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.

Complete the application fully and legibly. If completing on paper, use 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**.
- Update, as needed.
- Keep a copy of the application form for your files and future use.
- Keep the original, unsigned application form for your files and future use.
- If completing on paper, copy the original application and any addenda the credentialing entity has requested.
- If completing on paper, sign and date the copy of the application on pages 9 and 11.
- 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.

If completing the application electronically, by following the instructions above, your electronic signature will be considered an original and the date will be current. 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.

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 Reappointment

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

If completing a paper application, signature on pages 9 and 11 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 9. 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 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 Reappointment

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: _____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: _____Citizenship: _____

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 ☐ ECFMG number (If applicable): _____Date: ____/____/_____

Home Address: _____

City/State/Zip: _____Phone Number: _____

Current E-Mail Address (Required): _____

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: _____

Today's Date: _____/_____/_____

OTHER OFFICE LOCATIONS

Office or Group Name: _____

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

Phone: _____ Fax: _____ Email: _____

Office Contact Name: _____

OTHER OFFICE LOCATIONS

Office or Group Name: _____

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

Phone: _____ Fax: _____ Email: _____

Office Contact Name: _____

OTHER OFFICE LOCATIONS

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 since your last application.
***PLEASE ATTACH A SEPARATE CME LOG DETAILING CONTINUING MEDICAL EDUCATION PROGRAMS ATTENDED SINCE YOUR LAST REAPPOINTMENT APPLICATION. THE ABOVE SECTION IS NOT INTENDED FOR CME.**

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: _____

SECTION IV - SPECIALTY/BOARD CERTIFICATION

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 ☐

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.

_____

_____

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 11.**

Institution: _____

Address: _____City/State/Zip: _____

Phone: _____Fax: _____Position/Staff Category: _____

Department/Service: _____Department Chief: _____

Dates at this institution: From _____/_____to _____/ _____

Medical Staff Office Contact: _____

Insurance Carrier:_____

SECTION V - 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: ____
Insurance Carrier:____

Institution: ____

Address: _______________________________________City/State/Zip: __________________________________

Phone: ____________________Fax: _____________________Position/Staff Category: ______________________

Department/Service: ______________________________Department Chief: ________________________________

Dates at this institution: From _____/__________to _____/ __________

Medical Staff Office Contact: ____
Insurance Carrier:____

Institution: ____

Address: _______________________________________City/State/Zip: __________________________________

Phone: ____________________Fax: _____________________Position/Staff Category: ______________________

Department/Service: ______________________________Department Chief: ________________________________

Dates at this institution: From _____/__________to _____/ __________

Medical Staff Office Contact: ____
Insurance Carrier:____

Institution: ____

Address: _______________________________________City/State/Zip: __________________________________

Phone: ____________________Fax: _____________________Position/Staff Category: ______________________

Department/Service: ______________________________Department Chief: ________________________________

Dates at this institution: From _____/__________to _____/ __________

Medical Staff Office Contact: ____
Insurance Carrier:____

SECTION VI - LICENSING

STATE LICENSE

List all licenses for the past five (5) years

State	Type	License Number	Date Issued	Expiration Date	Status

***If the answer is "YES" to any of the above questions, please provide details on Page 11 or a separate piece of paper.**

1. Has your license to practice in any state or other jurisdiction involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions, or	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, since your last appointment, voluntarily withdrawn an application, resigned your license or permitted it to lapse?	Yes ☐	No ☐

DEA REGISTRATION

Federal DEA Registration Number	Date Issued	Expiration Date

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

***If the answer is "YES" to any of the above questions, please provide details on Page 11 or a separate piece of paper.**

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 119 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: _____ Email: _____

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

Coverage Amounts (incident/aggregate): _____

Other Insurance Carrier: _____

Address: _____ City/State/Zip: _____

Phone: Fax: Email:

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

Coverage Amounts (incident/aggregate): _____

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

*If the answer is "Yes" to any of the above questions, please explain on Page 11 or a separate sheet of paper.

12. Have you 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 since your last appointment?* 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 since your last appointment?	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 since your last appointment?	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.**

MALPRACTICE CLAIMS/SUIT HISTORY

PLEASE COMPLETE THIS FORM FOR EACH CLAIM/SUIT

NO CLAIMS: ☐ PLEASE SIGN AND DATE AT BOTTOM

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

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/re-credentialing.

Signature: _____ Date: _____/_____/_____

SECTION VIII – REQUIRED QUESTIONS (Since your last Appointment/Reappointment)

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 your clinical privileges or employment at any hospital or any other health care facility been 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 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) since your last appointment/reappointment or are there such proceedings **currently** pending?	Yes ☐ No ☐
17. Have you withdrawn an application to any healthcare entity since your last appointment/reappointment? If yes, the name of the entity _____	Yes ☐ No ☐
18. Have you voluntarily surrendered or modified your privileges or resigned from medical staff membership since your last appointment/reappointment? *For purposes of this question, moving out of state, end of contract denotes an affirmative response.	Yes ☐ No ☐
19. Have you 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 since your last appointment/reappointment or are there such proceedings **currently** pending?	Yes ☐ No ☐
20. Has there **ever** been, or are there currently any pending 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 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 since your last appointment/reappointment?	Yes ☐ No ☐
22. Have you 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 since your last appointment/reappointment?	Yes ☐ No ☐
23. Have you been excluded, suspended, or otherwise sanctioned by Medicare or Medicaid or are there such proceeding **currently** pending?	Yes ☐ No ☐
24. Have you been disciplined by a professional society or resigned while allegations were pending?	Yes ☐ No ☐
25. Have you 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 since your last appointment/reappointment?	Yes ☐ No ☐

26. Have you 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 since your last appointment/reappointment?	Yes ☐ No ☐

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 "YES" to question 29, 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.

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 additional space for any explanation(s).