

SOUTH DAKOTA UNIFORM APPLICATION INITIAL

Application is submitted by: _____

Name: _____
Last First Middle Suffix Title

For use by all practitioners including Allied Health Professionals.

Please note this is a universal application. Not all sections may apply to all practitioners.
Please mark all non-applicable sections with N/A.

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or, preferably, electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application.

Checklist (please complete)

- Appropriate fees enclosed

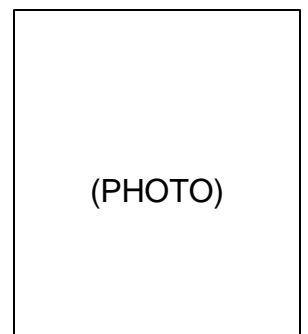
Current copies of the following documents must be submitted with this application:

- All active licenses
- Drug Enforcement Administration Registration(s) with correct address(es) (if applicable)
- Current state controlled substance registration(s) (CSR)
- Current Board certification
- Curriculum Vitae
- Malpractice Litigation and Professional Complaints Form (if applicable)
- Current malpractice liability insurance documentation (as defined on Page 8)
- Your diploma and ECFMG certificate (if educated outside of U.S. or Canada)
- Current documentation of TB and Rubella immunity. (TB within the past 12 months.)

If all documents are not immediately available, please forward application and send remaining documents as soon as available.

In addition, please verify that you have:

- Provided complete street addresses wherever indicated, including past employment, hospital affiliations and references
- Designated dates by month, day and year time frames
- Explained all gaps in chronology (Page 6)
- Answered all of the Disclosure Questions on Pages 11 and 12 and enclosed explanations for affirmative answers
- Signed and dated the Authorization to Conduct Criminal Background Check (Page 10)
- Signed and dated the Affidavit, Release, Immunity and Authorization Statement (Page 13)
- Signed and dated the Affidavit (Page 14)



ENCLOSE WITH THIS APPLICATION A CURRENT PHOTOGRAPH OF YOURSELF.

Enter date taken on photograph (within the past 5 years) and sign in ink across the bottom.

This box to be completed by Allied Health Professionals Only
Profession/Title _____
Supervising/Collaborative Physician _____

All information must be printed in black ink, typed, or electronically generated!

PERSONAL DATA

Name: _____
Last First Middle Suffix Title

Maiden/Former/Other Name(s) _____ Spouse Name (optional): _____

Marital Status (optional): Married Single Divorced Widowed Gender: Male Female

Date of Birth: ___/___/___ Birthplace (city/state/country): _____ U.S. Citizen: Yes No

Social Security Number: _____ UPIN or NPI: _____

Medicaid Number: _____ State _____ Medicare Number: _____ State _____

Current Home Address: _____
Street City/State/Country Zip Code

Local Home Address: _____
(if different from above) Street City/State/Country Zip Code

Preferred Mailing Address: Office Home E-mail address: _____

Pager / Mobile / Cell Number: _____ Home Phone Number: _____
(Please circle one)

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language? Yes No

If yes, specify language(s): _____

PRIMARY PRACTICE LOCATION (REFER TO LIST OF SPECIALITIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Primary practice name: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

Office Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ E-mail Address: _____

Credentialing Contact: _____ Phone Number: _____

Expected Start Date: _____

Primary Specialty: _____ Subspecialty: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION(S) (REFER TO LIST OF SPECIALITIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary): _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? Yes No Start Date: _____

If yes, will you continue to practice at this location? Yes No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION(S) (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? Yes No Start Date: _____

If yes, will you continue to practice at this location? Yes No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? Yes No Start Date: _____

If yes, will you continue to practice at this location? Yes No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

ADDITIONAL PRACTICE LOCATION (Make additional copies of this page if necessary) (Refer to list of specialties on page 20 when completing this page.)

Other Practice Name: _____ Phone Number: _____

Address: _____
Street City/State/Country Zip Code

Billing Address: _____
(if different from above) Street City/State/Country Zip Code

E-mail Address: _____ Fax Number: _____

Federal Tax ID Number (if different from primary) _____

Credentialing Contact: _____ Phone Number: _____

Currently practicing at this location? Yes No Start Date: _____

If yes, will you continue to practice at this location? Yes No If no, last date of employment: _____

Primary Care or Specialty Care: _____

Specialty/Subspecialty in which care will be provided: _____

MEDICAL/GRADUATE EDUCATION

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Degree and/or Certification Received: MD DO DDS DC DPM PhD Other: _____

Address: _____
Street City/State/Country ZIP Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Degree and/or Certification Received: MD DO DDS DC DPM PhD Other: _____

Address: _____
Street City/State/Country ZIP Code

Phone Number (if known): _____ Fax Number (if known): _____

ECFMG – APPLICABLE TO INTERNATIONAL MEDICAL GRADUATES

ECFMG Number: _____ Date Issued: _____ Valid Through: _____
(month/day/year) (month/day/year)

INTERNSHIP/POST-GRADUATE TRAINING (IF APPLICABLE)

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Internship Type/Specialty (transitional, rotating, 5th pathway, etc.): _____

Completed Training: Yes No If no, expected completion date: _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

RESIDENCY/POST-GRADUATE TRAINING

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Type of Program/Specialty: _____

Completed Training: Yes No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your residency: (To be verified by Program Director / Department Chair) _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

RESIDENCY/POST-GRADUATE TRAINING - CONTINUED (If additional space is required, attach a separate sheet.)

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Type of Program/Specialty: _____

Completed Training: Yes No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your residency: (To be verified by Program Director / Department Chair) _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

FELLOWSHIP/POST-GRADUATE TRAINING (If additional space is required, attach a separate sheet.)

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Type of Program/Specialty: _____

Completed Training: Yes No If no, expected completion date: _____

List of procedures (to include volume of such) you have performed in your fellowship: (To be verified by Program Director / Department Chair) _____

If not successfully completed, explain: _____

Program Director: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

PROFESSIONAL AND ACADEMIC/FACULTY AFFILIATIONS

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___ / ___ / ___ Institution Name: _____

To: ___ / ___ / ___ Appointment Held/Position: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

CHRONOLOGICAL EMPLOYMENT/PRACTICE HISTORY

Chronological listing (month/day/year) of employment/practice history since completion of your post-graduate training. List all experience, including armed service and public health, time out of medical practice in pursuit of other business or professional activities, sabbaticals, parenting, personal travel, personal crisis, etc. LEAVE NO GAPS IN CHRONOLOGY. (If additional space is required, attach a separate sheet. Make as many copies of this page as needed to facilitate this disclosure.)

From: / / Organization Name/Activity: _____

To: / / Reason for Leaving: _____

Conditions under which you left Voluntary Other (explain) _____

Contact Name: _____

Practice Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing name, address and phone number of someone who can verify your time there.
--	---

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

From: / / Organization Name/Activity: _____

To: / / Reason for Leaving: _____

Conditions under which you left Voluntary Other (explain) _____

Contact Name: _____

Practice Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing name, address and phone number of someone who can verify your time there.
--	---

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

From: / / Organization Name/Activity: _____

To: / / Reason for Leaving: _____

Conditions under which you left Voluntary Other (explain) _____

Contact Name: _____

Practice Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing name, address and phone number of someone who can verify your time there.
--	---

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

From: / / Organization Name/Activity: _____

To: / / Reason for Leaving: _____

Conditions under which you left Voluntary Other (explain) _____

Contact Name: _____

Practice Still Open? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, attach sheet listing name, address and phone number of someone who can verify your time there.
--	---

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

Explain any gaps/interruptions of medical/professional practice (if additional space is required, attach a separate sheet):

From: / / Explain: _____

To: / / _____

From: / / Explain: _____

To: / / _____

PRIMARY HOSPITAL AFFILIATION

If no hospital privileges, describe method/coverage for continuity of care. Please provide physician's name, if applicable.

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

OTHER HOSPITAL AFFILIATIONS – Present and past affiliations beginning with most recent. (Additional space is provided on the Hospital Affiliation Addendum, Page 18. You may make extra copies of Page 18 or attach a separate sheet for additional affiliations.)

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____
Street City/State/Country Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

SPECIALTY/SUBSPECIALTY CERTIFICATION (REFER TO LIST OF SPECIALTIES ON PAGE 20 WHEN COMPLETING THIS SECTION)

Certifying Board	Specialty/Subspecialty	Date Certified	Date Recertified	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If not certified, please state your intent for certification and describe the status of your efforts and eligibility, including scheduled date of exam, past failures of written or oral exams, if any. _____

LICENSURE – List all past and current professional licenses. (If additional space is required, attach a separate sheet.)

State	License Number	Date Issued	Expiration Date	License Status
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
_____	_____	____/____/____	____/____/____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive

DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (If additional space is required, attach a separate sheet.)

DEA Number: _____ State: _____ Expiration Date: ____/____/____

Approved for all schedules? Yes No, please explain _____

If you do not maintain a DEA certificate, please explain:

- Not applicable to practice. DEA certificate pending. Date application submitted to DEA: ____/____/____
- Other _____

STATE CONTROLLED SUBSTANCE CERTIFICATION/REGISTRATION (If applicable – not applicable to AZ, FL, MN, WI).

Issued by: _____ Number: _____ Expiration Date: ____/____/____

LIABILITY INSURANCE – INSURANCE CARRIER FOR PRIMARY PRACTICE LOCATION (10-year history)

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for primary practice location to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

COVERAGE DATES:

From: ____/____/____ Insurance Carrier Name: _____

To: ____/____/____ Address: _____
Street City/State/Country Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ____/____/____

Amount of coverage (per occurrence/aggregate): _____

LIABILITY INSURANCE - CONTINUED

From: ___/___/___ Insurance Carrier Name: _____

To: ___/___/___ Address: _____

Street

City/State/Country

Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): _____

From: ___/___/___ Insurance Carrier Name: _____

To: ___/___/___ Address: _____

Street

City/State/Country

Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): _____

From: ___/___/___ Insurance Carrier Name: _____

To: ___/___/___ Address: _____

Street

City/State/Country

Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): _____

From: ___/___/___ Insurance Carrier Name: _____

To: ___/___/___ Address: _____

Street

City/State/Country

Zip Code

Name in which policy issued: _____

Policy number: _____ Expiration Date: ___/___/___

Amount of coverage (per occurrence/aggregate): _____

PROFESSIONAL/PEER REFERENCES

List three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work. A peer is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD; PhD for PhD, Allied Health Professionals/Supervisor or Physician, etc.) **Limit to one (1) current office associate. Do not include your residency director, fellowship director, relatives, or pending partners.** At least one reference should be in your specialty (and if possible from the same subspecialty). Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

Name: _____ Title: _____

Relationship to Applicant: _____

Facility Name: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number: _____ Fax Number: _____

PROFESSIONAL/PEER REFERENCES - CONTINUED

Name: _____ Title: _____

Relationship to Applicant: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

Name: _____ Title: _____

Relationship to Applicant: _____

Facility Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Fax Number: _____

AUTHORIZATION TO CONDUCT CRIMINAL BACKGROUND CHECK AND RELEASE

Definitions:

Users: Any references to the terms "users" or "users of this application" in this Affidavit shall include the following entities, but is not limited to the following persons and entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any person or entity processing this application;
9. Any person or entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other person or entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above persons or entities.

I, _____, hereby authorize all users of this application, to request and receive any information and records concerning me, including but not limited to consumer credit, criminal record history, worker's comp., driving, employment, military, civil and educational data and reports, from any individuals, corporations, partnerships, associations, institutions, schools, governmental agencies and departments, courts, law enforcement and licensing agencies, consumer reporting agencies and any other entities, including my present and previous employers.

I further release and discharge the users and all of their agents and all their subsidiaries and affiliates, and every employee or agent of any of them, and all individuals and personal, business, private or public entities of any kind, from any and all claims and liability arising out of any request(s) made in the processing or consideration of this application. I also authorize the procurement of any investigative consumer report and understand that it may contain information about my character, general reputation, personal characteristics, and mode of living, whichever are applicable. I further understand that reporting of information pursuant to the Fair Credit Reporting Act is not intended to authorize or condone a prospective employer's request for and reliance upon information for purposes which are not legitimate under the Fair Credit Reporting Act or any federal or state employment laws. I acknowledge that I have voluntarily provided the above information for licensure, employment, and other purposes, and I have carefully read and I understand this authorization.

I further release all users from any and all claims, damages and liabilities whatsoever as a result of such user providing any information to any user as contemplated and authorized by this authorization and release.

This authorization and release shall constitute my stand-alone, consumer notification that a report will be requested and used for the purpose of evaluating me for licensure, employment, promotion, reassignment or retention as an employee, and other purposes. The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signature Date

DISCLOSURE QUESTIONS FOR INITIAL CREDENTIALING

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary.

- 1. Yes No Has your professional license or registration ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished, or not renewed by any licensing board or any health-related entity, or agency organization, or is there a review pending?

- 2. Yes No Have you ever been subject to proceedings by a licensing agency to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew a medical license?

- 3. Yes No Have you ever been requested to appear, or appeared, before any licensure board concerning any violation by you of any law, rule or regulation of any state, district, territory or province of the United States or Canada?

- 4. Yes No Has your professional license or registration ever been or is it currently being investigated, or have you ever been asked to appear before a licensing board or committee thereof? If so, what were the results?

- 5. Yes No Has your DEA registration ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed, or is there a review pending?

- 6. Yes No Have you ever been subject to proceedings by a professional society to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, voluntarily or involuntarily relinquish, or not renew membership?

- 7. Yes No Have you ever been notified of a complaint by a medical facility, professional society or association, or any licensing agency?

- 8. Yes No Have you ever been terminated, asked to resign or resigned, or otherwise not completed any post-graduate, residency, or fellowship training program?

- 9. Yes No Has your membership, participation, clinical privileges, or employment ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed by any peer review organization, third party payor, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

10. Yes No Have you ever served in the military, and, if so, if your discharge was anything other than an “honorable” discharge, please explain in detail.
-
-
11. Yes No Have you ever voluntarily relinquished your membership, participation, or clinical privileges or voluntarily withdrawn a request for privileges, employment, professional license, or registration to avoid disciplinary action, or prior to or during an investigation into your conduct or competency?
-
-
12. Yes No Have you ever involuntarily relinquished your membership, participation, clinical privileges or request for privileges, employment, professional license or registration?
-
-
13. Yes No Has your membership or fellowship in any professional organization or medical society or your specialty board certification ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?
-
-
14. Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing board, peer review organization, professional assistance program, third party payor, clinic, hospital, medical staff, or any health-related entity, or agency or organization?
-
-
15. Yes No Has your certificate or participation in any private, federal (i.e. Medicare, Medicaid, etc.), or state health insurance program ever been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily or involuntarily relinquished or not renewed, or is any investigation or proceeding with respect to any such action presently underway?
-
-
16. Yes No Are you currently charged with, aware of pending charges, or been found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), fraud, DWI, crime involving the practice of medicine, a crime involving moral turpitude, or other offense?
-
-
17. Yes No Have you ever been disciplined, found liable, guilty, or responsible for sexual impropriety, sexual harassment, disruptive behavior, or discriminatory behavior?
-
-
18. Yes No Have you ever had any professional liability claims or lawsuits brought against you, or do you have claims or lawsuits now pending, or have settlements or final judgments been rendered against you? If yes, please complete the enclosed Malpractice Litigation Addendum. You may be asked for additional information by individual organizations.
19. Yes No Has any professional liability carrier ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?
-
-

AFFIDAVIT, RELEASE, IMMUNITY AND AUTHORIZATION

(PLEASE READ CAREFULLY BEFORE SIGNING THIS SWORN STATEMENT)

Definitions:

Users: Any references to the terms "users" or "users of this application" in this Affidavit shall include the following entities, but is not limited to the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any person or entity processing this application;
9. Any person or entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other person or entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above persons or entities.

I, _____, being first duly sworn depose and say that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of South Dakota; that I am the person named on any diploma or certificate which I have received; that I am the lawful holder of said diploma or certificate; that said diploma or certificate was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to all users of this application any information, files or records required by the users of this application for their evaluation of my professional, ethical and physical qualifications.

By applying for licensure, appointment, membership, and clinical privileges, I accept the following conditions and intend to be legally bound thereby.

1. I extend absolute immunity to, and release from any and all liability, and agree not to sue any user of this application for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the above or their authorized representatives relating to, but not limited to, the following:
 - (a) matters regarding any license I now hold or have ever held;
 - (b) applications for appointment or clinical privileges, including temporary privileges;
 - (c) periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
 - (d) proceedings for denial, suspension, or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;
 - (e) summary suspensions;
 - (f) hearings and appellate reviews;
 - (g) hospital and medical staff quality assurance;
 - (h) utilization reviews;
 - (i) any other hospital, medical staff, department, service, or committee activities;
 - (j) matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior;
 - (k) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of the Hospital or any other hospital or health care facility; and
 - (l) matters involving my membership in any professional society or as a provider for any third party payor or other health plan.

I further release all such third parties from any and all claims, damages and liabilities whatsoever as a result of such third parties releasing the information to the above-described entities and their authorized representatives.

2. I further authorize the above described entities (users) and their authorized representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my qualifications for licensure, appointment to the medical staff, or membership in any third party payor, other health plan, or professional society. This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements, or disclosures relating to such questions. I also expressly authorize said third parties to release the information to the above described entities and their authorized representatives upon request.

I further release all such persons and entities from any and all claims, damages and liabilities whatsoever as a result of releasing such information, files or records requested by such users.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I

furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery in the State of South Dakota, or clinical privileges, participation as a provider for any third party payor or other health care entity utilizing and relying upon this application or membership in any professional society.

Signature of Applicant _____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public _____

(Seal)

My Commission expires: _____

AFFIDAVIT

(PLEASE READ CAREFULLY BEFORE SIGNING THIS SWORN STATEMENT)

Definitions:

Users: Any references to the terms “users” or “users of this application” in this Affidavit shall include the following entities, but is not limited to the following entities:

1. The South Dakota State Board of Medical and Osteopathic Examiners;
2. Any other Board of Medicine;
3. Any other state or federal agency;
4. Any hospital;
5. Any clinic;
6. Any medical society;
7. Any third party payor, health insurer, or any other health care benefit plan;
8. Any entity processing this application;
9. Any entity which ever utilizes, relies on, or processes this application;
10. Any individual or entity providing any information about my personal or professional background, or my ethical, physical or mental qualifications to practice, or obtain licensure, or any other status as applied for in this application;
11. Any other entity which may ever be involved in any respect with this application; and
12. Any and all agents, employees, and authorized representatives of any of the above entities.

Pursuant to SDCL 22-29-9.1, I now again assert and I declare and affirm under the penalties of perjury that this application, and all information I have provided, has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I have not only read all of the previous questions and answered them completely and truthfully, but I also state without reservation and unequivocally that I understand each and every above question. Moreover, I declare that should I at any time state that I did not read or understand the previous questions or that the application was in any way confusing as to questions it asks, or statements required of me, such statements by myself will be grounds for the users to immediately cease all processing of this application, and I acknowledge that I am not eligible for licensure in South Dakota, or clinical privileges, status as a participating provider, or member provider of any health plan or provider of services for any third party payor, professional society, or other health care entity. I also state that should users of this application discover any derogatory information regarding my personal background, that was not disclosed when completing this application, the users may immediately cease all processing of this application, and I acknowledge hereto that such shall disqualify me for licensure in South Dakota, as well as privileges or participation as a provider or any other status applied for by this application.

In addition, I further understand that my submission of this application and actions subsequent thereto, but prior to licensure, shall bear directly upon my qualifications for licensure, and I fully understand that the South Dakota State Board of Medical and Osteopathic Examiners may consider all such actions in its determination whether to grant licensure. To that end, I assert that any unprofessional or harassing behavior on my part regarding submission of this application or its subsequent processing as it relates to contacts with Board members, employees of Board members, Board staff, any other individual involved in the processing of this application, whether related to licensure, requests for clinical privileges, requests to become a participant for any third party payor, or otherwise, or any other person will again constitute grounds for the immediate cessation of all processing of this application and will disqualify myself for licensure in South Dakota. A determination regarding derogatory information or of unprofessional or harassing behavior shall be the sole determination of the South Dakota State Board of Medical and Osteopathic Examiners, or any of the entities described above, and I will not assert that any other entity, judicial, or otherwise, may make such determination.

I further understand that cessation of processing of this application by the users as a result of actions by myself as described above will not require the South Dakota State Board of Medical and Osteopathic Examiners, or any other users of this application, to offer me a hearing or any other due process right, or any other statutory or constitutional rights, and that I will not assert that I am entitled to a hearing or any other due process rights, or any other statutory or constitutional rights that I may enjoy pursuant to SDCL 1-26, SDCL 36-4, the South Dakota Constitution, or the U.S. Constitution, or any hospital, or third party payors' bylaws or regulations or any other entities' provisions for a hearing or other due process rights. I hereby waive any and all due process rights and any other statutory or constitutional rights that I may enjoy as it relates to all matters described above and in any manner related to this application.

Printed Name of Applicant _____

Signature of Applicant _____

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public _____

(Seal)

My Commission expires: _____

APPLICATION ADDENDUM

MEDICARE/CHAMPUS PENALTY STATEMENT: This statement is required by Medicare/Champus.

Penalty statement according to the Federal Register dated August 31, 1984, and effective October 1, 1984.

“NOTICE TO ALL PHYSICIANS”

Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient as attested to by the patient’s attending physician by virtue of his or her signature on 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.

Signature: _____ Date: _____

Name: _____
(Please print or type)

CONTINUING MEDICAL EDUCATION ATTESTATION

Please read the following attestation carefully before signing and dating the statement.

I hereby certify that I have a sufficient number of CME credits to meet the requirements and attest that an appropriate percentage relate to my specialty. I understand that these credits may be audited by any entity utilizing this application. I also certify and understand that my failure to maintain sufficient CME credits as required by the various entities utilizing this application may result in my immediate loss of licensure, clinical privileges, membership as a participating provider of any third party payor, membership in any professional society, or any other health care entity utilizing and relying upon this application as determined solely by the entity or entities that audited my CME credits and discovered an insufficiency. I also assert, certify, and understand that I am not entitled to any hearing on this issue, and I will not assert that I am entitled to a hearing on this issue or that I am entitled to any other due process right pursuant to any South Dakota statute, the South Dakota Constitution, the U. S. Constitution, or bylaws or regulations of any entity utilizing and relying upon this application.

Signature: _____ Date: _____

Name: _____
(Please print or type)

SIGNATURE/DEA VERIFICATION

Pharmacies are required to maintain signatures and DEA numbers on file for all physicians.

Signature: _____ Date: _____

Name: _____ DEA Number: _____
(Please print or type)

Office Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Specialty: _____

**MALPRACTICE LITIGATION
CONFIDENTIAL INFORMATION**

If you answered yes to disclosure question #18 on the Current Disclosure question page, please complete the following form. For each lawsuit, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e. statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

NAME(S) OF PLAINTIFF(S) OR COMPLAINANT(S)

MONTH/DAY/YEAR OF INCIDENT

WHERE INCIDENT OCCURRED

DESCRIBE THE NATURE OF INCIDENT (COMPLAINT, ALLEGATION)

PROVIDE A NARRATIVE DESCRIPTION OF YOUR PARTICIPATION/LEVEL OF CARE

OUTCOME OF INCIDENT

Pending Dropped/Settled/Closed – no payment Date Closed ____/____/____ Verdict for you – no payment
 Dropped/Settled/Closed with payment, amount: _____ Dismissed with prejudice
 Verdict for plaintiff, amount: _____ Dismissed without prejudice
Represented by Legal Counsel for this claim/malpractice lawsuit? Yes No If yes, give the name and address of counsel.

Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____

Insurance company that provided coverage for this claim:

Name: _____

Address: _____
Street City/State/Country Zip Code

Phone Number: _____ Policy Number: _____

Signature: _____ Date: _____

Print Name: _____ Phone Number: _____

HOSPITAL AFFILIATION ADDENDUM

(Please make as many extra copies as necessary)

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

From: ___/___/___ Facility Name: _____

To: ___/___/___ Type/category of privilege/affiliation (active, courtesy, etc.): _____

Department Name: _____

Department Chairperson or Chief of Staff: _____

Address: _____

Street

City/State/Country

Zip Code

Phone Number (if known): _____ Fax Number (if known): _____

HEALTH DISCLOSURE QUESTIONS

- 1. Yes No Do you have a physical or mental condition which would preclude you from performing the essential functions of your practice, job, or in the exercise of practice privileges, with or without reasonable accommodation?
Regardless of how this question is answered, the application will be processed in the usual manner. If you have answered this question affirmatively and are found to be professionally qualified for licensure or medical staff appointment and the clinical privileges requested, you will be given an opportunity to meet with the appropriate entity to determine what accommodations are necessary or feasible to allow you to practice safely.

- 2. Yes No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

- 3. Yes No Are you currently using illegal drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

- 4. Yes No Have you used illegal drugs within the last two years? ("Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

Signature: _____ Date: _____

Name: _____

(Please print or type)

AMA Self Designation of Specialties

Allergy
 Adolescent Medicine (Pediatrics)
 Addiction Medicine
 Addiction Psychiatry
 Allergy & Immunology
 Clinical Laboratory Immunology
 Aerospace Medicine
 Adolescent Medicine (Internal Medicine)
 Anesthesiology
 Pain Management (Anesthesiology)
 Abdominal Radiology
 Abdominal Surgery
 Anatomic Pathology
 Blood Banking/Transfusion Medicine
 Clinical Biochemical Genetics
 Critical Care Medicine (Anesthesiology)
 Clinical Cytogenetics
 Critical Care Medicine (Internal Medicine)
 Pediatric Critical Care Medicine
 Surgical Critical Care (Surgery)
 Cardiovascular Disease
 Craniofacial Surgery
 Clinical Genetics
 Child Neurology
 Child and Adolescent Psychiatry
 Clinical Pathology
 Clinical Molecular Genetics
 Clinical Neurophysiology
 Colon & Rectal Surgery
 Cardiothoracic Surgery
 Dermatology
 Developmental-Behavioral Pediatrics
 Clinical and Laboratory Dermatological Immunology
 Diabetes
 Dermatopathology
 Diagnostic Radiology
 Dermatologic Surgery
 Emergency Medicine
 Endocrinology, Diabetes and Metabolism
 Epidemiology
 Sports Medicine (Emergency Medicine)
 Medical Toxicology (Emergency Medicine)
 Forensic Pathology
 Family Practice
 Geriatric Medicine (Family Practice)
 Facial Plastic Surgery
 Sports Medicine (Family Practice)
 Gastroenterology
 Gynecological Oncology
 General Practice
 General Preventive Medicine
 General Surgery
 Gynecology
 Hematology (Internal Medicine)
 Hepatology
 Hematology (Pathology)
 Head & Neck Surgery
 Hospitalist
 Hand Surgery
 Interventional Cardiology
 Clinical Cardiac Electrophysiology
 Infectious Disease
 Immunology
 Clinical and Laboratory Immunology (Internal Medicine)
 Internal Medicine
 Geriatric Medicine (Internal Medicine)
 Sports Medicine (Internal Medicine)
 Legal Medicine
 Medical Management
 Maternal & Fetal Medicine
 Medical Genetics
 Molecular Genetic Path (Med Genetics)
 Molecular Genetic Path (Pathology)
 Medical Microbiology
 Internal Medicine/Pediatrics
 Public Health & General Preventive Medicine
 Musculoskeletal Radiology
 Neurology
 Neurodevelopmental Disabilities (Psych)
 Neurodevelopmental Disabilities (Ped)
 Nephrology
 Nuclear Medicine
 Neuropathology
 Neonatal-Perinatal Medicine
 Hematology/Oncology

AMA

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 NEP
 NM
 NP
 NPM
 OH

AMA Self Designation of Specialties

Nuclear Radiology
 Neurology/Diagnostic Neurology/Neuroradiology
 Neurological Surgery
 Pediatric Surgery (Neurology)
 Nutrition
 Adult Reconstructive Orthopedics
 Obstetrics-Gynecology
 Obstetrics
 Critical Care Medicine (Obstetrics & Gynecology)
 Foot and Ankle Orthopedics
 Occupational Medicine
 Other
 Osteopathic Manipulative Medicine
 Musculoskeletal Oncology
 Medical Oncology
 Pediatric Orthopedics
 Ophthalmology
 Orthopedic Surgery
 Sports Medicine (Orthopedic Surgery)
 Orthopedic Surgery of the Spine
 Otology/Neurotology
 Otolaryngology
 Orthopedic Trauma
 Psychiatry
 Clinical Pharmacology
 Pediatric Anesthesiology
 Pulmonary Critical Care Medicine
 Chemical Pathology
 Cytopathology
 Pediatrics
 Pediatric Allergy
 Pediatric Cardiology
 Pediatric Endocrinology
 Pediatric Infectious Disease
 Pediatric Otolaryngology
 Pediatric Cardiothoracic Surgery
 Pediatric Pulmonology
 Pediatric Radiology
 Pediatric Surgery
 Medical Toxicology (Pediatrics)
 Pediatric Emergency Medicine (Emergency Medicine)
 Pediatric Emergency Medicine (Pediatrics)
 Forensic Psychiatry
 Pediatric Gastroenterology
 Pediatric Hematology-Oncology
 Pharmaceutical Medicine
 Clinical and Laboratory Immunology (Pediatrics)
 Palliative Medicine
 Physical Medicine & Rehabilitation
 Pain Management
 Pediatric Nephrology
 Pediatric Ophthalmology
 Pediatric Pathology
 Pediatric Rheumatology
 Pain Management (Physical Med & Rehab)
 Plastic Surgery
 Sports Medicine (Pediatrics)
 Anatomic/Clinical Pathology
 Medical Toxicology (Preventative Medicine)
 Pulmonary Diseases
 Sports Medicine (Physical Med & Rehab)
 Psychoanalysis
 Geriatric Psychiatry
 Radiology
 Reproductive Endocrinology
 Rheumatology
 Pediatric Rehabilitation Medicine
 Neuroradiology
 Radiation Oncology
 Radiological Physics
 Spinal Cord Injury
 Sleep Medicine
 Surgical Oncology
 Selective Pathology
 Trauma Surgery
 Transplant Surgery
 Urology
 Undersea Medicine
 Pediatric Urology
 Plastic Surgery with the Head and Neck
 Thoracic Surgery
 Unspecified
 Vascular and Interventional Radiology
 Vascular Medicine
 General Vascular Surgery

AMA

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ADDENDUM TWO
CONFIDENTIAL HEALTH STATUS INFORMATION

Provider Name: _____

In order to process your application, it is necessary to inquire about your health status. The purpose of this form is to confirm whether you are capable of performing the duties and responsibilities of appointment and exercising the clinical privileges requested safely and competently.

Complete this questionnaire and return to the Central Verification Office. We will place this form in a *sealed Confidential Health Status envelope for each facility you are applying and send it to those medical staff offices.* The envelope will not be opened until *after* the Medical Executive Committee has taken initial action on your application and evaluated your professional qualifications.

1. Do you have any physical or mental condition that could affect your ability to exercise the clinical privileges requested and perform the duties of staff appointment or that would require an accommodation in order for you to exercise the privileges requested safely and competently?

_____ Yes _____ No
2. Have you ever had any problems with alcohol or drug dependency?

_____ Yes _____ No
3. Are you currently taking any medication that may affect either your clinical judgment or motor skills?

_____ Yes _____ No
4. Are you currently under any limitations concerning your activities or work load?

_____ Yes _____ No

If the answer is "yes" to any question, please explain and submit a report from your treating physician specifically addressing how the condition may affect your ability to exercise the privileges you have requested or the duties of staff appointment. Please also explain any proposed accommodation.

Certification

I certify that my staff appointment and clinical privileges are conditional upon my demonstrating that I am capable of exercising my privileges safely and competently and performing the duties and essential functions of staff appointment. I understand that the burden is on me to request any proposed accommodations and to justify its reasonableness. By my signature below, I hereby certify that all the information provided above is true, complete and correct. I agree to inform the hospital and supplement, as necessary, should any statement of the information contained above, although true when made, becomes untrue do to a change in circumstances of discovery of new information. Any falsification to this health status questionnaire is grounds for termination.

PRINTED NAME

SIGNATURE

DATE

**ADDENDUM THREE
HIPAA
ACKNOWLEDGMENT OF
ORGANIZED HEALTH CARE ARRANGEMENT**

The undersigned agrees that, with respect to activities at the Hospital, the undersigned shall be considered as part of an Organized Health Care Arrangement (OHCA) with the Hospital as that term is defined at 45 C.F.R. §164.501. The undersigned shall comply with all Hospital policies and federal and state laws and regulations relating to the use and disclosure of individually identifiable health information, and shall adopt such procedures and comply with such policies as may be required from time to time.

The Hospital will provide all patients presenting at their facilities with a Notice of Privacy Practices that includes a notification of the OHCA between the Hospital and its medical staff. The undersigned agrees to inform their patients seen outside the hospital setting of their participation in the OHCA, as a supplement to their own Notice of Privacy Practices.

PRINTED NAME

SIGNATURE

DATE

**ADDENDUM FIVE
SANFORD HEALTH PLAN
ACCESS AND AVAILABILITY QUESTIONS**

Sanford Health Plan requests the following information:

- o Are you in a recognition program for diabetes, stroke, etc? If so, please identify the program:

Access and Availability Questions:

1. Are you currently accepting new patients into your practice?

_____Yes _____No

2. Are you willing, in the future, to accept new patients?

_____Yes _____No

3. Does the office have wheelchair or handicapped access?

_____Yes _____No

PRINTED NAME

SIGNATURE

DATE

**ADDENDUM SIX
WAIVER OF LIABILITY &
CONSENT FOR RELEASE OF INFORMATION**

ALL Applicants must SIGN and DATE the Waiver of Liability & Consent for Release of Information.

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at such facilities I am applying (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand and agree that the CVO or Entity may communicate with me via e-mail over the Internet regarding my application for credentialing. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true 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 or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

PRINTED NAME

SIGNATURE

DATE

**ADDENDUM SEVEN
SUPERVISING PHYSICIAN STATEMENT**

I agree to serve as the supervising physician for _____. This person will provide services as my employee and/or will be directly supervised by me.

I verify that I have reviewed and approve of the scope of practice that this healthcare professional is requesting.

At all times, I agree to remain responsible for all acts of the above person while at the hospital.

Signature of Supervising Physician

Date

Printed Name

ADDENDUM NINE REQUIRED DOCUMENTS CHECKLIST

PROVIDER NAME: _____

PLEASE INCLUDE A COPY OF THE FOLLOWING WITH THIS APPLICATION:

- Copies of all current State License(s)
- Copies of all State Controlled Dangerous Substance Certificates (*if applicable*)
- Copies of all current Federal DEA registrations (*if applicable*)
- Copies of Board Certification Certificates **or qualifying letter**
- Copies of your Current and Past Professional Liability Insurance face sheets (*for past 10 years*)
- Copies of your Medical or Dental school graduation, internship and residency certificates, ECFMG (*if applicable*)
- Authorized list of procedures you have performed in your residency/fellowship. If your residency/fellowship was over two years ago, attach a certified copy of the list of procedures that you have performed since that time.**
- Pertinent training certificates to your area of specialty
- Emergency Care Training Certificates (CPR, BLS, ACLS, HCPC, ATLS, NALS, PALS etc., *as applicable*)
- Green Card or Work Permit (*if applicable*)
- DD-214 for Military Experience (*if applicable*)
- Notarized copy of state or federal issued photo ID (i.e. Drivers license or passport)
- Current Curriculum Vitae
- Results of your most current TB skin test or assessment if previously positive. Your last test must be within the prior 12 months. The Employee Health Services of Sanford USD Medical Center will provide this service, but documentation of the assessment or test must be complete prior to your appointment.
- A recent photograph for identification purposes. The photograph may be either black & white or color, but must be clear and light enough for scanning and reproducibility. It is preferred that a digital photo be emailed to credentialing@sanfordhealth.org in "JPEG" format.
- Evidence of a rubella titer. If you have not had a rubella test, the Employee Health Services of Sanford USD Medical Center will provide this service, but documentation of the vaccination or lab result must be complete prior to your appointment.
- Confidential Health Status Information Form
- Sanford Health Plan Access & Availability Questions

BEFORE YOU RETURN THIS APPLICATION – DID YOU:

- Provide complete street addresses wherever indicated, including past employment, affiliations, references, etc.
- Designated dates by mm/dd/yy format
- EXPLAIN ALL TIME GAPS** of 2 months or greater
- Answer all disclosure questions
- Provide explanation of any responses requiring such.
- Central Verification Attestation
- Apply for all applicable state licensure
- Include all of the enclosures and documents listed above

**Missing items will delay the processing of your application and
if not received will prevent the processing of your application.**

**ADDENDUM TEN
SANFORD HEALTH
APPOINTMENT REQUEST**

You may complete one application if applying to multiple facilities affiliated with Sanford Health. In order to process verifications for all facilities affiliated with Sanford Health, it is important to identify all facilities for which you are applying on this page. Please check those facilities which apply. If Unsure, please contact your clinic manager for assistance.

NOTE: All sites requested will be contacted for authorization of credentialing/privileging.

I, _____, am applying for appointment/privileges with each of the following facilities checked in the “Requesting at this Site” box:

Facility Name	City	State	Requesting at this Site
Bethesda Nursing Home	Beresford	SD	
Community Memorial Hospital	Burke	SD	
MN Veterans Home – Luverne	Luverne	MN	
Murray County Memorial Hospital	Slayton	MN	
Niobrara Valley Hospital	Lynch	NE	
Orange City Health System	Orange City	IA	
Pioneer Memorial Hospital & Health System	Viborg	SD	
Prairie Community Health	Buffalo, Eagle Butte, Faith, MacIntosh, Isabel	SD	
Prairie Lakes Healthcare System	Watertown	SD	
Sanford Canby Medical Center	Canby	MN	
Sanford Deuel County Medical Center	Clear Lake	SD	
Sanford Health Plan	Sioux Falls	SD	
Sanford Home Medical Equipment	Sioux Falls	SD	
Sanford Hospital Canton-Inwood	Canton	SD	
Sanford Hospital Luverne	Luverne	MN	
Sanford Hospital Rock Rapids	Rock Rapids	IA	
Sanford Hospital Webster	Webster	SD	
Sanford Jackson Medical Center	Jackson	MN	
Sanford Mid-Dakota Medical Center	Chamberlain	SD	
Sanford Regional Hospital Worthington	Worthington	MN	
Sanford Sheldon Medical Center	Sheldon	IA	
Sanford Tracy Medical Center	Tracy	MN	
Sanford USD Medical Center	Sioux Falls	SD	
Sanford Vermillion Medical Center	Vermillion	SD	
Sanford Westbrook Medical Center	Westbrook	MN	
TLC Advantage	Sioux Falls	SD	
West Holt Memorial Hospital	Atkinson	NE	
Windom Area Hospital	Windom	MN	
Winner Regional Healthcare Center	Winner	SD	