APPLICATION FOR:

- **CREDENTIALING**
- **CLINICAL PRIVILEGES AS AN ALLIED HEALTH PROFESSIONAL**

KAISER PERMANENTE
Kaiser Permanente Northern California
The Permanente Medical Group, Inc.
Kaiser Foundation Hospitals

Name: _____ o **CRNA** o **CNM** o **NP** o **PA** o **LCSW** o **MFT** o **LAc** o **OD**

Specialty: _____ o **Other**

_____

PURPOSE OF APPLICATION (CHECK ALL THAT APPLY):

- o I wish to be considered for credentialing by Kaiser Permanente Northern California (KPNC).
- o I wish to apply for clinical privileges at a Kaiser Foundation Hospital and/or Ambulatory Surgery Center.
- o I wish to be considered for employment by The Permanente Medical Group (TPMG), Inc.

Please state practice sites and list specific locations: _____

_____

INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. Do not leave blanks or write "See CV" in any blank area. Do not use "white-out" or any other kind of correction fluid. If you make an error draw a single line through it, write the correct information next to it and initial the change. If there are any gaps in time between education, training, or employment or affiliation as reported on your application please provide information about your activities during those times. An incomplete application will not be processed.

Kaiser Permanente is an integrated delivery system consisting of Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and The Permanente Medical Group, Inc. Credentialing is required in order to provide health care services to a Kaiser Foundation Health Plan, Inc. member on behalf of Kaiser Permanente.

Decisions regarding employment by TPMG, credentialing by KPNC and/or clinical privileges, are based upon an applicant's qualifications without unlawful discrimination based upon his/her race, sex, religion, color, national origin, gender, age, physical or mental disability, U.S. military veteran status, sexual orientation, marital status, medical condition or ancestry.

If you are hired by TPMG, you will be required to furnish proof that you are legally authorized to work in the United States.

If you are given an offer of employment, clinical privileges, and/or credentialing by KPNC, you will be required to furnish information regarding your health status. AHP applicants must also request specific clinical privileges using forms prescribed by the Hospital or Ambulatory Surgery Center.

NOTE: Although this form may be used for employment with The Permanente Medical Group, Inc. and credentialing by KPNC, the application processes are distinct. Employment by The Permanente Medical Group, Inc. does not bestow or imply that clinical privileges will be granted at a Kaiser Foundation Hospital or Ambulatory Surgery Center or credentialing will be approved. Nor does the granting or continuation of privileges at a Kaiser Foundation Hospital or Ambulatory Surgery Center bestow or imply continued employment with TPMG. Further, the granting of privileges at one Kaiser Foundation Hospital or Ambulatory Surgery Center does not bestow or imply that privileges will be granted at any other Kaiser Foundation Hospital or Ambulatory Surgery Center.

IDENTIFYING INFORMATION - SECTION 1

Last Name:	First Name:	Middle:
Other names you have been known by:		Social Security No.:
Office Address(s):		

Office Telephone No.: ( )	E-Mail Address:	Pager/Cell Phone No.: ( )	Fax No.: ( )

Home Address:	Home Telephone No.: ( )

If hired can you provide proof that you are legally authorized to work for Kaiser Permanente in the United States?
o YES o NO o N/A

CALIFORNIA AND OTHER PROFESSIONAL LICENSES/CERTIFICATES - SECTION 1A

*List **ALL** California Professional Licenses and designated certificates and please attach copies.*

Professional License Type:	License No.:	Expiration Date:
Professional License Type:	License No.:	Expiration Date:
Drug Enforcement Administration Registration: o YES o NO o PENDING o N/A If Yes, DEA No.: _____		Expiration Date:
Board of Registered Nursing Furnishing No.: o YES o NO o PENDING o N/A		Expiration Date:

OTHER STATE PROFESSIONAL LICENSES/CERTIFICATES - SECTION 1B

Does Not Apply o

*List **ALL Licenses/Certificates** from states other than California (past/present) and please attach copies. **If more space is needed, attach additional sheets.***

State & License/Certificate Type:	Number:	Expiration Date:	Current Status:
State & License/Certificate Type:	Number:	Expiration Date:	Current Status:

CERTIFICATION - SECTION 1C

Does Not Apply o

Certification:	Sub-certification:	Issued By:	Certification No.:	Certification Date:	Expiration Date:	Recertification Date:
Certification:	Sub-certification:	Issued By:	Certification No.:	Certification Date:	Expiration Date:	Recertification Date:

Are You Currently Applying For Certification?
o YES o NO Give Current Status of Application_____

EDUCATION AND TRAINING - SECTION 2

Please attach additional pages if necessary.

UNDER GRADUATE EDUCATION	Full Name and Address of Institution: Name of Contact Person, Title: Telephone No.: ( ) Fax No. ( )	Specialty: _____ Dates of Attendance: From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Degree Received: o YES o NO Degree Type: _____
PROFESSIONAL SCHOOL	Full Name and Address of Institution: Name of Contact Person, Title: Telephone No.: ( ) Fax No. ( )	Specialty: _____ Dates of Attendance: From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Degree Received: o YES o NO Degree Type: _____
PROFESSIONAL SCHOOL	Full Name and Address of Institution: Name of Contact Person, Title: Telephone No.: ( ) Fax No. ( )	Specialty: _____ Dates of Attendance: From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Degree Received: o YES o NO Degree Type: _____

PROFESSIONAL AFFILIATIONS - SECTION 3

HOSPITAL STAFF MEMBERSHIPS AND FACILITY ASSOCIATIONS

Does Not Apply o

*Please list **ALL** hospital staff memberships and associations with ambulatory surgery centers as well as other types of facilities relevant to health care practice where you have current or past affiliations. **If more space is needed, attach additional sheets. List your current primary hospital first.***

Full Name and Address of Current Primary Hospital/Organization:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Staff Status: Name of Contact Person: Title: Telephone No.: ( )
Full Name and Address of Hospital/Organization:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Staff Status: Name of Contact Person: Title: Telephone No.: ( )

PROFESSIONAL AFFILIATIONS - SECTION 3 (continued)

Full Name and Address of Facility:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Staff Status: Name of Contact Person: Title: Telephone No.: ( )
Full Name and Address of Facility:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Staff Status: Name of Contact Person: Title: Telephone No.: ( )

KAISER PERMANENTE EXPERIENCE - SECTION 3A

Have you ever been employed by any Permanente Medical Group or by any other Kaiser Permanente organization, or have you been affiliated with any Kaiser Foundation Hospital? **Attach additional pages as necessary.**

o YES o NO

If yes, what position did you have? _____

Why did you leave the position? _____

Dates of training or practice from: _____ **to:** _____

Which Kaiser Permanente Region: _____ Area or Facility: _____

Name/Title/Telephone Number of Supervisor:_____

LANGUAGES - SECTION 4

Do You Have The Ability To Communicate With Patients In A Language Other Than English?

o YES o NO If Yes, Indicate Language And Proficiency Level Below:

Language (Including American Sign Language)	Level Of Understanding	Speaking (Or Signing) Ability
	o Full o Good	o Full o Good

EMPLOYMENT OR ASSOCIATION – SECTION 5

Does Not Apply o

*Please list **ALL** employment or association with hospitals, private or group practices, independent practice associations, health care service plans, health maintenance organizations, or preferred provider organizations where you have current or past affiliations.* ***If more space is needed, attach additional sheets.***

Full Name and Address of Current/Past Practice:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Name of Contact Person: Title: Telephone No.: ( )
Full Name and Address of Current/Past Practice:	From: _____/_____ (MO./YR.) To: _____/_____ (MO./YR.) Name of Contact Person: Title: Telephone No.: ( )

CONTINUING PROFESSIONAL EDUCATION - SECTION 6

Please attach copies of certificates when possible. If certificates are not available, attach a list with name of activity, date attended, credit hours, subject matter, and sponsor.

o I have attached a list of continuing professional education activities for the past two years.

PROFESSIONAL REFERENCES - SECTION 7

List the names of three similarly licensed practitioners who are your peers and have supervised your clinical practice or have worked with you professionally and have knowledge of your current clinical competence, character, conduct and relationships with patients, staff and colleagues.

Full Name and Address of Reference and Include Institution or Practice:	Telephone No.: ( ) Fax No.: ( ) **E-mail address:** **Nature of professional association with reference:** o Training Program Director o Employer o Department Chief o Associate In Practice o Other: _________________ **Time period of association(must be at least 2 years):** From: ________/________ (MO./YR.) To: ________/________ (MO./YR.)
Full Name and Address of Reference and Include Institution or Practice:	Telephone No.: ( ) Fax No.: ( ) **E-mail address:** **Nature of professional association with reference:** o Training Program Director o Employer o Department Chief o Associate In Practice o Other: _________________ **Time period of association(must be at least 2 years):** From: ________/________ (MO./YR.) To: ________/________ (MO./YR.)
Full Name and Address of Reference and Include Institution or Practice:	Telephone No.: ( ) Fax No.: ( ) **E-mail address:** **Nature of professional association with reference:** o Training Program Director o Employer o Department Chief o Associate In Practice o Other: _________________ **Time period of association(must be at least 2 years):** From: ________/________ (MO./YR.) To: ________/________ (MO./YR.)

PROFESSIONAL LIABILITY REVIEW - SECTION 8

THIS SECTION MUST BE COMPLETED. PLEASE DO NOT ABBREVIATE.

CURRENT PROFESSIONAL LIABILITY COVERAGE – SECTION 8A

Please attach a copy of your current liability insurance policy declaration or other evidence of professional liability coverage.

If currently not covered by liability insurance, please attach and explanation:

Full Name and Address of Current Insurance Carrier: **Policy No.:** **Telephone No.: ( )**	Per Occurrence Amount: $ _____ Aggregate Amount: $ _____ Original Effective Date: _____ Expiration Date: _____

PRIOR PROFESSIONAL LIABILITY COVERAGE – SECTION 8B

Does Not Apply o

Please list all of your professional liability carriers or providers within the past ten (10) years, other than those listed in 8A above. Whenever possible, please attach a copy of the policy declaration or other evidence of professional liability coverage.

If more space is needed, attach additional sheets.

Full Name and Address of Carrier: **Policy No.:** **Telephone No.: ( )**	From: _____/_____ (MM/YY) To: _____/_____ (MM/YY)
Full Name and Address of Carrier: **Policy No.:** **Telephone No.: ( )**	From: _____/_____ (MM/YY) To: _____/_____ (MM/YY)

PROFESSIONAL LIABILITY COVERAGE HISTORY – SECTION 8C

If you answer "yes" to questions A or B below, please give full details in Section 9, "Claim Information." Each case will be judged on its own merits with respect to its affect on your professional qualifications and competence.

If the answer is "yes" to questions C, D, or E, please explain on a separate sheet of paper.

A.	Have you been named as a defendant, involved, and/or alleged to have been negligent, in a professional liability case in the **past ten (10) years,** or have any settlements been made on your behalf, or are any such cases pending? If so, describe each such case and it's current status or disposition.	o YES o NO
B.	Within the **past ten (10) years,** has the care that you provided been the subject of any claim of negligence or other action for damages?	o YES o NO
C.	Have you **ever** been denied professional liability coverage or insurance?	o YES o NO
D.	Has your professional liability coverage or insurance policy ever been revoked, cancelled, or voluntarily relinquished under a threat of cancellation?	o YES o NO
E.	Have you ever practiced without professional liability coverage when you were required to have it? If so, please state the reason(s) why on a separate piece of paper.	o YES o NO

CLAIM INFORMATION – SECTION 9

Does Not Apply o

If you answered "yes" to question A or B in Section 8B regarding a claim, you must complete this form, with respect to any claim, threatened claim, settlement, or suit against you, regardless of the outcome. ***(Note that the term "claim" includes, but is not limited to: an alleged claim, charge, settlement or suit.)*** *Please copy this form and complete it for each claim. All questions must be answered completely.*

If more space is needed, attach additional sheets.

1. Name of Patient: _____ Age: ____ Sex: ____

2. Relationship to patient (*e.g.*, surgery assistant): _____

3. Allegations made against you: _____

4. Date of Incident/Treatment: _____ Location: _____

5. Condition, diagnosis and care at time of incident:
_____

6. Subsequent condition or health of the patient: _____

7. Insurance Carrier or Provider of Professional Liability Coverage:
_____
Address:
_____
Policy No.: _____ Phone No.: _____
E-mail Address: _____

8. Defense Counsel (Name):
_____
Firm Name:
_____
Address: _____ Phone No.: _____
E-mail Address: _____

9. Other Defendants in case (if any):
_____

10. Status (check one):
o Incident Only (no claim made as yet) o Claim or Notice of Claim Filed o Suit Filed
Date of Claim: _____ o Open o Closed Date Closed: _____
Dismissed or Dropped: _____ With Prejudice: _____ Without Prejudice: _____

Settled: Total Amount: $_____ Amount paid on your behalf $_____
Judgment: Total Amount: $_____ Amount paid on your behalf $_____

11. Comments:
_____

I hereby declare that the above information is, to the best of my knowledge and belief, complete and accurate.

Signature of Applicant: _____ Date: _____

PROFESSIONAL HISTORY - SECTION 10

ALL QUESTIONS MUST BE ANSWERED. *If you answer "yes" to any of the following questions, please give details on a separate sheet of paper. Each case will be judged on its own merits with respect to its affect on your professional qualifications and competence.*

1.	a) Has your license, registration, certification, permit or authorization to practice your profession or occupation or to provide health care services of any nature (either as a student, intern, resident or in any other capacity) ever been denied, restricted, suspended, not renewed, revoked, voluntarily or involuntarily relinquished or been subject to investigation, review, reprimand, warning or any disciplinary action or probationary condition?	o YES o NO
	b) Has any such action ever been initiated?	o YES o NO
	c) Are any such actions pending?	o YES o NO
2.	Have you ever been, or are you currently the subject of a disciplinary action or investigation by any government or private agency, court or peer review organization concerning your professional license or registration, certification, permit or authorization to provide health care services?	o YES o NO
3.	Have you ever been denied clinical privileges, membership, participation, contractual affiliation and/or employment by any health care organization, including but not limited to, a hospital, medical/professional staff or HMO?	o YES o NO
4.	a) Have your clinical privileges, membership, participation and/or employment in any health care organization ever been investigated, restricted, reduced, suspended, terminated, revoked, not renewed or subject to a warning or any disciplinary action or probationary condition?	o YES o NO
	b) Are any such actions pending?	o YES o NO
5.	a) Have you ever voluntarily or involuntarily relinquished or withdrawn your request for clinical privileges, membership, participation, contractual affiliation or employment with any hospital or other health care organization?	o YES o NO
	b) Have you ever done so during or under the threat of an investigation?	o YES o NO
6.	Have you ever been: a) Terminated from, denied participation in or asked to resign from any post graduate educational training program or professional educational experience, including any residency, internship, fellowship, externship, or clerkship for reasons related to your quality of care, clinical competence, professional conduct, ethics, or academic or clinical performance?	o YES o NO
	b) The subject of any disciplinary action including, but not limited to, probation, investigation, reprimand, restriction, suspension, warning or limitation during your enrollment or participation in any post graduate education training program or professional educational experience, including any internship, residency, clinical rotation, externship or fellowship?	o YES o NO
7.	Have you ever been notified that a report, complaint or other filing regarding your practice, or a malpractice payment made on your behalf, has been or will be made to the National Practitioner Data Bank or any state licensing board?	o YES o NO
8.	a) Have you ever been convicted of, or plead guilty to, a criminal offense (i.e., a felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense?	o YES o NO
	b) Are any such actions pending?	o YES o NO
9.	Have your fees, quality of care or other practices ever been subject to investigation or action, including fraud or abuse proceedings, by a government agency or third party payor, including but not limited to suspension, sanction or other restriction by any private, federal or state health care program, including Medicare or Medicaid?	o YES o NO
10.	a) Have you ever been sanctioned by and/or excluded from a federal or state health care program (e.g., Medicare or Medicaid)?	o YES o NO
	b) Are any such actions pending?	o YES o NO
11.	Have you filed paperwork with any medical program to formally "opt out" of a federal or state health care program, such as Medicare, **within two (2) years** of the date of this application?	o YES o NO
12.	Have you engaged in illegal drug use **within one (1) year** of the date of this application?	o YES o NO

DEA (OR OTHER AUTHORIZATION TO ORDER CONTROLLED SUBSTANCES) HISTORY - SECTION 10A

Answer both questions *below only if you now have or have ever had a DEA or other authorization to order controlled substances. If you have never had a DEA/CDS or other authorization to order controlled substances certificate check the "Does Not Apply" box.* **Does Not Apply o**

13.	a) Has your DEA registration or other authorization related to the ordering or prescribing of drugs, including controlled substances, ever been investigated, reviewed, limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration or other authority during or under the threat of an investigation?	o YES o NO

b)	Are any such actions pending?	o YES o NO

APPLICANT RELEASE

By submitting this application, I consent to the exchange of information and documents by and between The Permanente Medical Group, Inc., Kaiser Foundation Hospitals, and Kaiser Foundation Health Plan, Inc. (herein referred to collectively as "Kaiser Permanente"), and by and between the above entities and any and all persons, institutions, individuals, licensing agencies and federal and state governmental bodies with whom I have been associated which are material to evaluating and monitoring my professional practices, employment, qualifications, competence or ethics.

I also authorize my professional liability insurance carrier(s) to disclose to Kaiser Permanente information regarding any malpractice claim, settlement and/or judgment made against the undersigned known to the carrier. I hereby release the carrier from any liability resulting from the authorized disclosure of this information.

I understand that Kaiser Permanente may perform searches of public records and other available data sources to investigate my personal and professional history.

I hereby release The Permanente Medical Group, Inc., Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc., and their representative(s) from liability for all acts performed and statements made in good faith in connection with evaluating my application and credentials and in monitoring my professional activities. I further release from liability all individuals and organizations which, in good faith, provide information to The Permanente Medical Group, Inc., Kaiser Foundation Hospitals and/or Kaiser Foundation Health Plan, Inc., including otherwise privileged or confidential information.

I understand that Kaiser Permanente will rely upon the information given in this application to assess my qualifications. Such information will be considered confidential. However, where permitted by law, I understand that I may review, and authorized persons may have access to, the application and any related information. Also, where appropriate, I may correct erroneous information.

I understand that the Professional Staff of hospitals and/or Ambulatory Surgery Centers to which I apply for clinical privileges and/or the management of the Kaiser Foundation Health Plan, Inc., and The Permanente Medical Group, Inc. are responsible for the evaluation of my professional competence and qualifications, and have the obligation to inquire into my professional training, experience, professional conduct and judgment and to make appropriate recommendations to the governing body of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., and/or The Permanente Medical Group, Inc.

_____ ____/____/____

APPLICANT SIGNATURE DATE

_____

PRINT NAME

APPLICANT AGREEMENT/ ATTESTATION

By filing this application, I agree to be bound by the bylaws, rules and regulations of the Professional Staff of any Kaiser Foundation Hospital and/or Ambulatory Surgery Center to which I have applied for membership and/or clinical privileges. Where applicable, I also agree to be bound by the policies, rules and regulations of The Permanente Medical Group, Inc. I agree that it is my duty and ethical responsibility as an individual practitioner and as an applicant for clinical privileges, and/or as an employee of The Permanente Medical Group, Inc., to cooperate with and assist colleagues in evaluating not only my professional qualifications, but also those of my colleagues. I agree to appear before Professional Staff officers and committees for interviews and inquiries at reasonable times and places.

If hired, appointed, granted clinical privileges and/or credentialed, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referrals; (2) refrain from delegating responsibility for diagnoses or care of patients to any practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever appropriate, necessary or required; (5) abide by generally recognized ethical principles applicable to my profession, including maintaining patient confidentiality; (6) provide continuous care and supervision as needed to all patients for whom I have responsibility; (7) accept such duties and responsibilities as shall be assigned to me by The Permanente Medical Group, Inc., and/or the Professional Staff and the hospital; (8) practice within the scope of my delineated privileges in the hospital and within the scope of practice authorized by The Permanente Medical Group, Inc., where applicable; and (9) maintain eligibility to accept Medicare/Medicaid payment.

I hereby affirm that the information furnished by me in connection with this application is true, accurate and complete to the best of my knowledge. I understand that I have the burden of producing adequate and complete information for the proper evaluation of this application. I agree to inform Kaiser Permanente of any changes or modifications to the information provided herein so that, at all times, Kaiser Permanente has accurate, complete and current information.

I also agree to provide updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc., or their authorized representatives. I understand that failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

The information given in this application is accurate, current and complete and represents the current level of my training, experience, capability and competence to exercise the clinical privileges requested and/or perform the duties of the position applied for. Where appropriate, I may correct erroneous information and, upon request, have the right be informed of the status of my credentialing and recredentialing application. However, as a condition to making this application, I understand that any material misrepresentations or misstatements in or omissions from this application, whether intentional or not, shall constitute cause for automatic and immediate denial of employment, credentialing and/or clinical privileges. If credentialing, employment and/or privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate suspension or termination of such employment, credentialing and membership and/or clinical privileges.

I understand that my employment, credentialing and/or the granting of membership and clinical privileges is contingent upon my furnishing information regarding my health status and demonstrating that my physical and mental health are adequate to perform the essential duties of the clinical privileges and/or position applied for.

_____ ____/____/____

APPLICANT SIGNATURE DATE

_____

PRINT NAME

ACTIONS

CREDENTIALING
CLINICAL PRIVILEGES

Service/Department Chief:

Recommended: _____

Not Recommended: _____

_____

Date: _____

Credentials & Privileges Committee:

Approved (Office Based Only): _____

Recommended: _____

_____

Not Recommended: _____

Date: _____

CLINICAL PRIVILEGES

Executive Committee:

Recommended: _____

Not Recommended: _____

_____

Date: _____

Assistant Secretary/Board of Directors/
Kaiser Foundation Hospitals:

Approved: _____

Not Approved: _____

_____

Date: _____