

Please describe the social/family services that are available to patients in your practice.

*Please note that information from this section will be used for directory listings as appropriate for the product line.  
 We do not accept P.O. Box numbers in this area.*

### Primary Office Location

Name of Practice/Facility: \_\_\_\_\_

Street Address \_\_\_\_\_

Suite Number \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

County \_\_\_\_\_

Office Telephone Number ( ) \_\_\_\_\_

Office Manager's Name \_\_\_\_\_

Office Fax Number ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Do you have 24 hour telephone coverage?  YES  NO

Partner

Specialty

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Partner

Specialty

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

Office Hours: \_\_\_\_\_

Evening hours: \_\_\_\_\_

Is office on a bus route?  YES  NO

Is the office handicap accessible?  YES  NO

Is handicapped parking available?  YES  NO

List languages (other than English) spoken by office staff : \_\_\_\_\_

Is Sign Language used by office staff?  YES  NO \_\_\_\_\_

**Billing Information (For Primary Office Location)**

Federal Tax ID as it appears on W-9: \_\_\_\_\_

Group name as it appears on W-9: \_\_\_\_\_

Please circle the type(s) of form used when submitting claims:      HCFA 1500 Form      UB92 Form

Make checks payable to: \_\_\_\_\_

Mail Checks/Correspondence to: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If you have **more than one tax ID number** (e.g. different tax ID numbers for each office location) then please complete this section under each appropriate office location.

**Additional Office Location (2)**

Name of Practice/Facility: \_\_\_\_\_

|  |           |                              |                             |
|--|-----------|------------------------------|-----------------------------|
| Street Address   |           |                              | Suite Number                |
| City   | State     | Zip Code                     | County                      |
| Office Telephone Number (      )   |           | Office Manager's Name        |                             |
| Office Fax Number (      )   |           | Email Address                |                             |
| Do you have 24 hour telephone coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO         |           |                              |                             |
| Partner  | Specialty | Partner                      | Specialty                   |
| _____  | _____     | _____                        | _____                       |
| _____  | _____     | _____                        | _____                       |
| _____  | _____     | _____                        | _____                       |
| _____  | _____     | _____                        | _____                       |
|  | Monday    | Tuesday                      | Wednesday                   |
|  | Thursday  | Friday                       | Saturday                    |
|  | Sunday    |                              |                             |
| Office Hours: _____  |           |                              |                             |
| Evening hours: _____   |           |                              |                             |
| Is office on a bus route?  |           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Is the office handicap accessible?   |           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Is handicapped parking available?  |           | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| List languages (other than English) spoken by office staff : _____                                       |           |                              |                             |
| Is Sign Language used by office staff? <input type="checkbox"/> YES <input type="checkbox"/> NO    _____ |           |                              |                             |

*Use Attachment A for additional office locations*

**Billing Information(2)** Same as primary office location?  YES     NO If no, then complete the below section.

Federal Tax ID as it appears on W-9: \_\_\_\_\_

Group Name as it appears on W-9: \_\_\_\_\_

Please circle the type(s) of form used when submitting claims:      HCFA 1500 Form      UB92 Form

Make checks payable to: \_\_\_\_\_

Mail Checks/Correspondence to: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If you have **more than one tax ID number** (e.g. different tax ID numbers for each office location) then please complete this section under each appropriate location.

## PRACTICE COVERAGE

Are you covering providers the members of your group practice?  YES  NO  BOTH

If no or both, then complete the information below for the practitioner(s) not a part of your group practice with whom you arrange after hours coverage, 24 hours a day, seven days a week.

|         |                |           |           |
|---------|----------------|-----------|-----------|
| 1. Name | Office Address | Telephone | Specialty |
| 2. Name | Office Address | Telephone | Specialty |
| 3. Name | Office Address | Telephone | Specialty |
| 4. Name | Office Address | Telephone | Specialty |
| 5. Name | Office Address | Telephone | Specialty |
| 6. Name | Office Address | Telephone | Specialty |

## EDUCATION AND PROFESSIONAL TRAINING

Please provide an explanation for any gaps in time to avoid delaying the credentialing process.

A Current Curriculum Vitae reflecting all dates (month/year), and explaining any time gaps may be attached in lieu of completing the Professional Training section.

**Undergraduate School:** \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Degree: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_ Attended From: \_\_\_\_\_ To: \_\_\_\_\_

**Graduate School: (if applicable)** \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Degree: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_ Attended From: \_\_\_\_\_ To: \_\_\_\_\_

**Residency/Fellowship:** Residency  Fellowship

Institution: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Degree: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Specialty: \_\_\_\_\_

**Residency/Fellowship:** Residency  Fellowship

Institution: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Degree: \_\_\_\_\_ Date of Graduation: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Specialty: \_\_\_\_\_

## PROFESSIONAL HISTORY

Please provide an all-inclusive chronological list of practice or other activity since completion of residency. *(Please provide an explanation for any gaps between medical education/training and/or practices to avoid delaying the credentialing process.)*

Current Curriculum Vitae reflecting an all-inclusive chronological list of practice or other activity since graduation of medical school showing all dates and explaining all gaps of time may be used in lieu of completing the Professional History section.

**Current Position:** \_\_\_\_\_ **From (MO/YR):** \_\_\_\_\_

**Previous Positions:**

| <u>PRACTICE NAME</u> | <u>LOCATION</u> | <u>DATES</u>          |
|----------------------|-----------------|-----------------------|
| _____                | _____           | From: _____ To: _____ |
| _____                | _____           | From: _____ To: _____ |
| _____                | _____           | From: _____ To: _____ |
| _____                | _____           | From: _____ To: _____ |

## PROFESSIONAL LIABILITY COVERAGE

**Current Carrier:**

Insurance Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Period of Coverage: \_\_\_\_\_

Coverage Amount: \_\_\_\_\_ Type of Policy: \_\_\_\_\_

Procedures excluded from coverage: \_\_\_\_\_

**Previous Carrier:**

Insurance

Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

Policy No.: \_\_\_\_\_ Period of Coverage: \_\_\_\_\_

Coverage Amount: \_\_\_\_\_ Type of Policy: \_\_\_\_\_

Procedures excluded from coverage: \_\_\_\_\_

## HOSPITAL AFFILIATIONS Please include all hospital affiliations.

| HOSPITAL                   | DEPARTMENT(S) | TYPE OF PRIVILEGES  | RESTRICTIONS   |
|----------------------------|---------------|---|--|
| Primary Admitting Hospital |               | <input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                            |               | <input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                            |               | <input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                            |               | <input type="checkbox"/> ACTIVE <input type="checkbox"/> COURTESY | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If any Restrictions, please explain:

## CLINICAL ACTIVITIES

Please provide a narrative discussing the clinical activities you have been involved in during the past two years in your department/section at Yale-New Haven Hospital. If you are a new Medical Staff member, please review the clinical criteria below and indicate your plans for involvement in the clinical area. (*Attach additional pages as necessary or attach supporting information.*)

---

---

---

---

---

---

---

---

## TEACHING ACTIVITIES

Please provide a narrative discussing the teaching activities you have been involved in during the past two years in your department/section at Yale-New Haven Hospital. If you are a new Medical Staff member, please indicate your plans for involvement in the teaching area. (*Attach additional pages as necessary or attach supporting information.*)

---

---

---

---

---

---

---

---

## ADMINISTRATIVE ACTIVITIES

Please provide a narrative discussing the administrative activities you have been involved in during the past two years in your department/section at Yale-New Haven Hospital. If you are a new Medical Staff member, please indicate your plans for involvement in the administrative area. (*Attach additional pages as necessary or attach supporting information.*)

---

---

---

---

---

---

---

---

## PRACTICE HISTORY INFORMATION

*If you answer "yes" to any of the following questions, you must supply full details on a separate sheet of paper.*

- 1) Regarding your license to practice your profession in any jurisdiction:
  - a. Has your application ever been denied?  yes  no
  - b. Has your license ever been limited, suspended or revoked?  yes  no
  - c. Has the relevant licensing board ever censured you for matters having to do with professional practice?  yes  no
  - d. Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board?  yes  no
  - e. Have you ever been fined by a medical licensing board?  yes  no
  
- 2) Have you ever been, or are you currently, under investigation or involved in any proceeding involving your practice before any state licensing board?  yes  no
  
- 3) Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation?  yes  no
  
- 4) Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily...
  - a. limited by the agency?  yes  no
  - b. suspended?  yes  no
  - c. revoked?  yes  no
  - d. denied renewal?  yes  no
  
- 5) Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization?  yes  no
  
- 6) Have you ever been sanctioned by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked?  yes  no
  
- 7) Has your eligibility to participate in the Medicare or Medicaid program ever been suspended or terminated in any state or have you ever been threatened with exclusion or debarment from either program?  yes  no
  
- 8) Have you ever been charged by any local, state or federal authority, official or agency, plead guilty to or been convicted of any of the following:
  - a. crimes or offenses related to the delivery of service under Medicare/Medicaid?  yes  no
  - b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of healthcare?  yes  no
  - c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state, or local government?  yes  no
  - d. obstruction of justice?  yes  no
  - e. crimes or offenses related to the manufacture, distribution, prescription or dispensing or any controlled substance?  yes  no
  - f. other crimes or offenses (including motor vehicle charges other than parking tickets)?  yes  no
  
- 9) Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of billing practice standards?  yes  no

- 10) Have you ever been denied privileges or medical staff membership at any hospital or other health care facility?  yes  no
- 11) Have you ever been the subject of disciplinary action and/or a hearing under any set of medical staff bylaws?  yes  no
- 12) Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily canceled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn?  yes  no
- 13) Are you dependent upon any controlled substance or alcohol?  yes  no
- 14) Are you currently engaged in illegal drug use?  yes  no
- 15) Do you have any physical, mental or emotional condition that would compromise your ability to practice medicine with reasonable skill and safety?  yes  no
- 16) Have you ever been reported to the National Practitioner Data Bank by any individual or organization for any reason?  yes  no
- 17) Has any malpractice or professional liability claim been brought against you within the last ten (10) years? \*  yes  no

If yes, please complete the "Claim/Suit Report" for each case and describe the case indicating the following:

- a. date and details of the incident(s)
- b. your role in the incident(s)
- c. current status of the claim
- d. if settled, amount paid
- e. if pending, amount being sought
- f. professional liability insurer involved

- 18) Have you ever been denied professional liability coverage?  yes  no

\* Please note that the Yale-New Haven Community Medical Group requires minimum insurance limits for its members of \$1 million per occurrence and \$3 million in the aggregate (proof of insurance coverage is required).

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Printed Name of Applicant)

## CREDENTIALS ATTESTATION AND AUTHORIZATION

By applying for membership/re-credentialing in the Yale-New Haven Community Medical Group, I hereby authorize the Yale-New Haven Community Medical Group, its representatives, employees, agents and Members to consult with anyone, including prior associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others.

I hereby agree to grant immunity to the fullest extent permitted by law and agree not to sue or take any action against any representatives, employees, agents and physicians of the Yale-New Haven Community Medical Group for their acts performed and statements made in connection with evaluating my credentials and qualifications.

I hereby agree to grant immunity to the fullest extent permitted by law and agree not to sue or take any action against any individuals and organizations who provide information to Yale-New Haven Community Medical Group, its representatives, employees, agents and physicians concerning my professional competence, ethics, character, and other qualifications for membership.

I authorize Yale New Haven Hospital, its employees and agents and any other health care institution to release to Yale-New Haven Community Medical Group such information which is requested by Yale-New Haven Community Medical Group by copying pertinent portions of my records as are maintained at Yale New Haven Hospital or such other health care institution.

I authorize Yale-New Haven Community Medical Group and Yale New Haven Hospital, its employees and agents to allow Delegated Entities and/or Accrediting Bodies access to my provider credentialing and recredentialing files as requested and to permit Delegated Entities and/or Accrediting Bodies to review said files.

I declare under penalty of law, that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge. I understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application. I agree to inform the Yale-New Haven Community Medical Group in writing within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating status in the Yale-New Haven Community Medical Group, and grants me no rights or privileges of participation until such time as I receive written notice of participating status.

I agree that photocopies of this document will be as binding as the original.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Printed Name of Applicant)

## ADDITIONAL PRACTICE INFORMATION

### Additional Office Location ( )

Name of Practice/Facility: \_\_\_\_\_

|                |              |
|----------------|--------------|
| Street Address | Suite Number |
|----------------|--------------|

|      |       |          |        |
|------|-------|----------|--------|
| City | State | Zip Code | County |
|------|-------|----------|--------|

|                             |                       |
|-----------------------------|-----------------------|
| Office Telephone Number ( ) | Office Manager's Name |
|-----------------------------|-----------------------|

|                       |               |
|-----------------------|---------------|
| Office Fax Number ( ) | Email Address |
|-----------------------|---------------|

Do you have 24 hour telephone coverage?  YES  NO

| Partner | Specialty | Partner | Specialty |
|---------|-----------|---------|-----------|
| _____   | _____     | _____   | _____     |
| _____   | _____     | _____   | _____     |
| _____   | _____     | _____   | _____     |
| _____   | _____     | _____   | _____     |

|                |        |         |           |          |        |          |        |
|----------------|--------|---------|-----------|----------|--------|----------|--------|
|                | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Office Hours:  | _____  | _____   | _____     | _____    | _____  | _____    | _____  |
| Evening hours: | _____  | _____   | _____     | _____    | _____  | _____    | _____  |

Is office on a bus route?  YES  NO  
 Is the office handicap accessible?  YES  NO  
 Is handicapped parking available?  YES  NO

List languages (other than English) spoken by office staff : \_\_\_\_\_  
 Is Sign Language used by office staff?  YES  NO \_\_\_\_\_

### Billing Information ( ) Same as primary office location? YES NO If no, then complete the below section.

Federal Tax ID as it appears on W-9: \_\_\_\_\_

Group Name as it appears on W-9: \_\_\_\_\_

Please circle the type(s) of form used when submitting claims:      HCFA 1500 Form      UB92 Form

Make checks payable to: \_\_\_\_\_

Mail Checks/Correspondence to: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

If you have **more than one tax ID number** (e.g. different tax ID numbers for each office location) then please complete this section under each appropriate location.