Instructions for Completing
The Maine Uniform Application for Reappointment

Contact each organization to which you are applying to determine if they accept the Maine Application and what other information may be required by the organization.

Type or legibly complete the application with blue or black ink.

When submitting your application to a credentialing entity (hospital, managed care entity,etc):

- Confirm that the information contained in the original application is up to date and correct. **It is the responsibility of the applicant to notify the facility of any changes to address, e-mail, phone, contact information, etc**.
- Update, as needed, using blue or black ink. Strike out any incorrect information and insert modification, initialing and dating any change.
- Keep the original, unsigned application form for your files and future use.
- Copy the original application and any addenda the credentialing entity has requested.
- Sign and date the copy of the application on pages 7 and 9.
- The format for entering dates is either MM/DD/YYYY or MM/YYYY.

Complete a unique Credentials Verification and Release Form for each organization to which you are applying. This may be a standard release or one specifically designed and supplied by the organization.

By following the instructions above, your signature will be an original and the date will be current. The information on the application must be complete and accurate. An incomplete application will delay processing.

- Submit the completed application as well as any requested addenda.
- Attach copies of the documents as requested on the application checklist each time the application is submitted.
- For your convenience and to ensure information accuracy, keep the application current at all times.
- If you have any questions, please call the healthcare organization to which you are applying.

This application form is available as a download at www.meamss.org

Revised: February 2014

Application Checklist for
The Maine Uniform Application for Reappointment

Before submitting your application, please take a minute to review this checklist to ensure the application is complete.

Signature on pages 7 and 9 must be original and must have a current date.

Essential facts about any pending or closed malpractice suit(s) must be included. Use the Malpractice Claims/Suit History form which is Page 7. If none, so indicate on this form, sign and date.

Most healthcare organizations in Maine require the following documents be attached to your application, if not previously provided:

- ✓ Copies of all current healthcare licenses
- ✓ Face sheet of current malpractice policy showing policy limits, expiration date and your name as an insured provider
- ✓ Copy of Maine DEA registration, if applicable
- ✓ Copies of Board certificates
- ✓ Certified copy of change of name document, if applicable
- ✓ Copy of any current Life Support certificates (i.e., BLS, ACLS, ATLS, PALS or NRP)
- ✓ For NPs under delegation and PAs – Copy of the Registration of Physician Extender and current Plan of Supervision. The Plan of Supervision must be specific to the healthcare facility to which you are applying. Please provide a Plan of Supervision for each position you hold.

Please check with each facility and/or managed care organization to which you are applying to determine if any additional documents are required.

The Maine Uniform Application for Reappointment

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Today's Date: __ __/__ __/__ __ __ __

It is the responsibility of the applicant to notify the facility of all changes to address, e-mail, phone, etc.

SECTION I - PERSONAL INFORMATION

Last Name: __________________________First Name: _______________________ Middle Name: ____________________

Suffix (Jr., II, etc.): _______ Professional Title/Degree: ___________ Any other surname used: _____________________

Social Security Number: __ __ __-- __ __--__ __ __ __ Date of Birth: __ __/__ __/__ __ __ __

If not a US Citizen, are you eligible to work lawfully in the United States? Yes ☐ No ☐

Do you hold a: J1 ☐ H1B ☐ Green Card ☐

Home Address: ____

City/State/Zip: ____ Phone Number: _____________________

Current E-Mail Address (Please print): ____

CAQH#: _________________________________ NPI #: ______________________________

SECTION II - LOCAL PRACTICE INFORMATION

PRIMARY OFFICE LOCATION

Office or Group Name: ____

Street and/or PO Box: ____

City/State/Zip: ____

Phone: __________________________ Fax: __________________________ Email: ________________________________

Office Manager Name: ____ Email: ________________________________

Credentialing Contact: ____ Email: ________________________________

Mailing Address (if different):

Street and/or PO Box: ____

City/State/Zip: ____

Applicant Name: ____

OTHER OFFICE LOCATIONS

Office or Group Name: ____

Street and/or PO Box: ____

City/State/Zip: ____

Phone: _________________________ Fax: ___________________________ Email: ____________________________

Office Contact Name: ____

Office or Group Name: ____

Street and/or PO Box: ____

City/State/Zip: ____

Phone: _________________________ Fax: __________________________ Email: ____________________________

Office Contact Name: ____

SECTION III - EDUCATION

List any graduate degree programs, formal residencies or fellowships completed <u>since your last application.</u>

Institution: ____

Address: ____

City/State/Zip: ____

Program Director (Please list the current director): ____

Phone: ______________________ Fax: _________________________ Email: ______________________________

Dates Attended: From __ __/__ __ __ __ to __ __/__ __ __ __ Specialty: _________________________________

Institution: ____

Address: ____

City/State/Zip: ____

Program Director (Please list the current director): ____

Phone: ______________________ Fax: _________________________ Email: ______________________________

Dates Attended: From __ __/__ __ __ __ to __ __/__ __ __ __ Specialty: _________________________________

****PLEASE ATTACH A SEPARATE CME LOG DETAILING CONTINUING MEDICAL EDUCATION PROGRAMS ATTENDED SINCE YOUR LAST REAPPOINTMENT APPLICATION. THE ABOVE SECTION IS <u>NOT</u> INTENDED FOR CME.**

Applicant Name: ____

SECTION IV - SPECIALTY/BOARD CERTIFICATION

Specialty Designation:

Primary (in which you spend 50% or more of your time): ______________________ Secondary: ___________________________

Certification Number (if applicable): __________________________________

Do you have clinical privileges at any hospital in the specialty noted? Yes ☐ No ☐

Specialty Board: ____

Initial Certification Date: __ __/__ __/__ __ __ __ Expiration Date: __ __/__ __/__ __ __ __ Lifetime? Yes ☐

Maintenance of Certification

Required to participate in MOC? Yes ☐ No ☐ Participating in MOC? Yes ☐ No ☐

If you are not currently Board certified are you pursuing certification? Yes ☐ No ☐

If 'Yes', name of Board: ____

Expected date of completion: ____

If 'No', do you have postgraduate training sufficient to meet the requirements of a specialty board? Yes ☐ No ☐

Please explain the reason(s) for not pursuing certification, including any unsuccessful attempts.

____

____

____

____

SECTION V - HOSPITAL AFFILIATIONS

List chronologically (most recent first) all current and previous hospitals where you hold or have held medical/professional staff membership and/or clinical privileges SINCE YOUR LAST APPLICATION, beginning with your PRIMARY hospital. If you require additional space, please use Page 9 or a separate sheet of paper.

Institution: ____

Address: _______________________________________City/State/Zip: _________________________________

Phone: ____________________ Fax: _____________________ Position/Staff Category: _____________________

Department/Service: _____________________________Department Chief: _______________________________

Dates at this institution: From __ __/__ __ __ __ to __ __/ __ __ __ __

Medical Staff Office Contact: ____

Applicant Name: ____

Hospital Affiliations Continued

Institution: ____

Address: ____________________________________City/State/Zip: ______________________________

Phone: __________________ Fax: ___________________ Position/Staff Category: ___________________

Department/Service: ___________________________Department Chief: ____________________________

Dates at this institution: From __ __/__ __ __ __ to __ __/ __ __ __ __

Medical Staff Office Contact: ____

Institution: ____

Address: ____________________________________City/State/Zip: ______________________________

Phone: __________________ Fax: ___________________ Position/Staff Category: ___________________

Department/Service: ___________________________Department Chief: ____________________________

Dates at this institution: From __ __/__ __ __ __ to __ __/ __ __ __ __

Medical Staff Office Contact: ____

Institution: ____

Address: ____________________________________City/State/Zip: ______________________________

Phone: __________________ Fax: ___________________ Position/Staff Category: ___________________

Department/Service: ___________________________Department Chief: ____________________________

Dates at this institution: From __ __/__ __ __ __ to __ __/ __ __ __ __

Medical Staff Office Contact: ____

Institution: ____

Address: ____________________________________City/State/Zip: ______________________________

Phone: __________________ Fax: ___________________ Position/Staff Category: ___________________

Department/Service: ___________________________Department Chief: ____________________________

Dates at this institution: From __ __/__ __ __ __ to __ __/ __ __ __ __

Medical Staff Office Contact: ____

Applicant Name: ____

SECTION VI - LICENSING

STATE LICENSE

List all current and/or active licenses for the past five (5) years

State	Type	License Number	Date Issued	Expiration Date	Status
MAINE					

1. Have you ever had your license to practice in any state or other jurisdiction involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions, or otherwise disciplined?	Yes ☐ No ☐
2. Are there any proceedings which could result in such action **currently** pending?	Yes ☐ No ☐
3. Have you ever voluntarily withdrawn an application, resigned your license or permitted it to lapse?	Yes ☐ No ☐

****If the answer is "YES" to any of the above questions, please provide details on Page 9 or a separate piece of paper.**

DEA REGISTRATION

Federal DEA Registration Number	Date Issued	Expiration Date

4. Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has your registration ever been modified, restricted, suspended or revoked?	Yes ☐ No ☐
5. Have you ever been denied registration by any state to prescribe or dispense controlled substances or has your registration ever been modified, restricted, suspended or revoked?	Yes ☐ No ☐
6. Are there any proceedings which could result in such action **currently** pending?	Yes ☐ No ☐
7. Have you ever voluntarily withdrawn your narcotics application, resigned your registration or permitted it to lapse?	Yes ☐ No ☐

****If the answer is "YES" to any of the above questions, please provide details on Page 9 or a separate piece of paper.**

Applicant Name: ____

SECTION VII - INSURANCE CARRIERS

List chronologically ALL insurance companies, hospitals, clinics or employers who have provided professional liability coverage in the past five (5) years. If you need additional space, please use page 9 or a separate sheet of paper.

ANY GAP IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE.

Current Insurance Carrier: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ______________________________ Fax: ______________________________

Policy Number: ______________ Initial Policy Date __ __/__ __/__ __ __ __ Expiration Date __ __/__ __/__ __ __ __

Coverage Amounts (incident/aggregate): ______________________________

Other Insurance Carrier: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ______________________________ Fax: ______________________________

Policy Number: ______________ Initial Policy Date __ __/__ __/__ __ __ __ Expiration Date __ __/__ __/__ __ __ __

Coverage Amounts (incident/aggregate): ______________________________

Question	Answer
8. Have you ever practiced medicine without liability coverage?	Yes ☐ No ☐
9. Have you ever been denied professional liability insurance or has your policy ever been canceled or denied renewal?	Yes ☐ No ☐
10. Have any restrictions ever been placed on your liability insurance?	Yes ☐ No ☐
11. Have you ever had an insurance carrier add a surcharge to your malpractice policy or increase your deductible?	Yes ☐ No ☐

****If the answer is "Yes" to any of the above questions, please explain on Page 14 or a separate sheet of paper.**

Question	Answer
12. Have you ***ever*** received a notice of claim* or been a defendant in a medical malpractice suit arising out of or in connection with your individual professional services? *Notice of claim is defined as a written communication from a claimant or plaintiff setting forth an allegation of professional malpractice, threatening or initiating legal action, and demanding monetary damages.	Yes ☐ No ☐
13. Are you aware of any such notice of claims against another person or entity rising out of or in connection with your individual professional services?	Yes ☐ No ☐
14. Have you or your malpractice carrier or any other person or entity made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf or on behalf of any other person or entity rising out of or in connection with your individual professional services in the past 10 years?	Yes ☐ No ☐

****If the answer is "Yes" to any of the above questions, please complete a Malpractice Claims/Suit History (page 11) for each event.**

Applicant Name: ______________________________

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COPY THIS FORM FOR EACH ADDITIONAL CLAIM/SUIT

NO CLAIMS: ☐ **PLEASE SIGN AND DATE AT BOTTOM**

Date of Alleged Incident: ____________________________ Date Lawsuit Filed: ________________________________

Carrier at the time of Alleged Incident: ____

Name of Court and Case Number: ____

Please explain the nature of allegations of wrongdoing/negligence:

Status of Case: (with reference to you specifically)

- ☐ Notice of Claim Filed: Date as of __ __/__ __/__ __ __ __
- ☐ Pending before malpractice panel: Date as of __ __/__ __/__ __ __ __
- ☐ Pending in court: Date as of __ __/__ __/__ __ __ __
- ☐ Closed without payment: Date __ __/__ __/__ __ __ __
- ☐ Pre-Trial Settlement: $__________________________ Date as of __ __/__ __/__ __ __ __
- ☐ Verdict for Defendant: Date as of __ __/__ __/__ __ __ __
- ☐ Verdict for Plaintiff: $___________________________ Date as of __ __/__ __/__ __ __ __

What was/is your status?

- ☐ Sole Defendant
- ☐ Co-Defendant with: ____
- ☐ Other: ____

I understand information submitted herein becomes part of my Application for staff reappointment/recredentialing.

Signature: ____ Date: __ __/__ __/__ __ __ __

Applicant Name: ____

SECTION VIII – REQUIRED QUESTIONS (Since your last appointment)

If the answer is "YES" to any of the following questions, please explain and include a copy of any order or settlement where applicable. ALL QUESTIONS MUST BE ANSWERED.

Question	Answer
15. Have you ever had your clinical privileges or employment at any hospital or any other health care facility limited or restricted, suspended, revoked, withdrawn involuntarily, not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings **currently** pending?	Yes ☐ No ☐
16. Have you ever had a request for any specific clinical privilege(s) denied as a result of disciplinary action or granted only with stated limitations (aside from ordinary initial probationary requirements of proctorship) or are there such proceedings **currently** pending? *For purposes of this question, voluntary withdrawal does not constitute denial.	Yes ☐ No ☐
17. Have you ever withdrawn an application to any healthcare entity? If yes, the name of the entity ____	Yes ☐ No ☐
18. Have you ever voluntarily surrendered or modified your privileges or resigned from medical staff membership? *For purposes of this question, moving out of state, end of contract denotes an affirmative response.	Yes ☐ No ☐
19. Have you ever had your medical staff membership or status on the staff of any hospital or other health care facility limited, denied, suspended, revoked, not renewed or made subject to probationary conditions or otherwise adversely affected or are there such proceedings **currently** pending?	Yes ☐ No ☐
20. Is there currently pending against you any litigation, investigatory or disciplinary proceeding with respect to privileges, licensure, DEA or other criminal or administrative matter (including Medicare, Medicaid or Quality Improvement Organization (QIO) sanctions) or civil matter initiated by the government?	Yes ☐ No ☐
21. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned, by any health care organization, including but not limited to, hospitals, or other health care facilities, based on professional competence?	Yes ☐ No ☐
22. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation or otherwise sanctioned by HMOs, PPOs, PHOs, independent practitioner associations (IPA) professional associations or societies, professional standards review organizations (PSRO) or peer review organizations (QIO) based on professional competence?	Yes ☐ No ☐
23. Have you ever been excluded, suspended, or otherwise sanctioned by Medicare or Medicaid or are there such proceedings **currently** pending?	Yes ☐ No ☐
24. Have you ever been disciplined by a professional society or resigned while allegations were pending?	Yes ☐ No ☐
25. Have you ever been convicted in a criminal proceeding or been subject to an adverse government agency administrative decision (including QIO, Medicare and/or Medicaid sanctions), been subject to an adverse decision in any civil litigation brought by a government agency, entered a plea of nolo contendere, or been subject to an adverse settlement in any such proceeding?	Yes ☐ No ☐
26. Have you ever been convicted of any criminal offense (including motor vehicle offenses but not including minor traffic or parking violation) or are there any such proceedings **currently** pending?	Yes ☐ No ☐
27. Are you currently engaged in the illegal use of drugs?	Yes ☐ No ☐
28. Have you been found guilty in a proceeding investigating substance abuse?	Yes ☐ No ☐

Applicant Name: ____

Section VIII continued – Health Questions

Your application will be processed in the usual manner regardless of how you answer the following questions. If your answer is "NO" to either question 29 or 30, please explain on a separate sheet of paper. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

Question	Answer
29. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without reasonable accommodations?	Yes ☐ No ☐
30. Are you able to perform these functions without significant risk or injury to yourself or others?	Yes ☐ No ☐

Signature of Applicant: ____ Date: __ __/__ __/__ __ __ __

Please use this additional space for any explanation(s).

Applicant Name: ____