

## ATTESTATION QUESTIONS

**INSTRUCTIONS:** Please answer the following questions “Yes” or “No”. If your answer to any of the following questions is “Yes”, please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending?

Yes   No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending?

Yes   No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes   No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes   No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes   No
6. Have you ever been denied certification/recertification by a specialty board?

Yes   No
7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?

Yes   No
8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense?

Yes   No
8. b. Are any such actions pending?

Yes   No
9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If YES, please complete Addendum B.

Yes   No
10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending?  
If YES, please complete Addendum B.

Yes   No
11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes   No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. Yes No

*Continue to the Next Page for Additional Attestation Questions*

### ATTESTATION QUESTIONS (Continued)

**INSTRUCTIONS:** Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? Yes No
14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? Yes No
15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? Yes No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

**APPLICANT SIGNATURE** (Stamp is Not Acceptable): \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

*Continue to the Next Page for Information Release/Acknowledgements*

**INFORMATION RELEASE/ACKNOWLEDGEMENTS**

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

**APPLICANT SIGNATURE** (Stamp is Not Acceptable)

**PRINTED NAME**

**DATE**

Addenda Submitting;

Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:  
- California Association of Health Plans (916) 552-2910  
- California Association of Physician Groups (916) 443-2274

*The CPPA has been completed. Please be sure you have signed the last two pages before submission.*

# California Participating Practitioner Application

## Addendum A *Practitioner Rights*

### *Right to Review*

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

### *Right to be Informed of the Status of Credentialing/Recredentialing Application*

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

### *Notification of Discrepancy*

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

### *Correction of Erroneous Information*

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**APPLICANT SIGNATURE** (Stamp is Not Acceptable): \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

# California Participating Practitioner Application

## Addendum B

### *Professional Liability Action Explained*

This Addendum is submitted to \_\_\_\_\_ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

Please check here if there are no pending/ settled claims to report (and sign below to attest).

#### I: Practitioner Identifying Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

#### II. Case Information

Patient's Name: \_\_\_\_\_ Patient's Gender:  Male  Female Patient's DOB: \_\_\_\_\_

City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:
--	------------------------------	--	------------------

Location of incident:

Hospital  My Office  Other doctor's office  Surgery Center  Other (specify): \_\_\_\_\_

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.)

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action?  Yes  No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name:	Telephone Number:	Fax Number:
-------	-------------------	-------------

### III. Status of Lawsuit/Arbitration (check one)

- Lawsuit/arbitration still ongoing, unresolved.
- Judgment rendered and payment was made on my behalf. Amount paid on my behalf: \_\_\_\_\_
- Judgment rendered and I was found not liable.
- Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: \_\_\_\_\_
- Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:

1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

## SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

**APPLICANT SIGNATURE** (Stamp is Not Acceptable) \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

# California Participating Physician Application Addendum C

Section A		CONFIDENTIAL QUESTIONS -- HEALTH HISTORY	
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.</b>			
2.	Are you a certified Worker's Compensation provider?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>If yes, please attach a copy of your certificate.</b>			
3.	Are you a reservist? If yes, what branch of the military? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anticipated date of separation from reserve duty? ____/____/____			
4.	Medicaid/Medi-Cal #:		

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature