

AGENDA

Advisory Committee on Physician Credentialing Information

Meridian Park Hospital
Community Health Education Center Room 107
19300 SW 65th Avenue, Tualatin, Oregon 97062
September 29, 2015
10:00-12:00 pm

Conference Line: 1-866-590-5055 / Participants: Enter Access Code: 262468# /
Host: Enter Access Code: 885325#

(All agenda items are subject to change and times listed are approximate)

#	Time	Item	Lead	Action Item
1	10:00 AM	Call to Order	Rebecca Jensen	
2	10:05 AM	<ul style="list-style-type: none">• New Member Introductions• Approval of Minutes<ul style="list-style-type: none">○ September 15, 2014 and September 23, 2014• Current Member Expirations	Rebecca Jensen	X
3	10:15 AM	Common Credentialing Update	Melissa Isavoran	
4	10:20 AM	Provider Data Systems Alignment	Melissa Isavoran	
5	10:40 AM	Review Solicited Suggestions	Melissa Isavoran	X
6	11:45 AM	Next Steps	Rebecca Jensen	
7	11:50 AM	Public Comment		
8	12:00 PM	Adjournment	Rebecca Jensen	

Attachments:

- ✓ Roster
- ✓ Process & Flow Chart for Amending Applications
- ✓ ORS 409-045
- ✓ 2014 Minutes
- ✓ Common Credentialing Program Brochure
- ✓ Suggestions
- ✓ Current Credentialing & Recredentialing Applications



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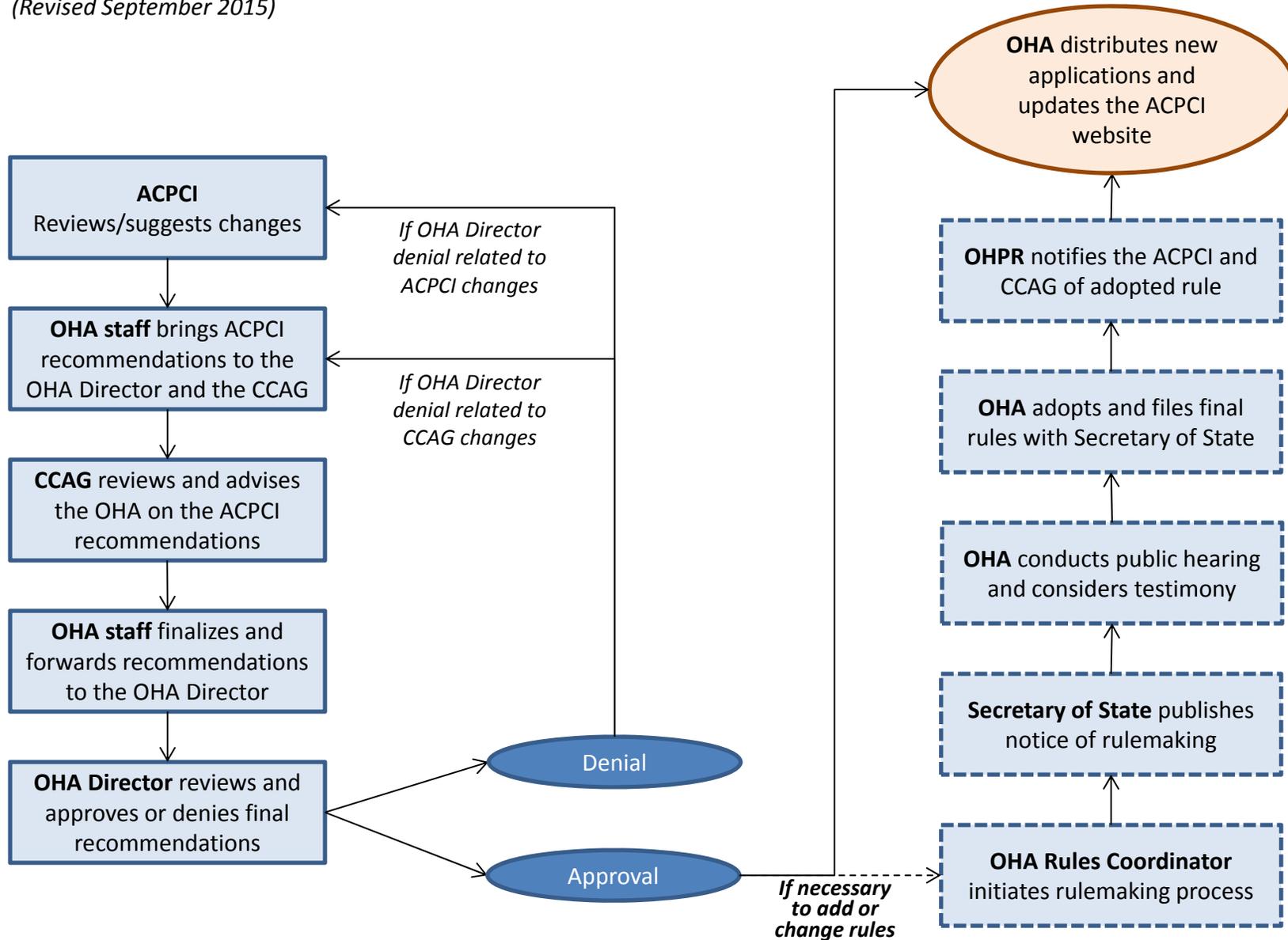
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ADVISORY COMMITTEE FOR PHYSICIAN CREDENTIALING INFORMATION (ACPCI)

PROCESS FLOWCHART FOR AMENDING THE OREGON PRACTITIONER CREDENTIALING/RECREREDENTIALING APPLICATIONS

(Revised September 2015)



CHAPTER 409
OREGON HEALTH AUTHORITY
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH
DIVISION 45
HEALTH CARE PRACTITIONER CREDENTIALING

409-045-0025

Definitions

The following definitions apply to OAR 409-045-0025 to 409-045-0135:

- (1) "Accreditation" means a comprehensive evaluation process in which a health care organization's systems, processes and performance are examined by an impartial external organization (accrediting entity) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.
- (2) "Advisory Group" means the Common Credentialing Advisory Group.
- (3) "Authority" means the Oregon Health Authority.
- (4) "Board" means a health care regulatory board or other agency that authorizes individuals to practice a profession in Oregon related to providing health care services for which the individual must be credentialed.
- (5) "Credentialing" means a standardized process of inquiry undertaken to validate specific information that confirms a health care practitioner's identity, background, education, competency and qualifications related to a specific set of established standards or criteria.
- (6) "Credentialing information" means information necessary to credential or recredential a health care practitioner.
- (7) "Credentialing organization" means a hospital or other health care facility, physician organization or other health care provider organization, coordinated care organization, business organization, insurer or other organization that credentials health care practitioners. This includes, but is not limited to the following:
 - (a) Ambulatory Surgical Centers.
 - (b) Coordinated Care Organizations.
 - (c) Dental Plan Issuers.
 - (d) Health Plan Issuers.
 - (e) Hospitals and Health Systems.
 - (f) Independent Physician Associations.
- (8) "Delegated credentialing agreement" means a written agreement between credentialing organizations that delegates the responsibility to perform specific activities related to the credentialing and recredentialing of health care practitioners. For telemedicine credentialing, delegated credentialing agreement has the same meaning given that term in ORS 442.015.

(9) "Distant-site hospital" means the hospital where a telemedicine provider, at the time the telemedicine provider is providing telemedicine services, is practicing as an employee or under contract.

(10) "Health care facility" has the same meaning given that term in ORS 442.015.

(11) "Health care practitioner" means an individual authorized to practice a profession related to the provision of health care services in Oregon for which the individual must be credentialed. This includes, but is not limited to the following:

- (a) Acupuncturists.
- (b) Audiologists.
- (c) Certified Registered Nurse Anesthetist.
- (d) Chiropractor.
- (e) Clinical Nurse Specialist.
- (f) Doctor of Dental Medicine.
- (g) Doctor of Dental Surgery.
- (h) Doctor of Medicine.
- (i) Doctor of Osteopathy.
- (j) Doctor of Podiatric Medicine.
- (k) Licensed Clinical Social Worker.
- (l) Licensed Dieticians.
- (m) Licensed Marriage and Family Therapists.
- (n) Licensed Massage Therapists.
- (o) Licensed Professional Counselor.
- (p) Naturopathic Physician.
- (q) Nurse Practitioner.
- (r) Occupational Therapists.
- (s) Optometrist.
- (t) Oral and Maxillofacial Surgeons.
- (u) Psychologists.
- (v) Physical Therapists.
- (w) Physician Assistants.
- (x) Psychologist Associate.
- (y) Registered Nurse First Assistant.
- (z) Speech Therapists.

(12) "Health services" has the same meaning given that term in ORS 442.015.

(13) "Hospital" has the same meaning given that term in ORS 442.015.

(14) "Originating-site hospital" means a hospital in which a patient is located while receiving telemedicine services.

(15) "Primary source verification" means the verification of an individual practitioner's reported qualifications by the original source.

(16) "Program" means the Oregon Common Credentialing Program.

(17) "Solution" means the Oregon Common Credentialing Program's electronic system through which credentialing information may be submitted to an electronic database and accessed.

(18) "Telemedicine" means the provision of health services to patients by physicians and health care practitioners from a distance using electronic communications.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

Credentialing Requirements for Health Care Practitioners

409-045-0030

Oregon Common Credentialing Program

The Oregon Common Credentialing Program is established within the Authority for the purpose of providing a credentialing organization access to information necessary to credential or recredential a health care practitioner. The Program shall include, but is not limited to the following:

(1) An electronic solution through which health care practitioner credentialing information must be submitted.

(2) A process by which health care practitioners or designees may access the Solution to submit information necessary for credentialing.

(3) A process by which credentialing organizations may input, access, and retrieve health care practitioner credentialing information.

(4) A process by which Boards may input and access health care practitioner credentialing information.

(5) Coordination with Boards and the process of primary source verification of credentialing information.

Stat. Auth.: ORS 413.042 & 2013 OL Ch. 603

Stats. Implemented: 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0035

Oregon Practitioner Credentialing Application

(1) Credentialing organization shall use the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both approved by

the Authority based on recommendations from the Advisory Committee on Physician Credentialing Information. The Authority approved applications are available at the on the Committee's website at <http://www.oregon.gov/OHA/OHPR/ACPCI/Pages/index.aspx>.

(2) Each credentialing organization shall use the application forms listed in section (1) of this rule for the purpose of credentialing and recredentialing health care practitioners.

(3) The Program shall use the application forms listed in section (1) of this rule as the template for health care practitioner credentialing information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0040

Credentialing Information Verifications

(1) The Program shall accept all Board verifications of credentialing information as provided in accordance with OAR 409-045-0055 and shall supplement those verifications, if necessary, to ensure compliance with national accrediting entity standards.

(2) Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source or sources that meet accrediting entity requirements.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0045

Health Care Regulatory Board Participation

(1) A Board that licenses health care practitioners shall provide practitioner information and documentation to the Solution in a format and frequency as agreed by the Board and the Authority beginning January 1, 2016. A Board may agree to provide practitioner information and documentation to the Solution prior to January 1, 2016.

(2) A Board that provides information to the Solution must also provide an annual attestation to the Authority that clearly identifies the Boards specific practices related to the process of primary source verification of health care practitioner information.

(3) Use of practitioner information provided by Boards shall be authorized through data use agreements that define the rights to use or disclose the practitioner information and any limitations to that use.

(4) A Board unable to provide information to the Solution by January 1, 2016, may submit a petition to the Authority director for consideration of a waiver from the requirements of section (1). The Authority shall review the waivers at least every two years for validity. The petition for a waiver must include:

(a) The name of the Board;

- (b) The phone number and email address for the Board contact person;
- (c) A description of specific barrier to submitting information and documentation;
- (d) Efforts or ideas to address the barrier and the timeframe for doing so; and
- (e) The identification of support, including funding, needed to accomplish the efforts or ideas.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0050

Credentialing Organization Participation

(1) Credentialing organizations shall obtain health care practitioner credentialing information from the Solution beginning January 1, 2016, if that information is kept and maintained by the Solution.

(2) Credentialing organizations may not request credentialing information from a health care practitioner if that information is available through the Solution. Credentialing organizations may request additional credentialing information from a health care practitioner for the purpose of completing credentialing procedures as required by the credentialing organization.

(3) A prepaid group practice health plan that serves at least 200,000 members in Oregon and that has been issued a certificate of authority by the Department of Consumer and Business Services may petition the Authority director to be exempt from the requirements of this section. The director may award the petition if the director determines that subjecting the health plan to this section is not cost-effective. If the director grants an exemption, the exemption also applies to any health care facilities and health care provider groups associated with the health plan which refers to financial ownership and does not include services associations. Exemptions may be reviewed by the Authority every two-years for validity. The petition for exemption must include:

(a) The name of the prepaid group practice health plan petitioning the Authority and the associated health care facilities and health care provider groups to be covered under the exemption;

(b) The phone number and email address for the health plan contact person;

(c) A description of the prepaid group practice health plan;

(d) A brief description of the prepaid group practice health plan's current credentialing practices; and

(e) A justification of why the Solution is not cost-effective.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0055

Health Care Practitioner Participation

(1) Health care practitioners required to be credentialed by a credentialing organization shall submit information and documentation required pursuant to OAR 409-045-0040 to the Solution beginning on January 1, 2016 to the extent that information is not available to the Solution from the Boards. Health care practitioners or their designee may agree to provide information and documentation required pursuant to 409-045-0040 to the Solution prior to January 1, 2016.

(2) Health care practitioners must attest to all credentialing information in the Solution.

(3) Attestation of credentialing information must occur within 120 days once the complete initial credentialing application information is submitted. Re-attestation must occur within 120 days from the date of the initial attestation and every 120 days thereafter. If credentialing information is updated and attested to by a provider outside of this 120 day re-attestation cycle, the next required re-attestation shall be due 120 days from the most recent attestation.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0060

Use of Health Care Practitioner Information

(1) A credentialing organization that, in good faith, uses credentialing information provided by the Solution for the purposes of credentialing health care practitioners is immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

(2) Health care practitioner information obtained by Credentialing Organizations through the Solution may only be used for the intended purpose of credentialing.

(3) All health care practitioner information that is received, kept, and maintained in the Solution, except for general information used for directories, is exempt from public disclosure under ORS 192.410 to 192.505.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0065

Common Credentialing Advisory Group

(1) The Authority establishes the Common Credentialing Advisory Group. Members of the Advisory Group shall be appointed by the director and shall include members who represent:

- (a) Credentialing organizations;
- (b) Health care regulatory boards;
- (c) Health care practitioners; and

(d) The ACPCI.

(2) All members appointed shall be knowledgeable about national standards relating to health care practitioner credentialing.

(3) The term of appointment for each member is three years. If, during a member's term of appointment, the member no longer qualifies to serve, the member must resign. If there is a vacancy for any reason, the director shall appoint a new member which is effective immediately for the unexpired term.

(4) The Authority and the Advisory Group shall meet at least once per year.

(5) The Advisory Group shall advise the Authority on the credentialing process, including but not limited to the following:

(a) Credentialing industry standards;

(b) Common Credentialing Solution;

(c) Recommended changes to the Oregon practitioner credentialing application pursuant to ORS 442.221 to 441.223; and

(d) Other proposed changes or concerns brought forth by interested parties.

(6) Committee members may not receive compensation or reimbursement of expenses.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0070

Imposition of Fees

Beginning January 1, 2016, the Authority shall impose fees on credentialing organizations that access the Solution and may impose fees on health care practitioners who submit credentialing information to the Solution. Fees may not exceed the cost of administering the Program.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0075

Complaints

Complaints regarding the Program and the Program's activities shall be submitted to Authority for evaluation through the Program's website. The Authority shall provide a response to each complaint within two weeks of receiving the complaint.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.221 - 441.223 & 2013 OL Ch. 603

Hist.: OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

Credentialing Requirements for Telemedicine Providers

409-045-0115

General Applicability

(1) These rules apply to all:

(a) Telemedicine health care practitioners who provide telemedicine services from any distant-site hospital in Oregon to patients in originating-site hospitals in Oregon.

(b) Originating-site hospitals located in Oregon that credential telemedicine health care practitioners located at distant-site hospitals in Oregon.

(2) Completion of credentialing requirements does not require a governing body of a hospital to grant privileges to a telemedicine health care practitioner and does not affect the responsibilities of a governing body under ORS 441.055.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0120

Standard List of Credentialing Documents

(1) To become credentialed by an originating-site hospital, a telemedicine healthcare practitioner or the distant-site hospital must provide the following information and documentation to the originating-site hospital:

(a) A completed current (within the past 6 months) Oregon Practitioner Credentialing Application (OPCA) and the following documents:

(A) A copy of state medical license;

(B) Drug Enforcement Agency certificate;

(C) State approved foreign education equivalency certificate or report, if applicable; and

(D) Certification of professional liability insurance.

(b) Attestation by medical staff at the distant-site hospital that they have conducted primary source verification of all materials of the OPCA except for:

(A) Hospital affiliations other than to the distant-site hospital;

(B) Work history beyond the previous five years.

(2) Originating-site hospitals may request documentation of all the verifications above from the distant-site hospital or the telemedicine health practitioner. Verifications that are not provided may be obtained separately by the originating-site hospital.

(3) Originating-site hospitals may not require either the telemedicine healthcare practitioner or the distant-site hospital to provide the following documentation for the purposes of credentialing or privileging a telemedicine provider:

(a) Proof of Tuberculosis Screening;

(b) Proof of vaccination or immunity to communicable diseases;

(c) HIPAA training verification;

(4) Originating-site hospitals may not require a telemedicine provider to attend physician and staff meetings at the originating-site hospital.

(5) Originating-site hospitals may not request credentialing information if the credentialing information was made available under OAR 409-045-0120(1) and is not subject to change.

(6) To become recredentialed by an originating-site hospital, every two years a telemedicine healthcare practitioner or the distant-site hospital must provide a completed current Oregon Practitioner Recredentialing Application and all other information required in OAR 409-045-0120(1).

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0125

Distant-Site Hospital Agreements

Hospitals may use delegated credentialing agreements instead of the requirements in OAR-409-045-0120 to stipulate that the medical staff of the originating-site hospital shall rely upon the credentialing and privileging decisions of the distant-site hospital in making recommendations to the governing body of the originating-site hospital as to whether to credential a telemedicine provider, practicing at the distant-site hospital either as an employee or under contract, to provide telemedicine services to patients in the originating-site hospital. If a delegated credentialing agreement is in place the originating-site hospital is not limited to the information and documents prescribed by the Authority in OAR 409-045-0120.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0130

Hold Harmless Clause

Originating-site hospitals that use credentialing information provided by distant-site hospitals are immune from civil liability that might otherwise be incurred or imposed with respect to the use of that credentialing information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

409-045-0135

Information Sharing or Use of Data

(1) Telemedicine healthcare practitioners must provide written, signed permission that explicitly allows the sharing of required documents and necessary evidence by a distant-site hospital with originating-site hospitals, including but not limited to any release required under HIPAA or other applicable laws.

(2) Dissemination of information received under these rules shall only be made to individuals with a demonstrated and legitimate need to know the information.

Stat. Auth.: ORS 413.042, 441.056, 441.223 & 2013 OL Ch. 603

Stats. Implemented: ORS 441.056, 441.223, 442.015 & 2013 OL Ch. 603

Hist.: OHP 10-2013(Temp), f. 12-31-13, cert. ef. 1-1-14 thru 6-30-14; OHP 3-2014, f. 6-30-14, cert. ef. 7-1-14

The Oregon Common Credentialing Program

September 2015

What is the issue?

Credentialing organizations currently credential health care practitioners independently, resulting in a duplication of efforts. While Oregon took the first step in minimizing this administratively burdensome process by mandating the use of a common Oregon Practitioner Credentialing Application, this did not limit the number of systems and processes used to capture and verify information reported in the application. Senate Bill (SB) 604, signed into law in July 2013, requires the Oregon Health Authority (OHA) to establish a program and database to provide credentialing organizations access to information necessary to credential or re-credential all health care practitioners in the state. New legislation introduced in 2015 (SB 594) added flexibility in the implementation date provided the agency give six months' notice to required participants.

What are the specific legislative requirements?

Under SB 604, health care practitioners or their designees must submit necessary credentialing information into a Common Credentialing solution and credentialing organizations must use the solution to obtain that information. An efficient solution would capture and store credentialing information and documents and perform verifications of select credentialing information according to local and national standards. Overall, the program will reduce the considerable duplication that exists today. Program requirements are as follows:

Credentialing Organizations are required to:

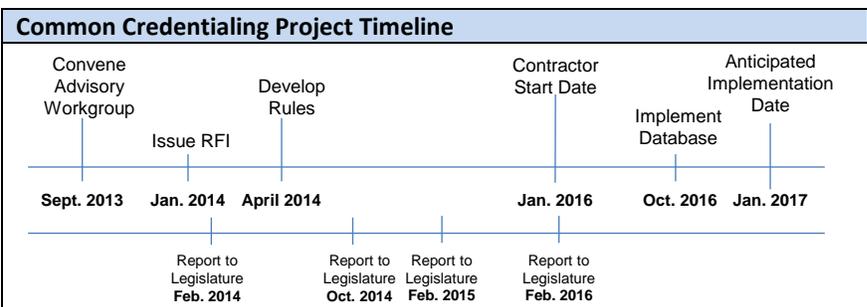
- Use the solution to obtain health care practitioner credentialing information and verifications
- Not ask health care practitioners for information that is available in the solution
- Pay fees to support program administration costs

Health Care Practitioners are required to:

- Use the solution to enter in credentialing information (a health care practitioner's designee may be used)
- Attest every 120 days that information in the solution is correct or make changes as necessary
- Pay fees to support program administration costs

What has been done so far?

In September 2013, the OHA convened the Common Credentialing Advisory Group (CCAG) that is responsible for advising the implementation of SB 604. Meetings for the CCAG have been conducted monthly since October 2013 and have resulted in the development of a list of health care practitioners expected to participate in the Program, the identification of accrediting entity requirements for credentialing, and a Request for Information (RFI) released in January 2014. OHA also published rules in July 2014 that solidified the Oregon Common Credentialing Program (OCCP). Stakeholder input and RFI responses were used to develop requirements for the Solution.



What are the next steps?

OHA intends to use Harris Corporation to competitively procure and manage the implementation of the Solution as part of a portfolio of projects (e.g., provider directory and clinical quality metrics registry) under the agency's Office of Health Information Technology. Harris is the current prime vendor for CareAccord®, Oregon's Health Information Exchange (HIE), and has successfully managed large health care related IT projects including Veteran's Administration Benefit Management System upgrades, Florida's HIE, Department of Homeland Security's Electronic Health Record System. OHA anticipates implementation of the Solution by January 2017.

More information on SB 604 and the CCAG can be found at: <http://www.oregon.gov/oha/OHPR/occp>

Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application					
ACPCI Considerations and Recommended Actions - September 2015					
No.	Received	Suggestor	Suggestions	Action	Notes
1	8/5/2015	Mike Bond, PrimeCare	<p>1) Page 3 Section III Specialty Information Principal clinical specialty (For most current specialties list, see: http://www.wpe-di.com/codes:)</p> <p>a. The portion in parenthesis is confusing to some applicants. We find that once someone has referenced the website they list the taxonomy code and not the specialty.</p> <p>Suggest clarifying this to ensure that the type of specialty is listed not the taxonomy code for the specialty. Replace "most current" with "examples".</p>		
			<p>b. Category of professional activity, check all boxes that apply:</p> <p>Suggest giving examples next to "Other" box and move (explain) next to the "Part time" box.</p>		
			<p>2) Page 4 Section V Other Certificates</p> <p>Suggest adding a "Does Not Apply" box</p>		
			<p>3) Page 5 Section IX Graduate Education Does not include address of school.</p> <p>Suggest using the same format as Section X below.</p>		
			<p>4) Page 7 Section XIV Health Care Licensure, Registration, Certifications & ID Numbers</p> <p>Suggest adding Group NPI Number. This will eliminate the need for separate communication between the Health Plan or IPA and the practitioner or their practice.</p>		

Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application					
ACPCI Considerations and Recommended Actions - September 2015					
No.	Received	Suggestor	Suggestions	Action	Notes
2	8/5/2015	Darcy Stjernberg Morey, Multnomah County Health Department	1) Page 12 Section XXI Attestation Questions a. (J) Have you ever been charged with a criminal violation (felony or misdemeanor)? b. (K) Do you presently use any illegal drugs? Suggest changing to: a. (J) Have you ever been charged with a criminal violation (including DUII), misdemeanor, or felony? b. (K) Have you in the past or currently use illegal drugs?		
			2) Attachment A Page 1 Professional Liability Action Detail Instructions: Please list any past or current professional liability claim or lawsuit, which has been filed against you. Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit. It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary. a. Suggest creating Attachment B for those that answer "yes" to the Attestation question. b. Suggest adding to instructions: Please provide an explanation to any questions with an answer of YES from the Attestation page.		

Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application					
ACPCI Considerations and Recommended Actions - September 2015					
No.	Received	Suggestor	Suggestions	Action	Notes
	8/10/2015	Donald O'Malley, PCS Credentialing Services, LLC	<p>1) Page 1 Section I Instructions</p> <p>5th Bullet – Instruction to “Identify the Health Care release organization(s) to which this application is being submitted in the space provided below.” This is most likely the least followed instruction. Of all the state applications that our CVO reviews and processes, Oregon’s is the only one that has this requirement. Too often we must request that the names of the organizations be added and that the page be returned to us prior to processing.</p> <p>Suggest eliminating the requirement and have the release general enough to be all encompassing.</p>		
			<p>7th Bullet - “If a section does not apply to you, please check the provided box at the top of the section.” Again this is a completely overlooked instruction and is not needed.</p> <p>Suggest writing “N/A” instead and eliminate the boxes.</p>		
			<p>8th bullet – “Mail application to the requesting organization(s).”</p> <p>Suggest changing to “Email, fax or mail...”</p>		
			<p>2) Page 2 Section II Practitioner Information</p> <p>Home address is general enough to include the city, state, and zip.</p> <p>Suggest eliminating the boxes for City, State, and Zip</p>		

Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application					
ACPCI Considerations and Recommended Actions - September 2015					
No.	Received	Suggestor	Suggestions	Action	Notes
3			Boxes for the birth date and citizenship are too large for the need.		
			Suggest reviewing all of the boxes for proper length and format. (Email address boxes should be lengthened)		
			3) Page 4 Section X Medical / Professional Education (two sections) a. Complete Medical / Professional School Name and Street Address – Most individuals do not know the street address of the schools that they attended much less the correct address for the registrar’s office. Anyone that performs verifications will have email addresses and / or fax numbers for the institutions. Additionally, many institutions now use a verification service (e.g., National Student Clearinghouse). Suggest changing to “Medical / Professional Institutions name and city, state.”		
			b. Degree Received Suggest shortening the box.		
			c. Fax Number Suggest eliminating the box.		
			d. From Month / Year and To Month / Year Suggest eliminating the boxes.		
			4) Page 5 Sections XI, XII, XIII a. This page could be completely re-formatted to allow more entries as needed and avoid redundancy in the form.		

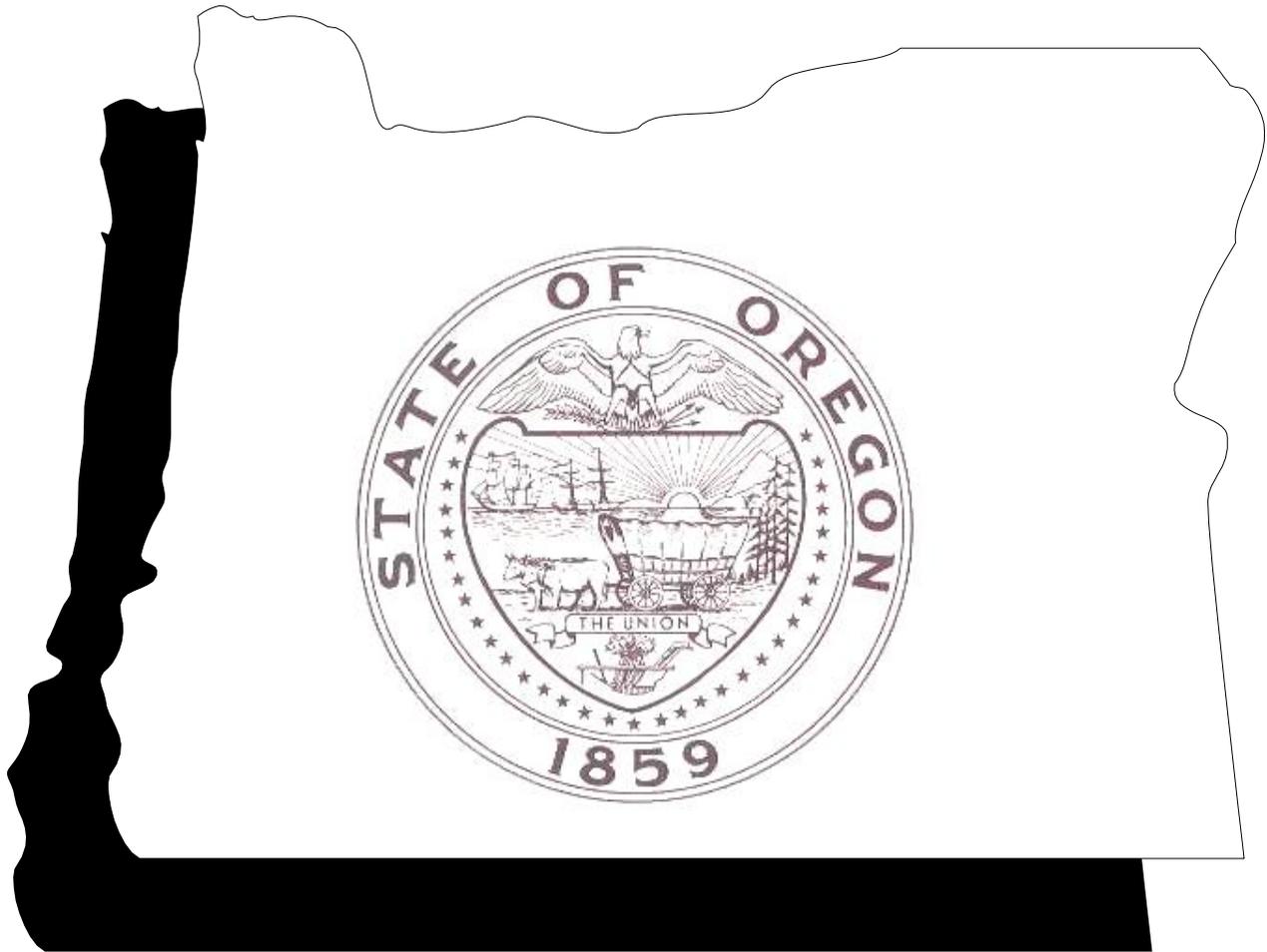
Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application																														
ACPCI Considerations and Recommended Actions - September 2015																														
No.	Received	Suggestor	Suggestions	Action	Notes																									
			<p>b. Entries for fax number and Month / Year of Completion are not needed.</p> <p>Suggest the following format:</p> <table border="1"> <thead> <tr> <th>Institution City, State (or country)</th> <th>Dates (from - to) (MMM YY - MMM YY)</th> <th>Specialty</th> <th>Type (inter, Res, Fellow)</th> </tr> </thead> <tbody> <tr> <td>Johns Hopkins Univ Med Center Baltimore, MD</td> <td>Jul 04 - Jun 05</td> <td></td> <td>Internship</td> </tr> <tr> <td>Johns Hopkins Univ Med Center Baltimore, MD</td> <td>Jul 05 - Jun 08</td> <td>Ophthalmology</td> <td>Residency</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Institution City, State (or country)	Dates (from - to) (MMM YY - MMM YY)	Specialty	Type (inter, Res, Fellow)	Johns Hopkins Univ Med Center Baltimore, MD	Jul 04 - Jun 05		Internship	Johns Hopkins Univ Med Center Baltimore, MD	Jul 05 - Jun 08	Ophthalmology	Residency															
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Johns Hopkins Univ Med Center Baltimore, MD	Jul 05 - Jun 08	Ophthalmology	Residency																											
			<p>5) Page 6 XV Other State Health Care Licenses, Registrations & Certificates Year Relinquished and Reason are not needed. Verification of the license will reveal the dates and the reason.</p> <p>Suggest the following format:</p> <table border="1"> <thead> <tr> <th>Type</th> <th>State</th> <th>Number</th> <th>Year Licensed</th> <th>Expires(d)</th> </tr> </thead> <tbody> <tr> <td>MD</td> <td>OR</td> <td>456789</td> <td>2010</td> <td>2016</td> </tr> <tr> <td>MD</td> <td>WA</td> <td>3258745</td> <td>2010</td> <td>2014</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Type	State	Number	Year Licensed	Expires(d)	MD	OR	456789	2010	2016	MD	WA	3258745	2010	2014												
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Recommendations for 2015 Review

Suggestions for the Oregon Practitioner Credentialing Application																	
ACPCI Considerations and Recommended Actions - September 2015																	
No.	Received	Suggestor	Suggestions	Action	Notes												
			<p>6) Page 7 Section XVI Hospitals and Other Health Care Facility Affiliations Most providers would not know the hospital affiliations address' like educational institutions. Status and reason for leaving would be discovered in the verification process.</p> <p>Suggest re-working the entire page to a table and eliminate the address, status, and reason for leaving.</p> <table border="1"> <thead> <tr> <th>Name, City, State</th> <th>Dates (MMM YY – MMM YY)</th> <th>Staff Status</th> </tr> </thead> <tbody> <tr> <td>Providence Portland MC, Portland, OR</td> <td>Jul 10 - present</td> <td>Active</td> </tr> <tr> <td>St. Joseph MC, Houston, TX</td> <td>Jul 06 – May 10</td> <td>Resigned</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Name, City, State	Dates (MMM YY – MMM YY)	Staff Status	Providence Portland MC, Portland, OR	Jul 10 - present	Active	St. Joseph MC, Houston, TX	Jul 06 – May 10	Resigned					
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Providence Portland MC, Portland, OR	Jul 10 - present	Active															
St. Joseph MC, Houston, TX	Jul 06 – May 10	Resigned															
			<p>7) Page 8 Section XVII Professional Practice / Work History With the exception of the “Previous Practice / Employer” how is the section different than Page 3, section VI?</p>														
			<p>8) Page 9 Section XIX Professional Liability Insurance Suggest adding email address for broker / carrier.</p>														
			<p>9) Page 10 Section XX Attestation Question The signature line is one of the most missed items on the application. Isn't this attestation information contained on the “Authorization and Release of Information Form: (page 11)?</p> <p>Suggest making the signature on the Authorization all encompassing for the application.</p>														

OREGON PRACTITIONER CREDENTIALING APPLICATION



- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RE-CREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.

REVIEWED, AMENDED & APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
JULY 16, 2015

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

I. INSTRUCTIONS

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 11, Attestation Questions and page 12, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable).**
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you, please check the "Does Not apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying not to the State of Oregon. OREGON PRACTITIONER CREDENTIALING APPLICATION**

II. PRACTITIONER INFORMATION

Please provide the practitioner's full legal name.

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):
Is there any other name under which you have been known or have used since starting professional training? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name(s) and Year(s) Used:			

Home Street Address:		Home Telephone Number () -	Mobile/Alternate Number () -
		Email Address:	
City:	State:	ZIP:	
Country:	Birth Date: Month / Day / Year	Birth Place:	
Citizenship:	Social Security Number:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Immigrant Visa Number (if applicable):	Visa Expiration Date	Status:	Type:
Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):		Month / Year Issued:	

III. SPECIALTY INFORMATION

This information may be included in directory listings.

Principal clinical specialty (For most current specialties list, see: http://www.wpc-edi.com/codes):	Do you want to be designated as a primary care practitioner (PCP)? Yes <input type="checkbox"/> No <input type="checkbox"/>
--	--

Additional clinical practice specialties:

Category of professional activity, check all boxes that apply:

<u>Clinical Practice:</u>		<u>Other Professional Activities:</u>	
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Administration	<input type="checkbox"/> Teaching
<input type="checkbox"/> Locum / Temporary	<input type="checkbox"/> Telemedicine	<input type="checkbox"/> Research	<input type="checkbox"/> Retired
<input type="checkbox"/> Other (explain)		<input type="checkbox"/> Other (explain)	

IV. BOARD CERTIFICATION / RECERTIFICATION

Does Not Apply

This section does not apply to licensure.

List all current and past certifications. Please attach additional sheets, if necessary.

Name and Address of Issuing Board	Specialty	Date Certified/Recertified Month / Year	Expiration Date (if any) Month / Year

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.

V. OTHER CERTIFICATIONS		<i>Please attach copy of certificate(s), if applicable.</i>	
Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.			
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of Certification:	Month / Year of Expiration:
For additional certifications, please attach a separate sheet.			

VI. PRACTICE INFORMATION			
Name of Primary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Primary Clinical Practice Street Address:		Effective Date at Location, Month / Year:	
City:	County:	State:	ZIP:
Primary Office Telephone Number: () - Ext	Primary Office Fax Number: () -	Patient Appointment Telephone Number: () - Ext	
Mailing/Billing Address (if different from above):		Attn:	
Office Manager:	Office Manager's Telephone Number: () - Ext	Office Manager's Fax Number:	
Exchange / Answering Service Number: () - Ext	Pager Number: () -	Office Email Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: () - Ext	Credentialing Contact's Fax Number: () -	Credentialing Contact's Email Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:	Name Affiliated with Tax ID Number:		
Name of Secondary Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Secondary Clinical Practice Street Address:		Effective Date at Location, Month / Year:	
City:	County:	State:	ZIP:
Secondary Office Telephone Number: () - Ext	Secondary Office Fax Number: () -	Patient Appointment Telephone Number: () - Ext	
Mailing/Billing Address (if different from above):		Attn:	
Office Manager:	Office Manager's Telephone Number: () - Ext	Office Manager's Fax Number: () -	
Exchange / Answering Service Number: () - Ext	Pager Number: () -	Office Email Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: () - Ext	Credentialing Contact's Fax Number: () -	Credentialing Contact's Email Address:	
Federal Tax ID Number or Social Security Number, if used for business purposes:	Name Affiliated with Tax ID Number:		
Please list other office locations with above information on a separate sheet.			

VII. PRACTICE CALL COVERAGE		<i>Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.</i>
NAME:	SPECIALTY:	
1.		
2.		
3.		
4.		
5.		

VIII. UNDERGRADUATE EDUCATION			<i>Please attach additional sheets, if necessary.</i>
Complete School Name:	Degree Received:	Month / Year of Graduation:	
City:	State:	Course of Study or Major:	

IX. GRADUATE EDUCATION			<i>Please attach additional sheets, if necessary.</i>	Does Not Apply <input type="checkbox"/>
Complete School Name:	Degree Received:	Month / Year of Graduation:		
City:	State:	Course of Study or Major:		

X. MEDICAL / PROFESSIONAL EDUCATION					<i>Please attach additional sheets, if necessary.</i>
Complete Medical / Professional School Name:					
City:		State		ZIP:	
Degree Received:		Phone Number: () -		Fax Number, if available () -	
From Month / Year:		To Month / Year:		Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)					
Complete Medical / Professional School Name and Street Address:					
City:		State:		ZIP:	
Degree Received:		Phone Number: () - :		Fax Number, if available () -	
From Month / Year:		To Month / Year:		Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)					

XI. POST-GRADUATE YEAR 1 / INTERNSHIP			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	ZIP:	
Type of Internship / Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XII. RESIDENCIES			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	ZIP:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

Complete Institution Name and Street Address:			
City:	State:	ZIP:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XIII. FELLOWSHIPS, PRECEPTORSHIPS, OR OTHER CLINICAL TRAINING PROGRAMS			Does Not Apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary.</i>			
Complete Institution Name and Street Address:			
City:	State:	ZIP:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

Complete Institution Name and Street Address:			
City:	State:	ZIP:	
Specialty:	Phone Number: () -	Fax Number, if available () -	
From Month / Year:	To Month / Year:	Month / Year of Completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> (If you did not complete the program, please explain on a separate sheet.)			

XIV. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES & ID NUMBERS		
<i>Please attach additional sheets, if necessary.</i>		
Oregon License or Registration Number:	Type:	Month / Day / Year of Expiration:
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Month / Day / Year of Expiration:
Controlled Substance Registration (CSR) Number (if applicable):		Month / Day / Year of Issue:
Individual NPI Number:	Medicare Number:	DMAP Number:
Physician Assistant Supervising Physician Full Name and Oregon License Number:		

XV. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES		Does Not Apply <input type="checkbox"/>
<i>Please include all ever held.</i>		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
State / Country:	Number:	Type:
Year Obtained:	Month / Day / Year of Expiration:	Year Relinquished:
Reason:		
<i>Please attach additional sheets, if necessary.</i>		

XVI. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.

A. CURRENT AFFILIATIONS			Does Not Apply <input type="checkbox"/>
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Appointment		

If you do not have hospital admitting privileges, check here:
Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. APPLICATIONS IN PROCESS			Does Not Apply <input type="checkbox"/>
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / Day / Year of Submission:		
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
Status:	Month / Day / Year of Submission:		

C. PREVIOUS AFFILIATIONS			<i>Please attach additional sheets, if necessary.</i> Does Not Apply <input type="checkbox"/>
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			
Facility Name:	Phone Number: () -	Fax Number, if available () -	Complete Address:
From Month / Day / Year:	To Month / Day / Year:		
Reason for Leaving:			

XVII. PROFESSIONAL PRACTICE / WORK HISTORYDoes Not Apply *Curriculum vitae is not sufficient.*

A. Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. Please attach additional sheets, if necessary.

Name of Current Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
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Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:
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Telephone Number: () - Ext	Fax Number: () -	Complete Address:
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Name of Previous Practice / Employer:		Contact's Name:
Telephone Number: () - Ext	Fax Number: () -	Complete Address:
From Month / Year:	To Month / Year:	
Contact's Email Address, if available:		Professional Liability Carrier:

B.	Please explain any gaps greater than two (2) months. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.	Does Not Apply <input type="checkbox"/>	
	Activities and/or Names:	From Month / Year:	To Month / Year:

XVIII. PEER REFERENCES			
Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.			
Name of Reference:		Complete Address, include Department if applicable:	
Specialty:			
Professional Relationship:			
Telephone Number: () - Ext	Fax Number: () -	Email Address, if available:	
Name of Reference:		Complete Address, include Department if applicable:	
Specialty:			
Professional Relationship:			
Telephone Number: () - (Ext	Fax Number: () -	Email Address, if available:	
Name of Reference:		Complete Address, include Department if applicable:	
Specialty:			
Professional Relationship:			
Telephone Number: () - Ext	Fax Number: () -	Email Address, if available:	

XIX. CONTINUING MEDICAL EDUCATION			Does Not Apply <input type="checkbox"/>
<i>Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.</i>			
Name:	Month / Year Attended:	Hours:	
Name:	Month / Year Attended:	Hours:	
Name:	Month / Year Attended:	Hours:	
Name:	Month / Year Attended:	Hours:	
Name:	Month / Year Attended:	Hours:	
Name:	Month / Year Attended:	Hours:	

XX. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number, if available: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Please list all previous professional liability carriers within the past five (5) years. Please attach additional sheets, if necessary.

Does Not Apply

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number, if available: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number, if available: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number, if available: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: () - Ext	Fax Number, if available: () -		
Per claim limit of liability:	Aggregate amount:		
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:	Month / Day / Year of Expiration:	

XXI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C	Have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D	Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization’s final action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G	Have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H	Have you ever had board certification revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I	Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K	Do you presently use any illegal drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
M	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
N	Have any professional liability claims or lawsuits ever been closed and/or filed against you? If yes, please complete Attachment A, Professional Liability Action Detail , for each past or current claim and/or lawsuit.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
O	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?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

**e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system*

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____ **Date:** _____

OREGON PRACTITIONER CREDENTIALING APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending 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.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name:	
Signature:	Date:

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's Name (print or type):

Month / Day / Year of the incident: and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month / Day / Year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Month / Day / Year of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature:

Date:

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

OREGON PRACTITIONER RECREDENTIALING APPLICATION



- APPLICATION
- PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)
- GLOSSARY OF TERMS AND ACRONYMS

Purpose: Established by house bill 2144 (1999), the advisory committee on physician credentialing information (ACPCI) develops the uniform applications used by hospitals and health plans to credential and recredential PRACTITIONERS within the State of Oregon.

REVIEWED, AMENDED AND APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
July 16, 2015

Oregon Practitioner Recredentialing Application

Prior to completing this recredentialing application, please read and observe the following:

I. INSTRUCTIONS

This form should be **typed** (*using a different font than the form*) or **legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 8, Attestation Questions and page 9, Authorization and Release of Information Form (*and Attachment A, Professional Liability Action Detail, if applicable*).**
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you, please check the "Does Not Apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (*if applicable*)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying, not to the State of Oregon.**

OREGON PRACTITIONER RECREDENTIALING APPLICATION

II. PRACTITIONER INFORMATION				<i>Please provide the practitioner's full legal name.</i>	
Last name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):		
Is there any other name under which you have been known or have used since starting professional training? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Name(s) and year(s) used:					
Home street address:			Home telephone number: () ()	Mobile/alternate number: () ()	
Email address:					
City:	State:		ZIP:		
Country:	Birth date (month/day/year): / /		Birth place:		
Citizenship:	Social Security number:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		
Immigrant visa number (if applicable):	Visa expiration date:		Type:		

III. SPECIALTY INFORMATION		<i>This information may be included in directory listings.</i>	
Principal clinical specialty (<i>For most current specialties list, see: http://www.wpc-edi.com/codes</i>):	Do you want to be designated as a primary care practitioner (PCP)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Additional clinical practice specialties:			
Category of professional activity, check all boxes that apply:			
<u>Clinical practice:</u> <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Locum/temporary <input type="checkbox"/> Telemedicine <input type="checkbox"/> Other (<i>explain</i>):		<u>Other professional activities:</u> <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Retired <input type="checkbox"/> Other (<i>explain</i>):	

IV. BOARD CERTIFICATION/RECERTIFICATION			Does not apply <input type="checkbox"/>
<i>This section does not apply to licensure.</i>			
List all current and past certifications. Please attach additional sheets, if necessary.			
Name and address of issuing board	Specialty	Date certified/recertified month/year	Expiration date (if any) month/year
If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.			

V. OTHER CERTIFICATIONS <i>Please attach copy of certificate(s), if applicable.</i>	Does not apply <input type="checkbox"/>		
Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.			
Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:
For additional certifications, please attach a separate sheet.			

VI. PRACTICE INFORMATION			
Name of primary practice/affiliation or clinic:		Department name (if hospital based):	
Primary clinical practice street address:			Effective date at location, month/year:
City:	County:	State:	ZIP:
Primary office telephone number: () Ext.:	Primary office fax number: ()	Patient appointment telephone number: () Ext.:	
Mailing/billing address (if different from above):			Attn:
Office manager:	Office manager's telephone number: () Ext.:	Office manager's fax number: ()	
Exchange/answering service number: () Ext.:	Pager number: ()	Office email address:	
Recredentialing contact and address (if different from above):			
Recredentialing contact's telephone number: () Ext.:	Recredentialing contact's fax number: ()	Recredentialing contact's email address:	
Federal tax ID number or Social Security number, if used for business purposes:		Name affiliated with tax ID number:	
Name of primary practice/affiliation or clinic:		Department name (if hospital based):	
Secondary clinical practice street address:			Effective date at location, month/year:
City:	County:	State:	ZIP:
Secondary office telephone number: () Ext.:	Secondary office fax number: ()	Patient appointment telephone number: () Ext.:	
Mailing/billing address (if different from above):			Attn:
Office manager:	Office manager's telephone number: () Ext.:	Office manager's fax number: ()	
Exchange/answering service number: () Ext.:	Pager number: ()	Office email address:	
Recredentialing contact and address (if different from above):			
Recredentialing contact's telephone number: () Ext.:	Recredentialing contact's fax number: ()	Recredentialing contact's email address:	
Federal tax ID number or Social Security number, if used for business purposes:		Name affiliated with tax ID number:	
Please list other office locations with above information on a separate sheet.			

VII. PRACTICE CALL COVERAGE		<i>Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.</i>
NAME:	SPECIALTY:	
1. _____	_____	
2. _____	_____	
3. _____	_____	
4. _____	_____	
5. _____	_____	

VIII. ADDITIONAL EDUCATION		<i>If you have completed additional residencies, internships or advanced specialized education within the past three (3) years, please provide the following information. Please attach additional sheets, if necessary.</i>	Does not apply <input type="checkbox"/>
Complete name and street address of program:			
City:	State:	ZIP:	
Specialty:	Phone number: ()	Fax number, if available: ()	
From month/year:	To month/year:	Month/year of completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(If you did not complete the program, please explain on a separate sheet.)</i>			
Complete name and street address of program:			
City:	State:	ZIP:	
Specialty:	Phone number: ()	Fax number, if available: ()	
From month/year:	To month/year:	Month/year of completion:	
Did you complete the program? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(If you did not complete the program, please explain on a separate sheet.)</i>			

IX. CONTINUING MEDICAL EDUCATION		<i>Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.</i>	Does not apply <input type="checkbox"/>
Name:	Month/year attended:	Hours:	
Name:	Month/year attended:	Hours:	
Name:	Month/year attended:	Hours:	
Name:	Month/year attended:	Hours:	
Name:	Month/year attended:	Hours:	

X. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES AND ID NUMBERS			<i>Please attach additional sheets, if necessary.</i>
Oregon license or registration number:	Type:	Month/day/year of expiration date:	
Drug Enforcement Administration (DEA) registration number <i>(if applicable)</i> :		Month/day/year of expiration date:	
Controlled substance registration (CSR) number <i>(if applicable)</i> :		Month/day/year issued:	
Individual NPI number:	Medicare number:	OMAP number:	
Physician Assistant Supervising Physician Full Name and Oregon License Number:			

XI. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS AND CERTIFICATES			Does not apply <input type="checkbox"/>
<i>Please attach additional sheets, if necessary</i>			
State/country:	Number:	Type:	
Year obtained:	Month/day/year of expiration:	Year relinquished:	
Reason:			
State/country:	Number:	Type:	
Year obtained:	Month/day/year of expiration:	Year relinquished:	
Reason:			
State/country:	Number:	Type:	
Year obtained:	Month/day/year of expiration:	Year relinquished:	
Reason:			

XII. HOSPITAL AND OTHER HEALTH CARE FACILITY AFFILIATIONS
--

Please list for the past three (3) years all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include all (A) affiliations in the past three (3) years, and/or (B) applications in process (*i.e., hospitals, surgery centers or any other health care related facility*). **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XIII, Professional Practice/Work History.**

A. AFFILIATIONS IN THE PAST THREE (3) YEARS
--

Facility name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status (<i>e.g. active, courtesy, provisional, allied health, etc.</i>):	Month/day/year of appointment:		
Facility name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status:	Month/day/year of appointment:		
Facility name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status:	Month/day/year of appointment:		

If you do not have hospital admitting privileges, check here:
Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. APPLICATIONS IN PROCESS	Does not apply <input type="checkbox"/>
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Facility name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status (<i>e.g. active, courtesy, provisional, allied health, etc.</i>):	Month/year of submission:		
Facility name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status:	Month /year of submission:		
Facility Name:	Phone number: () ()	Fax number, if available: () ()	Complete address:
Status:	Month/year of submission:		

XIII. PROFESSIONAL PRACTICE/WORK HISTORY*A curriculum vitae is not sufficient.*

- A.** Please chronologically list and account for work, professional and practice history activities **for the past three (3) years** to present, including military service. **Please explain in section B any gaps greater than two (2) months.**
Please attach additional sheets, if necessary.

Name of current practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To Month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month / Year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice/employer:		Contact's name:
Telephone number: () Ext.:	Fax number: ()	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

B. Please explain any gaps greater than two (2) months in the past three (3) years. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.		Does not apply <input type="checkbox"/>
Activities and/or names:	From month/year:	To month/year:

XIV. PEER REFERENCES		
Please list three (3) references, from peers who through recent observations, are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.		
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: () Ext.:	Fax number: ()	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: () Ext.:	Fax number: ()	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: () Ext.:	Fax number: ()	Email address, if available:

XV. PROFESSIONAL LIABILITY INSURANCE

Current insurance carrier/provider of professional liability coverage:		Policy number:	Type of coverage (<i>check one</i>): Claims-made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of local contact:		Mailing address:	
Contact's telephone number: () Ext.:	Fax number, if available: ()		
Per claim limit of liability:	Aggregate amount:		
Month/day/year effective:	Month/day/year retroactive date, if applicable:		

**Please list all previous professional liability carriers within the past three (3) years.
Please attach additional sheets, if necessary.**

Does not apply

Insurance carrier/provider of professional liability coverage:		Policy number:	Type of coverage (<i>check one</i>): Claims-made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of local contact:		Mailing address:	
Contact's telephone number: () Ext.:	Fax number, if available: ()		
Per claim limit of liability:	Aggregate amount:		
Month/day/year effective:	Month/day/year retroactive date, if applicable:		

Insurance carrier/provider of professional liability coverage:		Policy number:	Type of coverage (<i>check one</i>): Claims-made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of local contact:		Mailing address:	
Contact's telephone number: () Ext.:	Fax number, if available: ()		
Per claim limit of liability:	Aggregate amount:		
Month/day/year effective:	Month/day/year retroactive date, if applicable:		

Insurance carrier/provider of professional liability coverage:		Policy number:	Type of coverage (<i>check one</i>): Claims-made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of local contact:		Mailing address:	
Contact's telephone number: () Ext.:	Fax number, if available: ()		
Per claim limit of liability:	Aggregate amount:		
Month/day/year effective:	Month/day/year retroactive date, if applicable:		

Insurance carrier/provider of professional liability coverage:		Policy number:	Type of coverage (<i>check one</i>): Claims-made <input type="checkbox"/> Occurrence <input type="checkbox"/>
Name of local contact:		Mailing address:	
Contact's telephone number: () Ext.:	Fax number, if available: ()		
Per claim limit of liability:	Aggregate amount:		
Month/day/year effective:	Month/day/year retroactive date, if applicable:		

XVI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	In the last three (3) years has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B.	In the last three (3) years have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	In the last three (3) years have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	In the last three (3) years have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E.	In the last three (3) years has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization’s final action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F.	In the last three (3) years has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G.	In the past three (3) years, have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H.	In the last three (3) years have you ever had board certification revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I.	In the last three (3) years have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J.	In the last three (3) years have you ever been charged with a criminal violation (<i>felony or misdemeanor</i>)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K.	Do you presently use any illegal drugs?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L.	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (<i>alcohol or other substance</i>) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
M.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
N.	In the last five (5) years have any professional liability claims or lawsuits ever been closed and/or filed against you? If yes, please complete Attachment A, Professional Liability Action Detail , for each past or current claim and/or lawsuit.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
O.	In the last three (3) years has your professional liability insurance ever been terminated, not renewed, restricted, or <i>modified</i> (e.g. <i>reduced limits, restricted coverage, surcharged</i>), or have you ever been denied professional liability insurance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

*e.g. *hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system*

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:

Date:

OREGON PRACTITIONER RECREDENTIALING APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system] indicated on this application, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending 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.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and recredentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name: _____

Signature: _____

Date: _____

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Please list any past or current professional liability claim or lawsuit, which has been filed against you **in the past five (5) years. Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's name (*print or type*):

Month/day/year of the incident and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month/day/year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action (*primary defendant, co-defendant, other*):

Current status of suit or other action:

Month/day/year of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

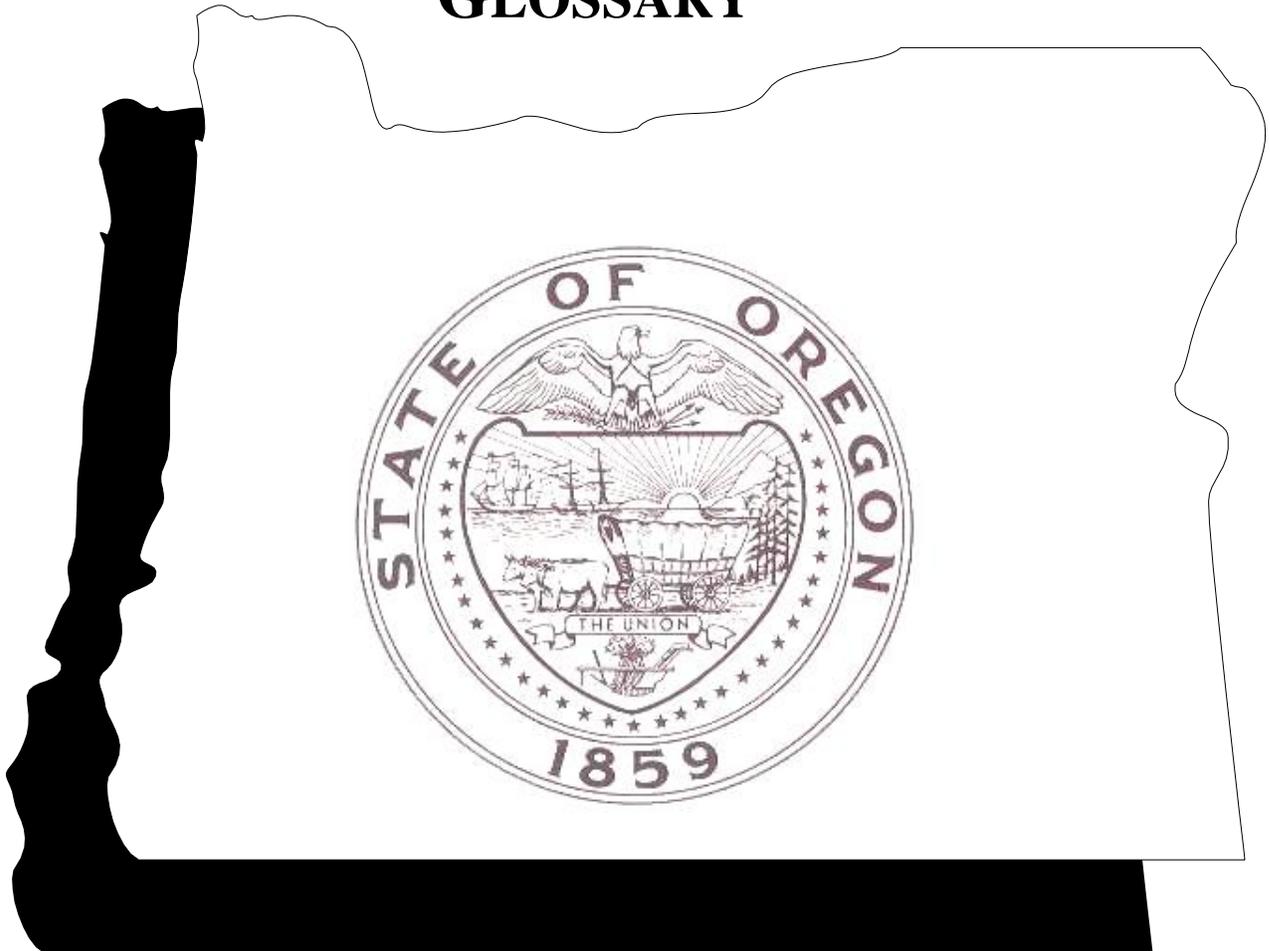
I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature:

Date:

Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.

OREGON PRACTITIONER CREDENTIALING APPLICATION GLOSSARY



GLOSSARY OF TERMS AND ACRONYMS

AAHC: Accreditation Association for Ambulatory Health Care - An organization that offers voluntary accreditation for ambulatory care organizations.

AANA: American Association of Nurse Anesthetists

ACUMENTRA: Oregon Medical Professional Review Organization - A private, non-profit organization that contracts to undertake appropriateness of care, utilization management and quality improvement projects for the CMS, other public agencies and insurance companies.

ACCREDITATION: A comprehensive, standardized evaluation process that involves assessing the degree to which an organization/individual complies with a defined set of standards.

ACGME: Accreditation Council for Graduate Medical Education - This organization is responsible for the Accreditation of post-M.D. medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

ACLS: Advanced Cardiac Life Support

ADMITTING PRIVILEGES: The right granted to a doctor to admit patients to a particular hospital.

AGENT: An insurance company representative licensed by the state, who solicits, markets, negotiates, binds and administers contracts of insurance.

AGPA: American Group Practice Association

AHA: American Hospital Association

AHP: Allied Health Personnel - Specially trained and licensed, or registered when required by Oregon law, health workers who perform tasks, which might otherwise be performed by physicians or nurses.

AMA: American Medical Association

ANA: American Nurses Association

ANCILLARY SERVICES: Supplemental health care services provided to a person while being treated. Included are laboratory, radiology, physical therapy, etc.

ATLS: Advanced Trauma Life Support

ATTESTATION: A signed statement indicating that a practitioner personally confirmed the validity, correctness, and completeness of his or her credentialing/recredentialing application.

BHC: Behavioral Health Care - A broad array of mental health, chemical dependency, forensic, mental retardation or developmental disabilities and cognitive rehabilitation services provided in settings such as acute, long term and ambulatory care.

BLS: Basic Life Support

CALL COVERAGE: Practitioners who provide care for your patients when you are unavailable.

CLAIM PENDING: A current request by the insured for indemnification by the insurance company for a loss that is a covered peril.

CLAIMS-MADE COVERAGE: A policy providing liability coverage only if a written claim is made during the policy period or any applicable extended reporting period. For example, a claim made in the current year could be charged against the current policy even if the injury or loss occurred many years in the past. If the policy has a retroactive date, an occurrence prior to that date is not covered. (contrast with Occurrence Coverage).

CME: Continuing Medical Education

CMS: Centers for Medicare and Medicaid Services - The federal agency that administers funds and oversees provision of medical care to Medicare and Medicaid patients.

COA: Certificate of Authority - A certificate issued by a state government, licensing the operation of a health maintenance organization.

CON: Certificate of Need - A certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment or offer a new or different health service.

CONTINUITY OF CARE: The provision of care by the same set of practitioners over time or, if the same practitioners are not available, a mechanism to promptly provide appropriate clinical information to the practitioners who continue to provide the same type and level of care.

COORDINATION OF CARE: The mechanisms ensuring that patients and practitioners have access to, and take into account, all required information on patient condition and treatment to ensure that the patient receives appropriate health care services.

COVERAGE: The services for which an insurance policy does and does not pay.

CPR: Cardio-Pulmonary Resuscitation

CREDENTIALING/RE-CREDENTIALING: The process of determining eligibility, for organizations such as hospitals or PHOs, for medical staff membership and privileges to be granted to physicians. Credentials and performance are periodically reviewed, which could result in physician privileges being denied, modified or withdrawn.

CSO: Clinical Service Organization - A medical center integrating the activities of the medical school, faculty practice plan and hospital to negotiate with managed care plans.

CSR: Controlled Substance Registration

CVO: Credential Verification Organization - A group that provides a centralized, uniform process for state medical boards, private and governmental entities to obtain a verified, primary source record of a physician's core medical credentials by gathering, verifying and permanently storing a physician's credentials in a centralized repository.

DCO: Direct Contracting Organization - Individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary.

DEA: Drug Enforcement Agency - The federal agency that issues licenses to prescribe and dispense scheduled drugs.

DMAP: Division of Medical Assistance Programs - A state agency that acts as the administrator for the Medicaid component of the Oregon Health Plan.

ECFMG: Educational Commission for Foreign Medical Graduates - A certification process that assesses the readiness of graduates of foreign medical schools to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

EPO: Exclusive Provider Organization - A managed care organization that designates specific physicians and other providers who can provide health care services.

EXCLUSIONS: The specific conditions or circumstances listed in an insurance policy for which the policy will not provide benefit payments.

HCFA: See CMS.

HMO: Health Maintenance Organization - An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Health care services are rendered by practitioners affiliated with the health care system. In these types of managed care organizations, in order to receive reimbursement, members must obtain all services from an affiliated practitioner or provider and must comply with a pre-defined authorization system.

HSA: Health Systems Agency - A health-planning agency created under the National Health Planning and Resource Development Act of 1974.

ID: Identification

INCIDENT REPORT: The documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established health department licenses, policies, procedures and/or practices.

INDEMNIFICATION: Insurance benefits paid to or on behalf of an insured for the provision of goods and services covered by the policy.

INSURANCE: Protection by written contract against financial hazards (in whole or in part) of the happenings of specified fortuitous events.

INSURED: A person or organization, covered by an insurance policy, including the “named insured” and any other parties for whom protection is provided under the policy.

INSURER: The party to the insurance contract who promises to pay losses or benefits or a corporation engaged primarily in the business of furnishing insurance.

INTERNSHIP: Receiving supervised practical experience in the health care field, usually as an advanced or graduate student, also referred to as post-graduate year 1 (PGY1)

IPA: Independent Practice Association - A federation of independently-practicing physicians and/or other practitioners organized to contract with health plans and other third party payers as to the conditions under which medical services will be covered for insured patients with the understanding that said conditions shall be considered and independently agreed to by each practitioner or legally-integrated group of practitioners belonging to the IPA.

IPN: Integrated Provider Network - A group comprised of primary and secondary hospitals, physicians and other health care practitioners within a city or other geographic area.

ISN: Integrated Service Network - A group comprised of a combination of physicians and other health care providers who deliver health care in an integrated way.

LAPSED POLICY: A policy terminated for non-payment of premiums.

LOCUM TENENS: The act of a practitioner temporarily taking the place of another practitioner.

MALPRACTICE: Professional misconduct or lack of ordinary skill in the performance of a professional act, which renders the responsible practitioner liable to suit for damages.

MCO: Managed Care Organization - Any type of organizational entity providing managed care such as an HMO, PPO, and EPO, etc.

MEDICAID: A joint federal and state-funded health care program for low-income families and individuals or disabled persons.

MEDICARE: Federal health insurance administered by CMS. It is the nation's largest health insurance program, which provides health insurance to people age 65 and over, those who have permanent kidney failure and certain people with disabilities.

NA (N/A): Not Applicable

NCHSR: National Center for Health Services Research

NCQA: National Committee for Quality Assurance - An independent non-profit organization that has worked with consumers, health care purchasers, state regulators and the managed care industry in developing standards that evaluate the structure and function of medical and quality management systems in managed care organizations.

NEGLIGENCE: The failure to use the reasonable care that a prudent person would have used under the same or similar circumstances.

NIMH: National Institute of Mental Health

NPI: National Provider Identification number, a unique health identification number for health care providers, became an HIPAA (Health Insurance Portability and Accountability Act of 1996) standard by May 23, 2007 for most covered health care entities and May 23, 2008 for small health plans.

NON-PARTICIPATING PROVIDER: Physicians/providers and facilities that are not under contract as health providers for a HMO/PPO.

NOTICE OF CANCELLATION: A written notice by an insurance company of their intent to cancel the policy.

NRP: Neonatal Resuscitation Program

OCCURRENCE COVERAGE: A policy form providing liability coverage only for injury or damage that occurs during the policy period, regardless of when the claim is actually made. For example, a claim made in the current policy year could be charged against a prior policy period, or may not be covered, if it arises from an occurrence prior to the effective date. (contrast with Claims-Made Coverage)

OHMO: Office of Health Maintenance Organizations - A component of the U.S. Department of Health and Human Services that is charged with the responsibility for directing the federal HMO program.

OMB: Oregon Medical Board - A state agency responsible for administering the Medical Practice Act and establishing the rules and regulations pertaining to the practice of medicine in Oregon. The board determines requirements for Oregon licensure as a Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Physician Assistant (PA), and Acupuncturist (LAc).

PALS: Pediatric Advanced Life Support

PARTICIPATING PROVIDER: A physician or other health care practitioner who has contracted with a health plan to provide medical services to members.

PCG: Physician Care Groups - A classification system used to determine payment for physician services.

PCN: Primary Care Network - A group of primary care providers linked for purposes of administering health coverage.

PCP: Primary Care Provider - A physician or other health care practitioner who is responsible for monitoring an individual's overall health care needs.

PEER: Individual(s) in the same professional discipline as the applicant with personal knowledge of the applicant.

PERIL: The cause of a loss insured against in a policy.

PGY 1: Post-graduate Year 1 (see Internship)

PHO: Physician/Hospital Organization - A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests.

POLICY: The term used for the legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

POS: Point of Service - A type of managed care coverage that allows members to choose to receive services either from participating HMO physicians and other health care practitioners and providers, or from those not in the HMO's network. Patients pay less for in-network care and for out-of-network care; members usually pay deductibles and a percentage of the cost of care.

PPO: Preferred Provider Organization - A network of doctors and hospitals that provide care to an enrolled population at a pre-arranged discounted rate.

PRACTITIONER: A physician or other licensed or registered health care professional qualified to render medical services.

PREMIUM: The amount paid for any insurance policy.

PRO: Peer Review Organization or Physician Review Organization

PROFESSIONAL LIABILITY CLAIM: Written demand for money or services.

PROFESSIONAL LIABILITY INSURANCE: Insurance purchased by physicians and other health care providers to help protect themselves from financial risks associated with medical liability claims.

PROVIDER: An institution or organization, such as hospitals, home health agencies, and skilled nursing facilities, that provides services to patients.

PROVIDER TAXONOMY CODES: A provider classification system, which is a nationally recognized list of provider types and specializations, initially setup by the Centers for Medicare/Medicaid Services (CMS) with the intent to provide a single coding structure to support work on the National Provider System. The current list is now administered and published by the National Uniform Claim Committee (NUCC).

REHABILITATION SERVICE: An organization service providing medical, health-related, social and vocational services for disabled persons to help them attain or retain their maximum functional capacity.

RISK: The degree of probability of loss or the amount of possible loss to the insuring company.

SETTLEMENT: A policy benefit or claim payment. It refers to an agreement between both parties to the policy contract as to the amount and method of payment.

SNF: Skilled Nursing Facility - A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

TAXONOMY CODES: See Provider Taxonomy Codes.

TELEMEDICINE: Using telecommunication technology to deliver health services, including but not limited to clinical diagnosis, clinical services, patient consultation and the practice of medicine across state lines.

TERM: The period of time a policy is in effect.

TJC: The Joint Commission - A private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care and long term care services.

USMLE: United States Medical Licensing Examination - A certifying examination that fulfills requirements for medical licensure, as well as providing a common evaluation system for all applicants for medical licensure. Results of USMLE are reported to medical licensing authorities in the United States for use in granting the initial license to practice medicine.