Gila Multi-Specialty Independent Provider Association
1268 E. 32nd Street
Silver City, NM 88061
575-538-2355

Date of Application: _____

Name: _____
Last First Middle Maiden or Other Names Used

Circle all that apply and for which you are currently licensed: MD DO DDS DC DPM OD PA CNM CNP CRNA RN PT OT ST DOrienMed Acup Clin Psych Psych Assoc LMHC LPAT LADAC LISW LMSW LPC LPCC LMFT CNS/Psych CNS/Medical Spch Path

Other:_____ Specialty: _____

Gender: ☐ F ☐ M Citizenship:_____ Place of Birth: _____

Social Security Number:_____ Date of Birth: _____

State Tax ID#:_____ ☐ Pending Federal Tax ID#: _____ ☐ Pending

Medicare #:_____ ☐ Pending Medicaid #: _____ ☐ Pending

Unique Physician Identification Number (UPIN):_____ ☐ Pending

National Provider Identifier Number (NPI): _____ ☐ Applied

CLIA Number (if applicable):_____ Approval Level:_____ Expiration Date: _____

Home Address:

Street Address:_____

City, State/Province and Zip Code:_____

Telephone Number:_____ Pager Number:_____

Cell Phone Number:_____ Spouse's Name (Optional): _____

Credentials Correspondence Address:

Department:_____

Street Address:_____

City, State/Province and Zip Code:_____

Email Address: _____

Telephone Number:_____ Facsimile Number: _____

Military Service:

Branch:_____ Dates: From: _____ To: _____

Rank:_____ Type of Discharge:_____

Immigration:

Immigration Status: _____ Immigration Certification Number: _____

ECFMG (Educational Commission for Foreign Medical Graduates) Number (if applicable):_____

Date Issued:_____ (Please attach a copy of your ECFMG certificate.}

Languages:

Foreign Languages (spoken fluently by practitioner): _____

Certifications:

ACLS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires:_____

ATLS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires: _____

PALS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires: _____

HOSPITAL AND HEALTHCARE AFFILIATIONS

Are you a PCP? ☐ Yes ☐ No
Do you deliver babies? ☐ Yes ☐ No
Are you an MD, DO, or DPM? ☐ Yes ☐ No

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) **OR**
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Do you have courtesy or consulting privileges at your current primary admitting facility? ☐ Yes ☐ No

If yes, do these courtesy or consulting privileges allow you to admit patients? ☐ Yes ☐ No

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name):_____

Street Address:_____

City, State/Province, Country and Zip Code: _____

Telephone Number:_____ Facsimile:_____

Appointment Dates: From:_____ To:_____ ☐ Present Type of Appointment:_____

Privileges Assigned:_____

Facility Name: _____

Street Address:_____

City, State/Province, Country and Zip Code: _____

Telephone Number:_____ Facsimile: _____

Appointment Dates: From:_____ To:_____ ☐ Present Type of Appointment:_____

Privileges Assigned:_____

Facility Name: _____

Street Address:_____

City, State/Province, Country and Zip Code: _____

Telephone Number:_____ Facsimile: _____

Appointment Dates: From:_____ To:_____ ☐ Present Type of Appointment:_____

Privileges Assigned:_____

Facility Name: ______________________________
Street Address: ______________________________
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Facsimile: ______________________
Appointment Dates: From: ________ To: ________ ☐ Present Type of Appointment: ______________
Privileges Assigned: ______________________________

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: ______________________________ From: ____/____ (Mo/Yr) To: ____/____ (Mo/Yr)
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Contact Person: ______________________
Type of Practice: ______________________________

Organization: ______________________________ From: ____/____ (Mo/Yr) To: ____/____ (Mo/Yr)
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Contact Person: ______________________
Type of Practice: ______________________________

Organization: ______________________________ From: ____/____ (Mo/Yr) To: ____/____ (Mo/Yr)
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Contact Person: ______________________
Type of Practice: ______________________________

Organization: ______________________________ From: ____/____ (Mo/Yr) To: ____/____ (Mo/Yr)
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Contact Person: ______________________
Type of Practice: ______________________________

Organization: ______________________________ From: ____/____ (Mo/Yr) To: ____/____ (Mo/Yr)
Street Address: ______________________________ ☐ Present
City, State/Province, Country and Zip Code: ______________________________
Telephone Number: ______________________ Contact Person: ______________________
Type of Practice: ______________________________

Please provide a written explanation for any gaps in work history of six (6) months or more.

____
____
____
____
____
____
____

PRACTICE LOCATIONS

Primary Practice/Group Name: _____ Effective Date: _____

Street Address: _____

City, State/Province and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

E-Mail Address: _____ Answering Service Number: _____

Foreign Languages (spoken fluently at practice): _____

Office Manager or Contact Person: _____

Billing Address: ☐ Same as above

Contact Person: _____ Tax ID #: _____

Street Address: _____

City, State/Province and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

Practice Associates: **Call Coverage** (if different):

_____ / _____

_____ / _____

_____ / _____

_____ / _____

What are the office hours for your Practice or Group Practice? (Provide days/hours):

_____

_____

What provisions have been made for after hours? _____

_____

_____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name: _____ Tax ID #: _____

Street Address: _____

City, State/Province and Zip Code: _____

Telephone Number: _____ Facsimile Number: _____

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please attach documentation of all continuing education hours you have obtained in the last two (2) years or complete the attached statement of continuing medical education.
2. If you are applying for privileges at a hospital or clinic, please complete the enclosed privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: ______________________ Specialty: ______________________
Street Address: ______________________ Email: ______________________
City, State/Province, Country and Zip Code: ______________________
Telephone Number: ______________________ Facsimile: ______________________

Name and Title: ______________________ Specialty: ______________________
Street Address: ______________________ Email: ______________________
City, State/Province, Country and Zip Code: ______________________
Telephone Number: ______________________ Facsimile: ______________________

Name and Title: ______________________ Specialty: ______________________
Street Address: ______________________ Email: ______________________
City, State/Province, Country and Zip Code: ______________________
Telephone Number: ______________________ Facsimile: ______________________

Name and Title: ______________________ Specialty: ______________________
Street Address: ______________________ Email: ______________________
City, State/Province, Country and Zip Code: ______________________
Telephone Number: ______________________ Facsimile: ______________________

Name and Title: ______________________ Specialty: ______________________
Street Address: ______________________ Email: ______________________
City, State/Province, Country and Zip Code: ______________________
Telephone Number: ______________________ Facsimile: ______________________

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number: ______________________ ☐ Pending
State: __________ Issue Date: __________ Expiration Date: __________

State Professional License/Certification Number: ______________________ ☐ Pending
State: __________ Issue Date: __________ Expiration Date: __________

State Professional License/Certification Number: ______________________ ☐ Pending
State: __________ Issue Date: __________ Expiration Date: __________

State Professional License/Certification Number: ______________________ ☐ Pending
State: __________ Issue Date: __________ Expiration Date: __________

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A
DEA Number: __________ Expiration Date: __________ ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A
CSR Number: __________ Expiration Date: __________ State: __________ ☐ Pending
CSR Number: __________ Expiration Date: __________ State: __________ ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post-graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary) Check the type of education listed.

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

☐Undergraduate ☐Graduate ☐Post Graduate ☐Internship ☐Residency ☐Fellowship ☐Teaching position

Institution:________________________ Dates Attended: From:____/____ Mo/Yr

Street Address:________________________ To:____/____ Mo/Yr

City, State/Province, Country, Zip: ________________________ Graduation Year:________

Degree Earned:________________ or Specialty: ________________

If teaching appointment: Department/Position: ________________________

SPECIALTY BOARD CERTIFICATIONS

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified: __________ Date Last Recertified: __________ Expiration Date: __________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation: __________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified: __________ Date Last Recertified: __________ Expiration Date: __________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation: __________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified: __________ Date Last Recertified: __________ Expiration Date: __________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation: __________

____

☐ **Board or** ☐ **Specialty or** ☐ **Subspecialty** ____________________

Date Certified: __________ Date Last Recertified: __________ Expiration Date: __________ ☐ N/A

Certification Number: __________ Accepted for Examination ☐Yes ☐No Expiration Date: __________

If not accepted, have you made application? ☐ Yes ☐ No If no, provide an explanation: __________

____

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☐ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page, if necessary.

Current Carrier: ____________________ Limits: __________

Street Address: ____________________ ☐ Current ☐ Pending

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From: __________ To: __________ Policy Number: __________

Carrier: ____________________ Limits: __________

Street Address: ____________________

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From: __________ To: __________ Policy Number: __________

Carrier: ____________________ Limits: __________

Street Address: ____________________

City, State/Province, Country and Zip Code: ____________________

Dates Insured: From: __________ To: __________ Policy Number: __________

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response except for question #16. **If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.**

1. Has your professional liability coverage ever been terminated by action of the insurance company (except as a result of the company ceasing to offer insurance coverage to physicians or other practitioners)?	☐ Yes	☐ No
2. Have you ever been denied professional liability insurance coverage?	☐ Yes	☐ No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes	☐ No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☐ No
5. Have you ever had any sanctions imposed by Medicare and/or Medicaid?	☐ Yes	☐ No
6. Have you ever been convicted of a misdemeanor or felony (excluding minor traffic violations) in the United States or any crime in another country?	☐ Yes	☐ No
7. Have you ever been arrested, indicted, charged, or been a defendant in a trial, regardless of the outcome, of any crime involving: • Intoxication • Illegal use, possession or distribution of an illegal substance • Trafficking of DEA Schedule II drugs • Sexual offenses • Domestic violence; or • Harm to a minor	☐ Yes	☐ No
8. Have you ever been subject to investigation by a governmental entity or licensing board that could have resulted, or did result, in licensure sanctions or other adverse actions, irrespective of the outcome?	☐ Yes	☐ No
9. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered, or denied?	☐ Yes	☐ No
10. Are any currently held licenses pending investigation or being challenged?	☐ Yes	☐ No
11. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes	☐ No
12. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes	☐ No
13. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records delinquency?	☐ Yes	☐ No
14. Have you ever agreed not to exercise your clinical privileges while under investigation?	☐ Yes	☐ No
15. Have you ever resigned from a healthcare entity while under investigation for or to avoid modification, suspension, or termination of privileges?	☐ Yes	☐ No
16. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	☐ Yes	☐ No ☐ N/A
17. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please list on a separate sheet of paper for each case: • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	☐ Yes	☐ No
18. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting, with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	☐ Yes	☐ No

19. Do you use illegal drugs or have you illegally used drugs in the past five years?	☐ Yes	☐ No
20. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, prescription medication or alcohol?	☐ Yes	☐ No
21. Have you ever, for any reason: a. Resigned from or withdrawn from a medical or professional school or postgraduate training program? b. Been suspended, dismissed, or expelled from a medical or professional school or postgraduate training program? c. Been placed on probation or remediation, including academic probation or remediation, by a medical or professional school or postgraduate training program? d. Taken a leave of absence or break from, or had any interruptions or extensions in, a medical or professional school or postgraduate training program for any reason, personal or professional (including illness or disability, pregnancy or maternity, any academic issues, or other similar reasons)?	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No

GMIPA
CREDENTIALS VERIFICATION SERVICE
STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

Authority to Release: I consent to complete disclosure by the recipient of this release to Hospital Services Corporation's Credentials Verification Service ("HSC") of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications") on behalf of those organizations and their authorized representatives (hereafter "Health Care Entity") to which I have applied as a health care provider and which have designated HSC as their agent. I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986.

Attestation: I certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date

Please upload or email to:
Gila Multi-Specialty Independent Provider Association
1268 E. 32nd Street
Silver City, NM 88061
melodie.shaver@gmipa.com
575-538-2355

CHECKLIST OF DOCUMENTS TO BE RETURNED BY APPLICANT

☐ Completed and signed application (and supplemental documents required by the healthcare organization if applicable).

☐ Completed and signed authorization, attestation and release form which must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.

☐ Current curriculum vitae or resume including months and years for all places of employment during the past fifteen (15) years. Explain any gaps of six (6) months or more during the past five (5) years.

☐ Copy of latest professional state license/certificate or registration. ☐ Pending

☐ Proof of current medical malpractice coverage that includes the effective date, amount and type of coverage. If your coverage will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current state Controlled Substance Registration. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current federal DEA registration certificate. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ For hospital appointments, please attach privileges requested.

☐ Copy of ECFMG Certificate, if foreign medical graduate.

☐ Copies of continuing medical education credits obtained during the last two (2) years or since your last appointment.

☐ Documentation that supports any affirmative response on the Professional Practice Questionnaire, if needed.

☐ Any additional attachments required by the application.

Return to:

Please upload or email to:
Gila Multi-Specialty
Independent Provider
Association
1268 E. 32nd Street
Silver City, NM 88061
melodie.shaver@gmipa.com
575-538-2355

GMIPA
CREDENTIALS VERIFICATION SERVICES
STATEMENT OF CONTINUING MEDICAL EDUCATION

This form is only required for those applicants applying for hospital or clinic privileges. It is not required for health plan credentialing.

Each licensing Board has specific requirements governing the amount of CME credits needed each year to maintain current licensure. Please list below the courses completed, and the location, date and the number of hours of CME credits you have obtained during the past two (2) years. If necessary, use an additional sheet, or you may send us a copy of your own listing of courses completed.

Course Taken	Location	Date	Number of CME Hours

During the past two (2) years, _____% of my continuing medical educational activities was related to the privileges requested. I hereby certify that within the past two (2) years I have completed at least the minimum number of hours of continuing education credits required by the board through which I am licensed, and have participated in all performance improvement activities as specified by the hospital(s) at which I have privileges. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical staff.

_____ _____

Provider Name (Printed) Medical Director's Name (Printed)

_____ _____

Signature Medical Director's Signature

_____ _____

Date (do not type) Date (do not type)