Instructions for Completing
The Maine Uniform Application for Initial Appointment

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**.
- ➢ Confirm that there are no chronological gaps greater than 60 days in medical education, professional training and experience.
- ➢ 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 11 and 14.
- ➢ 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
http://www.namss.org/About/StateAssociationWebsites/MaineAssociationMedicalStaffServices.aspx

Application Checklist for
The Maine Uniform Application for Initial Appointment

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

Signature on pages 11 and 14 **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 11. If none, so indicate on the Malpractice Claims/Suit History form, sign and date.

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

- √ Copy of current Curriculum Vitae
- √ 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
- √ Copies of Malpractice Insurance 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)
- √ Original passport sized photograph. This photo may be sent to references or current hospital(s) for identification
- √ 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 the healthcare facility(s) to which you are applying to confirm whether there are additional requirements for supervision.

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 Initial Appointment

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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: ______________________ Gender: Male Female

Name used when degree obtained/Any other surname used: ____

Social Security Number: ______________________ Date of Birth: ________________________

Place of Birth: City/State or Country: ________________ Citizenship: _______

ECFMG number (If applicable): ______________

Date: _______________

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

MILITARY SERVICE: Yes No

Branch of Service: ____

Last Duty Station: ____

Please provide a copy of DD214, if applicable.

Are you a member of the reserves? Yes No

Reserve Branch: ____________________________

Home Address: ____

City/State/Zip: ________________________ Phone: ____________________ Home Cell

Current E-Mail Address (Required): ________________________________

CAQH#: ____________________________ NPI#: ______________________

SECTION II – LOCAL AREA INFORMATION

Name of Practice/Hospital that you will be joining: ______________________ Expected Start Date: __________

PRIMARY OFFICE LOCATION/ANTICIPATED OFFICE LOCATION

Office or Group Name: ____

Street and/or PO Box: ________________________________ City/State/Zip: ____________________________

Phone: ________________ Fax: ______________________ Email: ______________________________

Office Manager: __________________________________ Phone / Email: ________________________

Credentialing Contact: __________________________________ Phone / Email: ________________________

Applicant Name: ____

SECTION II – LOCAL AREA INFORMATION

OTHER OFFICE LOCATIONS:

Office or Group Name: ______________________________

Street and/or PO Box: ______________________________ City/State/Zip: ______________________________

Phone: ______________ Fax: ______________ Email: ______________________________

Office Manager: ______________________________ Phone / Email: ______________________________

Credentialing Contact: ______________________________ Phone / Email: ______________________________

Office or Group Name: ______________________________

Street and/or PO Box: ______________________________ City/State/Zip: ______________________________

Phone: ______________ Fax: ______________ Email: ______________________________

Office Manager: ______________________________ Phone / Email: ______________________________

Credentialing Contact: ______________________________ Phone / Email: ______________________________

Office or Group Name: ______________________________

Street and/or PO Box: ______________________________ City/State/Zip: ______________________________

Phone: ______________ Fax: ______________ Email: ______________________________

Office Manager: ______________________________ Phone / Email: ______________________________

Credentialing Contact: ______________________________ Phone / Email: ______________________________

SECTION III - EDUCATION PLEASE LIST IN CHRONOLOGICAL ORDER DO NOT “REFER TO ATTACHED CV”

(Post Graduate Training is on the next page.)

UNDERGRADUATE EDUCATION

College/University: ______________________________ Degree Awarded: __________

Address: ____
City/State/Zip Country

Dates Attended: From: __________ to: __________ Graduation Date: __________

PROFESSIONAL/GRADUATE EDUCATION

College/University: ______________________________ Degree Awarded: __________

Address: ____
City/State/Zip Country

Dates Attended: From: __________ to: __________ Graduation Date: __________

Applicant Name: ______________________________

SECTION III - EDUCATION PLEASE LIST IN CHRONOLOGICAL ORDER DO NOT "REFER TO ATTACHED CV"

PROFESSIONAL/GRADUATE EDUCATION

College/University: ____________________ Degree Awarded: __________

Address: ____________________

City/State/Zip Country

Dates Attended: From: __________ to: __________ Graduation Date: __________

PROFESSIONAL/GRADUATE EDUCATION

College/University: ____________________ Degree Awarded: __________

Address: ____________________

City/State/Zip Country

Dates Attended: From: __________ to: __________ Graduation Date: __________

PROFESSIONAL/GRADUATE EDUCATION

College/University: ____________________ Degree Awarded: __________

Address: ____________________

City/State/Zip Country

Dates Attended: From: __________ to: __________ Graduation Date: __________

POST GRADUATE TRAINING Please provide an explanation for any GAPS greater than 60 days

INTERNSHIP

Institution: ____________________

Address: ____________________

City/State/Zip

Dates Attended (Mo/Yr): From: __________ to: __________ Specialty __________

Program Director:

Name: __________ Degree: ______ Title: __________

Phone: __________ Fax: __________ Email: __________

Applicant Name: ____________________

POST GRADUATE TRAINING Please provide an explanation for any GAPS greater than 60 days

RESIDENCIES

Institution: ______________________________

Address: ______________________________
City/State/Zip

Dates Attended (Mo/Yr): From:__________to: ____________Specialty: ______________________

Program Director:

Name: ______________________Degree: ______Title:______________________

Phone: ______________Fax: ______________Email: ______________________

Institution: ______________________________

Address: ______________________________
City/State/Zip

Dates Attended (Mo/Yr): From:__________to: ____________Specialty:______________________

Program Director:

Name: ______________________Degree: ______Title:______________________

Phone: ______________Fax: ______________Email: ______________________

FELLOWSHIPS

Institution: ______________________________

Address: ______________________________
City/State/Zip

Dates Attended (Mo/Yr): From:__________to: ____________Specialty: ______________________

Program Director:

Name: ______________________Degree: ______Title: ______________________

Phone: ______________Fax: ______________Email: ______________________

***For additional fellowship information please use the space on below or attach a separate sheet of paper.**

Applicant Name: ______________________________

Specialty Designation:

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

Certification Number_________________ Certification Date: _________________ Expiration Date: ____________

Specialty Board: ____

Lifetime Yes No

Secondary: __________________________

Certification Number_________________ Certification Date: _________________ Expiration Date: ____________

Specialty Board: ____

Lifetime Yes No

Other Specialty: __________________________

Certification Number_________________ Certification Date: _________________ Expiration Date: ____________

Specialty Board: ____

Lifetime Yes No

Other Specialty: __________________________

Certification Number_________________ Certification Date: _________________ Expiration Date: ____________

Specialty Board: ____

Lifetime Yes No

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

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______________________

____

____

____

Applicant Name: ____

SECTION V – HOSPITAL AFFILIATIONS DO NOT "REFER TO ATTACHED CV"

List CHRONOLOGICALLY (most recent first) all current and previous hospitals where you hold or have held medical staff membership and/or clinical privileges, for the past ten (10) years, beginning with your current PRIMARY hospital. Please provide an explanation of any gaps greater than 60 days. If additional space is required, please use page 14 or a separate sheet of paper. You may submit your certificates of insurance for EACH location.

Institution: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ____________ Fax: ____________ Position/Staff Category: ____________

Department/Service: ______________________________ Department Chief: ______________________________

Dates at this institution: From: ____________ to: ____________

Institution: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ____________ Fax: ____________ Position/Staff Category: ____________

Department/Service: ______________________________ Department Chief: ______________________________

Dates at this institution: From: ____________ to: ____________

Institution: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ____________ Fax: ____________ Position/Staff Category: ____________

Department/Service: ______________________________ Department Chief: ______________________________

Dates at this institution: From: ____________ to: ____________

Institution: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ____________ Fax: ____________ Position/Staff Category: ____________

Department/Service: ______________________________ Department Chief: ______________________________

Dates at this institution: From: ____________ to: ____________

Institution: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Phone: ____________ Fax: ____________ Position/Staff Category: ____________

Department/Service: ______________________________ Department Chief: ______________________________

Dates at this institution: From: ____________ to: ____________

Applicant Name: ______________________________

Please list CHRONOLOGICALLY (since completing training) all professional activities, paid or volunteer, self-employment, service as an independent contractor (including Locums agencies), and/or any healthcare entities OTHER THAN THE HOSPITALS listed on pages 1 and 2. If you need additional space, please use page 14 or a separate piece of paper. You may submit your certificates of insurance for EACH location.

ANY GAP OF GREATER THAN 60 DAYS IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE.

Name of Organization: ______
Address: ______ City/State/Zip: ______
Contact Name: ______
Phone: ______ **Fax**: ______ **Email**: ______
Your position held/Title: ______ Dates: From: ______ to: ______

Name of Organization: ______
Address: ______ City/State/Zip: ______
Contact Name: ______
Phone: ______ **Fax**: ______ **Email**: ______
Your position held/Title: ______ Dates: From: ______ to: ______

Name of Organization: ______
Address: ______ City/State/Zip: ______
Contact Name: ______
Phone: ______ **Fax**: ______ **Email**: ______
Your position held/Title: ______ Dates: From: ______ to: ______

Name of Organization: ______
Address: ______ City/State/Zip: ______
Contact Name: ______
Phone: ______ **Fax**: ______ **Email**: ______
Your position held/Title: ______ Dates: From: ______ to: ______

Applicant Name: ______

SECTION VIII – LICENSING LIST ALL CURRENT AND PAST LICENSES

State	Type	License Number	Date Issued	Expiration Date	Status

1. Have you **ever** had your license to practice medicine 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 for licensure, 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 1 or a separate sheet 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 1 or a separate sheet of paper.**

Applicant Name: ____

SECTION VII – INSURANCE CARRIERS LIST CHRONOLOGICALLY (Current carrier first)

Please include ALL insurance companies for the last ten (10) years, or if applicable since internship, that have provided professional liability coverage. If you require additional space, please use Page 14 or a separate sheet of paper.

ANY GAP IN COVERAGE REQUIRES EXPLANATION ON A SEPARATE PAGE.

Primary Insurance Carrier: ____________________

Address: ____________________ City/State/Zip: ____________________

Institution Affiliation: ____________________

Phone: __________ Fax: __________ Policy Number: ____________________

Date of Coverage (Mo/Yr) From: ________ to: ________ Coverage Amounts (incident/aggregate): ____________

Secondary Insurance Carrier: ____________________

Address: ____________________ City/State/Zip: ____________________

Institution Affiliation: ____________________

Phone: __________ Fax: __________ Policy Number: ____________________

Date of Coverage (Mo/Yr) From: ________ to: ________ Coverage Amounts (incident/aggregate): ____________

Prior Insurance Carrier: ____________________

Address: ____________________ City/State/Zip: ____________________

Institution Affiliation: ____________________

Phone: __________ Fax: __________ Policy Number: ____________________

Date of Coverage (Mo/Yr) From: ________ to: ________ Coverage Amounts (incident/aggregate): ____________

Prior Insurance Carrier: ____________________

Address: ____________________ City/State/Zip: ____________________

Institution Affiliation: ____________________

Phone: __________ Fax: __________ Policy Number: ____________________

Date of Coverage (Mo/Yr) From: ________ to: ________ Coverage Amounts (incident/aggregate): ____________

Applicant Name: ____________________

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 complete a Malpractice Claims/Suit History (page 1) for each event.**

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 **ever** 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

Applicant Name: ____

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COPY THIS FORM FOR EACH ADDITIONAL CLAIM/SUIT FOR ALL CASES YOU HAVE EVER BEEN NAMED IN

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

Date of Alleged Incident: _____________ Date Lawsuit Filed: _________________

Carrier at 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 appointment/credentialing and may also be used in future credentialing.

Signature: ____**Date:** ___________________

Applicant Name: ____

SECTION IX – REFERENCES

Please provide names and complete addresses of four (4) professional references.

- These individuals must have personal knowledge, over the past **24-month period**, of your current clinical skills, ability, ethical character, judgment, professional performance, and clinical competence or have been responsible for professional observation of your work.
- References may not be provided by relatives, current classmates, spouse or domestic partner.
- Acceptable references include referring physicians or professional peers – defined as being in the same professional discipline with equal qualifications. (MD/DO – MD/DO; DMD/DDS –DMD/DDS; PA/NP – PA/NP, etc.)
- References should be individuals other than your business partners or associates, if possible.
- If you currently hold hospital privileges, one reference must be your current department chief.
- If you are currently completing a residency or fellowship, one reference must be the program director.

Advanced Practice Provider's (APP's) MUST provide at least one MD/DO.

Current Department Chief or Residency/Fellowship Director

First Name: ______________________ Last Name: ______________________ Degree: ________

Specialty: ____________________ **Email** (required): ____________________

Phone: ______________ **Fax** (required): ______________

Address: ______________________________ City/State/Zip: ______________________________

In what capacity has this individual observed your clinical abilities? ______________________________

First Name: ______________________ Last Name: ______________________ Degree: ________

Specialty: ____________________ **Email** (required): ____________________

Phone: ______________ **Fax** (required): ______________

Address: ______________________________ City/State/Zip: ______________________________

In what capacity has this individual observed your clinical abilities? ______________________________

First Name: ______________________ Last Name: ______________________ Degree: ________

Specialty: ____________________ **Email** (required): ____________________

Phone: ______________ **Fax** (required): ______________

Address: ______________________________ City/State/Zip: ______________________________

In what capacity has this individual observed your clinical abilities? ______________________________

First Name: ______________________ Last Name: ______________________ Degree: ________

Specialty: ____________________ **Email** (required): ____________________

Phone: ______________ **Fax** (required): ______________

Address: ______________________________ City/State/Zip: ______________________________

In what capacity has this individual observed your clinical abilities? ______________________________

Applicant Name: ______________________________

SECTION X - REQUIRED QUESTIONS

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, 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 not renewed, 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 X - REQUIRED QUESTIONS CONTINUED

Your application will be processed in the usual manner regardless of how you answer questions 29 and 30 below. If you have answered "NO" to questions 29 or 30, please explain completely, using a separate sheet of paper if necessary. 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 space for additional information and explanations (including any gaps in training, work history, insurance coverage, or hospital affiliations). A separate sheet of paper may be used.

Applicant Name: ____