Majoris Health Systems Wyoming Credentialing Application

Contracted Group (Clinic)____

TIN*______________________ **Effective Date with Group**______________________

Provider Name & Title____, __________
Last Name First Name MI Title

Social Security Number ______________________ **DOB** __________________ ☐**Male** ☐**Female**

Languages Spoken

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List Specialties:

1)

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Specialty | Board Certification Date (if applicable) | Board Eligibility Date (if applicable)

2)

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Sub-Specialty | Board Certification Date (if applicable) | Board Eligibility Date (if applicable)

Attending Provider in your specialty? ☐**Yes** ☐**No** **Perform 2nd Opinions?** ☐**Yes** ☐**No**

State License Number ______________________ **State**__________ **Expiration Date**______________

State License Number______________________ **State**__________ **Expiration Date**______________

DEA Certification Number ______________________ **Expiration Date** ______________

NPI Number____

List hospital affiliations*:

____ ☐ **Active**

____ ☐ **Active**

Work History:

Any gaps in professional work history that are greater than six months? ☐ **Yes** ☐ **No**

You need only provide information on work history from after your first professional licensure.

If you responded yes to the above, please explain the gap(s).

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****Please provide a copy of current malpractice insurance coverage when submitting the credentialing application.***

PO Box 1728 – Lake Oswego, OR 97035 – Phone (503) 639-6080 – Credentialing Fax (503) 601-8438
providerrelations@majorishealthsystems.com

Attestation Questions

Please answer the following questions. If you answer "Yes" to any of the questions below, please provide an explanation on a separate page.

		Yes	No
1.	Has your medical license ever been suspended, revoked, limited, placed on probation or been subject to any type of disciplinary action?		
2.	Has your DEA license ever been suspended, revoked, limited, placed on probation or been subject to any type of disciplinary action?		
3.	Have you ever voluntarily surrendered your license or hospital privileges to avoid discipline, revocation, and/or termination?		
4.	Have you ever had your privileges at any hospital suspended, diminished, revoked, and/or placed on probationary status?		
5.	Have you ever been subject to disciplinary action by a state agency or any professional body (i.e. Medical Society, IPRO, etc.)?		
6.	Have you ever been convicted of a crime other than a minor traffic offense?		
7.	Have you ever been denied, suspended or removed from participation with Medicare, Medicaid, Health Plan or any other third party insurer?		
8.	Have you ever been involved in a National Practitioner Data Bank reportable incident?		
9.	Have you ever had any health problems, including drug addiction, alcoholism, or psychiatric illness that might affect your ability to diagnose and treat patients?		
10.	Have you ever had any judgments or settlements made against your in professional liability cases?		
11.	Are you presently involved in any professional liability cases that are pending?		

All information submitted by me in this application is true to the best of my knowledge and belief. I understand that any misstatement(s) in, or omissions(s) from this application shall be cause for denial of acceptance or termination of membership.

Applicants Signature: ____ Date: ____________

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RELEASE OF INFORMATION

By applying to Majoris Health Systems Wyoming, LLC (Majoris) directly, or through participation in an affiliated medical group or IPA of Majoris, I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications. In this application I have provided information on my qualifications, prior and current licensure, Drug Enforcement Agency registration, and applicable certifications. I have disclosed and explained any past professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

I further understand and acknowledge that Majoris will investigate the information of this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Majoris as part of the verification and credentialing process. I am willing to make myself available for interviews or provide additional information if required or requested.

I consent to the inspection of records and documents that may be material to an evaluation of my professional qualifications and my ability to carry out high quality clinical care. I authorize and consent to the release of information by any hospital, insurance company, or medical staff with which I am or have been affiliated or to which I have applied for privileges, to Majoris Health Systems Wyoming, LLC as long as such release of information is done in good faith and without malice; and hereby release from liability any hospital, insurance company, medical staff, and other health care organizations for so doing.

I release from liability all representatives of Majoris Health Systems Wyoming LLC for acts performed in good faith and without malice, in connection with evaluating my application, credentials and qualifications. I consent, without reservation to the release of such information and do hereby release from liability any and all individuals and organizations that provide information to Majoris Health Systems Wyoming, LLC in good faith and without malice concerning my professional, ethical and other qualifications.

Print Name: ____

Signature: ____

Date: ____________________

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