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. Complete the application fully and legibly, and if on paper, with blue or black ink. Do not leave any questions blank. Contact the organization to which you are applying with questions.

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 the application**.
- Confirm that there are no chronological gaps greater than 60 days in medical education, professional training and experience.
- Update, as needed.
- Keep a copy of the application form for your files and future use.
- If submitting a paper application, copy the original application and any addenda the credentialing entity has requested.
- If submitting a paper application, 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 electronic signature will be considered an original and the date will be current if you are submitting an electronic application. The information on the application must be complete and accurate, and your electronic signature attests to that fact. An incomplete application will delay processing.

- Submit the completed application as well as any requested addenda. Please read the application carefully and make sure you attach all required materials.
- Attach copies of the documents as requested on the application checklist each time the application is submitted.
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- 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 if you are submitting a paper application.

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 Professional Practice Agreement/Plan of Supervision. The Professional Practice Agreement/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 and/or what their specific requirements are around 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

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: _ _ _ _ _ _ _ _ _ _ _ _ _ _

Preferred Pronoun(s): _____

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

Social Security Number: _____ Date of Birth: _____

Place of Birth: City/State or Country: _____

MILITARY SERVICE: Yes ☐ No ☐

ECFMG number (If applicable): _____

Citizenship: _____

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 ☐

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: _____

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: _____

***If completing a paper application : for additional education/training information please use the space below or attach a separate sheet of paper.**

SECTION IV – SPECIALTY/BOARD CERTIFICATION DO NOT "REFER TO ATTACHED CV"

Specialty Designation:

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

Applicant Name: _____

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 <u>CHRONOLOGICALLY</u> (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 <u>current PRIMARY hospital</u>. Please provide an explanation of any gaps greater than <u>60 days</u>. If additional space is required, please use page 14 or a separate sheet of paper. You may submit your certificates of insurance for <u>EACH</u> 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: ______________________________

SECTION VI – WORK HISTORY/PROFESSIONAL AFFILIATIONS DO NOT "REFER TO ATTACHED CV"

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 must 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 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. Have you **ever** been notified of the existence of allegations, investigations and/or complaints involving you, filed by ANY licensing authority, including any that remain open as of the date of this application? ?	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 14 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 14 or a separate sheet of paper.**

Applicant Name: _____

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

Please include ALL insurance companies, hospitals, clinics or employers, BEGINNING WITH YOUR INTERNSHIP, who have provided professional liability coverage. If you require additional space, please use Page 14 or a separate sheet of paper. You must submit your certificates of insurance for EACH location in lieu of completing the following.

ANY GAP IN CHRONOLOGY REQUIRES EXPLANATION ON A SEPARATE PAGE.

Primary Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Contact Email: _____ Policy Number: _____

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

Certificate Provided: Yes ☐ No ☐

Secondary Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Contact Email: _____ Policy Number: _____

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

Certificate Provided: Yes ☐ No ☐

Prior Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Institution Affiliation: _____

Phone: _____ Fax: _____ Contact Email: _____ Policy Number: _____

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

Certificate Provided: Yes ☐ No ☐

Prior Insurance Carrier: _____

_____ Address: _____

_____ City/State/Zip: _____

_____

Institution Affiliation: _____

_____

Phone: _____ Fax: _____ Contact Email: _____ Policy Number:

_____ Date of Coverage (Mo/Yr) From:

_____ to: _____ Coverage Amounts (incident/aggregate): _____

Certificate Provided: Yes ☐ No ☐

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 11) 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 ☐

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COMPLETE THIS FORM FOR EACH CLAIM/SUIT YOU HAVE <u>EVER</u> BEEN NAMED IN

NO CLAIMS: ☐ PLEASE SIGN AND DATE AT BOTTOM

Date of Alleged Incident: _____ Organization Where Alleged Incident Occurred: _____

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: _____

SECTION IX – REFERENCES

Please provide names and complete addresses of four (4) professional references, including the period with which they observed your clinical work in the past 24 months.

- 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, whenever possible, their primary supervising/collaborating physician if applicable.

Current Department Chief or Residency/Fellowship Director

First Name: _____ Last Name: _____ Degree: _____

Specialty: _____ **Email** (required): _____

Phone: _____ **Fax** (required): _____ Observed From: _____ to _____

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): _____ Observed From: _____ to _____

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): _____ Observed From: _____

_____ to _____

Address: _____ City/State/Zip: _____

First Name: _____ Last Name: _____ Degree: _____

Specialty: _____ **Email** (required): _____

Phone: _____ **Fax** (required): _____ Observed From: _____

_____ to _____

Address: _____ City/State/Zip: _____

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.

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. Have you **ever**, or 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 ☐

Applicant Name: _____

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 below. If you have answered "YES" to questions 29, 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.

29. Do you have a medical condition that currently impairs your ability to safely and competently practice medicine? *"Medical condition" includes any physiological or psychological disease, disorder, syndrome or condition.*	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.