California Participating Physician Application

This application is submitted to: Northeast Valley Health Corporation, herein, this Healthcare Organization[1]

I. INSTRUCTIONS:

This form should be typed 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. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State: CA	ZIP:
Home Telephone Number: (Home Fax Number: ( )	E-Mail Address: Pager Number: ()	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable): NEVHC-San Fernando Health Center	Department Name (If Hospital Based): N/A	
Primary Office Street Address: 1600 San Fernando Road	City: San Fernando	
	State: CA	ZIP: 91340
Telephone Number: (818) 365-8086	Fax Number: (818) 898-4826	
Office Manager/Administrator:	Telephone Number: (818) 365-8086	
	Fax Number: (818) 898-4826	
Name Affiliated with Tax ID Number: NEVHC	Federal Tax ID Number: 23-7120632	

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City: Pacoima	
	State: CA	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number	Federal Tax ID Number:	

Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation:
Mailing Address:	City:	
	State: CA	ZIP:

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	Degree Received:	Date of Graduation:
Mailing Address:	City:	ZIP:
	State & Country:	Telephone:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	ZIP:
	State & Country:	Telephone #:

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country: CA	ZIP:
Type of Internship :	Telephone #:	

Specialty:	From: ()	To: ()

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (eg. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			Telephone #:

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			Telephone #:

Institution:		Program Director:	
Mailing Address:		City:	
		State: CA	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? Yes No (If "No," please explain on separate sheet.)			Telephone #:

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? ☐Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS **(Remember to attach copies of documents)**

California State Medical License Number:	Issue Date:	Expiration Date:

Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:
ECFMG Number (applicable to foreign medical graduates):	Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY **(Remember to attach copy of professional liability policy or certification face sheet)**

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference	Specialty:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State: CA	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason of Leaving	

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason of Leaving	

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason of Leaving	

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason of Leaving	

Current Practice:	Contact Name:	Telephone Number: ()	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason of Leaving	

Physician Name:

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through M is "yes," or if your answer to N & O is “no,” please provide full details on separate sheet.

	Question	Yes / No
A.	Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes ☐ No ☐
B.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes ☐ No ☐
C.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes ☐ No ☐
D.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes ☐ No ☐
E.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes ☐ No ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending?	Yes ☐ No ☐
G.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes ☐ No ☐
H.	Have you ever been convicted of any crime (other that a minor traffic violation)?	Yes ☐ No ☐
I.	Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	Yes ☐ No ☐
J.	Have you had a history of chemical dependency or substance abuse that might adversely affect your ability and safely perform the essential functions of a practitioner in your area of practice?	Yes ☐ No ☐
K.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others. **If yes, please describe any accommodations which could reasonably be made to facilitate your performance of such functions without risk of compromise.**	Yes ☐ No ☐
L.	Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes ☐ No ☐
M.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes ☐ No ☐
N.	Is your professional liability insurance valid and current?	Yes ☐ No ☐
O.	Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes ☐ No ☐

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

Print Name Here: ______________________________

Physician Signature______________________________ Date: __________

(Stamped Signature Is Not Acceptable)

(Not acceptable If Not Dated)

Physician Name:

INFORMATION RELEASE/ACKNOWLEDGMENTS

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

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

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation.

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

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

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

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the state license board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization (including hospital) which has resulted in the filing of a report with the National Practitioner Data Bank (NPDB) or with the Healthcare Integrity Protection Data Bank (HIPDB); or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization (including hospital); or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

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

Print Name Here____

Applicant Signature____

(Stamped Signature Is Not Acceptable)

Date: ____

Addenda Submitting (Please check the following):	*This Application and Addenda A and B were created and are endorsed by:*
☐ Addendum A - Health Plan and IPA/Medical Group ☐ Addendum B - Professional Liability Action Explanation	• American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267/1999) • The Medical Quality Commission - (310/936-1100 x230)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

Physician Name:

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: Northeast Valley Health Corporation, herein, this Healthcare Organization.

I. IDENTIFYING PROVIDER INFORMATION

Last Name:	First:	Middle:

Medical Group (s) /IPA(s) Affiliation: Northeast Valley Health Corporation

Do you intend to serve as a primary care provider? ☒ Yes ☐ No
Do you intend to serve as a specialist? ☐ Yes ☒ No (If yes, please list specialty(s))

Please check all that apply:
☐ Solo Practice
☒ Group Practice
☐ Single Specialty
☐ Multi specialty

II. BILLING INFORMATION

Billing Company: Northeast Valley Health Corporation

Street Address: 1172 North Maclay Avenue	City: San Fernando	
	State: CA	ZIP: 91340
Contact: Northeast Valley Health Corporation	Telephone Number: (818) 898-1388	
Name Affiliated with Tax ID Number: NEVHC	Federal Tax ID Number: 23-7120632	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐Yes ☐No
If so, please list:

Name:	Type of Provider:	License Number:

If you are a Physician Assistant Supervisor, please include State License Number:______
Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐Yes ☒No
If so, please list:

Name:	California Medical License Number:
_______	_______
_______	_______

Please list any clinical services you perform that are not typically associated with your specialty: Dental cleanings, local anesthesia, scale& root planning, oral cancer exam

Please list any clinical services you **do not** perform that are typically associated with your specialty: _

Is your practice limited to certain ages? ☐Yes ☒No
If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council?	☐Yes ☒No
Do you participate in EDI (electronic data interchange)? If so, which Network? ______ Do you use a practice management system/software: If so, which one? _The Medical Manager - MMClient_____	☐Yes ☒No ☒Yes ☐No

What type of anesthesia do you provide in your group/office?
☒ Local ☐Regional ☐Conscious Sedation ☐General ☐None ☐Other (please specify) _____

Has your office received any of the following accreditations, certifications or licensures?
- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ California Department of Health Services Licensure
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☒ Other _JCAHO

IV. OFFICE HOURS - Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays
8-5	8-5	8-5	8-5	8-5	8-5	Closed	Closed
Evening	0	5-9	0	0	0	Closed	Closed

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company: Tel-Us Answering Call Center	Phone Number: (310) 205-2100	Fax Number: (323) 944-0141

Mailing Address: 8447 Wilshire Blvd., Suite #401	City: Beverly Hills	
	State: CA	ZIP: 90211

Covering Physician's Name: 24 hours on call provider panel	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #: 23-7120632	Billing Name: NEVHC	Type of Service Provided: Non-Waived
Do you have a CLIA certificate?	☒Yes	☐No
Do you have a CLIA waiver?	☐Yes	☐No
Certificate Number:		Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name Here: ______________________________

Physician Signature: ______________________________ Date: ____________________

(Stamped Signature Is Not Acceptable)

California Participating Physician Application
Addendum B
Professional Liability Action Explanation

This Addendum is submitted to **Northeast Valley Health Corporation** herein, this Healthcare Organization [2].

Please check here if there is no pending/settled claim to report: ☐

If no claim is reported, please proceed to the next page, sign and date it to validate your answer.

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

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address: 1172 N. Maclay Avenue	City: San Fernando	
	State: CA	ZIP: 91340

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident: ☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center
☐ Other, (please specify) ____________________

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

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

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

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

Name ____________________ Phone Number (______) ____________ Fax: __________

Name ____________________ Phone Number (______) ____________ Fax: __________

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $___________ Date Paid: _______
☐ Judgment rendered and I was found not liable.
☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $___________ Date Paid: _______
☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

____

____

____

____

____

____

____

____

____

____

____

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

Print Name Here: ____

Physician Signature ____Date:_____________

(Stamped Signature Is Not Acceptable) (Not acceptable If Not Dated)

California Participating Physician Application

Addendum E
HIV/AIDS Specialist Designation

This Addendum is submitted to:____, herein, this Healthcare Organization6.

Health plans and health care organizations must implement regulations related AB 2168 (Ch. 426, 2000). This legislation required standing referrals to HIV/AIDS Specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS-34-01.
In order to comply with this regulation, we need to identify appropriately qualified specialist within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Cal-Optima Specialist Intranet Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ **Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:**

- **If Yes: Are you willing to take CalOptima member referrals?** ☐Yes ☐ No

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.

OR

I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member board of the American Board of Medical Specialties;

OR

☐ I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

☐ In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

* Reimbursement rates are available on the CalOptima website.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Print Name Here:____ Date: ____________

(Not acceptable If Not Dated)

Physician Signature ______________________________ _____ License # ____________________Telephone # ___________.

(Stamped Signature Is Not Acceptable)

California Participating Physician Application

IPA Addendum C

This addendum is submitted to:___Northeast Valley Health Corporation_ herein, this Healthcare Organization.

Confidential Questions

Question	Answer
1. 2. In the last five (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? **If yes, identify and describe any rehabilitation program in which you are or were enrolled which assures your abstinence prospectively and your adherence to prevailing standards of professional performance.**	Yes ☐ No
3. 4. Do you have any ongoing physical or mental impairment or condition which would make your unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations which could reasonably be made to facilitate your performance of such functions without risk of compromise**.	Yes ☐ No
5. Are you a certified Worker's Compensation provider? **If yes, please attach a copy of your certificate**	Yes ☐ No
6. Are you reservist? If yes, what branch of the military?______________________ Anticipate date of separation from reserve duty? ________/________/_________	Yes ☐ No
7. Medicare/Medi-Cal #:	
8. Do you accept HMO Medi-Cal Membership:	☐ Yes No

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

_____________________________________ _________________
Please Print Name Date

____
Signature

MedPoint Management
Addendum C

I. Healthy Families	
Number of days open per week __________	Total office operating hours per week_______
Participation in the Healthy Family Program requires a minimum of 5 days and 36 office hours per week	

II. Additional Attestation Question

1. 1. Do you have any ongoing or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could possibly be made to facilitate your performance of such functions without risk of compromise.** **Yes** ☐ No ☒
2. Is your professional liability insurance valid and current? **Yes** ☒ No ☐
3. 3. Are you currently on active duty and/or military reserve? **Yes** ☐ No ☒

III. Practitioner's Rights

1. **Right of Review**
   A practitioner has the right to review information obtained by MedPOINT Management for the purpose of evaluating that practitioner's credentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice information carriers, state licensing boards, National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

   A practitioner may request to review such information at any time by sending a written request via letter to the Credentialing Department at MedPOINT Management, 6400 Canoga Ave Suite 163, Woodland Hills, CA 91367 or by fax (818) 702-9128. The Credentialing Department will notify the practitioner within 72 hours of the receipt of the request of the date and time when such information will be available for review at the Credentialing Department at MedPOINT Management.

2. **Notification of Discrepancy**
   Practitioners will be notified in writing, via letter or fax, within 30 business days, when information obtained from the primary sources varies substantially from information provided on the practitioner's application. Examples of information of substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board certification expiration, when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Source will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

3. **Correction of Erroneous Information**
   If practitioner believes that erroneous information has been supplies to MedPOINT Management by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice (via letter or fax) along with a detailed explanation to the Credentialing Department, MedPOINT Management, 6400 Canoga Ave. Suite 163, Woodland Hills, CA 91367, fax number (818) 702-9128. Notification to MedPOINT Management must be received within 15 business days of MedPOINT Management's notification to the practitioner of a discrepancy as provided in Section 1 above or within 24 hours of a practitioner's review of his/her credentials files as provided Section 2.

4. **Status of Application**
   Practitioner's will be informed, upon request, of the status of their initial or recredentialing application. The practitioner may request the status of his/her application at any time by sending a written request via fax or mail to the Credentialing Department. The Credentialing Department will respond to the practitioner within 10 business days of the receipt of the written request.

I hereby affirm that the information is this section is true, correct, and complete to the best of my knowledge. I have also read and acknowledge my rights, as described above.

Physician Name: ____

Physician Signature ____________________________________ **Date**_________________________

(Stamped Signature is not acceptable)

Foundation Health Managed Care
Medi-Cal Program Addendum

Identifying Information:

Physician Name: ________________________________ Ethnicity:_______________________

California License #”______________________________

Medi-Cal Provider Number:_________________________

Social Security #: _________________________________

Are you a Traditional Provider?	☒Yes	No
Are you CHDP (Child Health and Disability Prevention Program) certified?	Yes	No
Are you CPSP (Comprehensive Perinatal Services Program) certified?	Yes	No
Are you CCS (California Children Services) certified?	Yes	No

Languages (other than English) used effectively when communicating with patients during treatment:

1.________________________	Speak	Read	Speak/Read	Read/Write	Speak/Read/Write
2.________________________	Speak	Read	Speak/Read	Read/Write	Speak/Read/Write
3.________________________	Speak	Read	Speak/Read	Read/Write	Speak/Read/Write
4.________________________	Speak	Read	Speak/Read	Read/Write	Speak/Read/Write

Office Hours (Primary): __________________________ Office Hours (Secondary)________________________

Billing Address:

Address 1172 North Maclay Avenue		Suite
City San Fernando	State CA	Zip 91340
Phone Number: 818-898-1388	Fax Number 818-365-4031	
Contact Person:	Title:	

Medi-Cal Patient Capacity Information:

Address		Suite
City	State	Zip
Phone #:	Approx. number of Fee For Service:	
Current number of managed care Medi-Cal patients seen per month:		

(Any additional offices please list on separate sheet.)

Section B: Ancillary Personnel

List any licensed ancillary/physician extender personnel with whom you employ, who provide direct patient care (including Nurse Practitioners, Physician Assistant and Certified Nurse Midwives.)

Name	Ancillary Type	California Professional License#	Expiration Date

Section C: Practice Information

(Specialty)

Do you intend to serve as a Primary Care Physician______________________________ ☒Yes No

Do you intend to serve as a Specialty Care Physician_____________________________ Yes ☒No

If you wish to serve as a specialist, please list your:

Primary specialty: ____

Secondary specialty: ____

As PCP, please list your PPG (Participating Provider Group) affiliations:

1.____ Federal Tax ID #: ___________________

2.____ Federal Tax ID #: ___________________

3.____ Federal Tax ID #: ___________________

Language(s) spoken fluently by office staff:

Person Languages

1.____

2.____

3.____

CONFIDENTIAL/PROPRIETARY

Physician Name:

Primary Care Experience
Attestation
Addendum E

This Addendum is submitted to: **Care 1st Healthplan.**

Please indicate below the age of the patients for whom you have provided primary care services to in the last 5 years. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with and routinely follow standard preventive services, such as CHDP **(for pediatrics only)** and United States Preventive Task Force (USPTF). Please check all those that apply:

Adults (18 years of age and older)
Pediatrics (0 to 21 years of age)
If you desire age limitations different from above, please specify: ______

____

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial or participation or dismissal from participation with Care 1st Healthplan.

Physician's Name: ____

Physician's Signature: ___________________________________ Date:__________
(Stamped signature is not acceptable)

Provider Name:

Work History

Chronologically list all work history activities for the **last five years.** A Curriculum vitae is sufficient provided it is current and contains **all** the information below **including dates**. **Please explain any gaps that exceed 6 months. No P.O. Boxes.**

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Address:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)		

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Address:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)		

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Address:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)		

Submit Application