Applicant's Name:	Degree:
Mailing Address: Is this: __ Work __ Home	
Phone Number:	Work: Home:
Fax Number:	Work: Home:
Cell Phone/Pager:	Cell Phone: Pager:
E-mail Address:	
Contact Person in your office to confirm receipt of faxes and give status reports.	Name: Phone: Extension: Office Title:
Tax I.D. # or Social Security #	
Professional License(s): Please list **ALL** states in which you **HAVE BEEN** licensed, the license number and expiration date. **Also, please submit a copy of your Medical License Certificate for EACH state in which you are currently licensed.**	State License # Expiration Date Active Inactive 1. _____ _____ _____ ❑ ❑ 2. _____ _____ _____ ❑ ❑ 3. _____ _____ _____ ❑ ❑ 4. _____ _____ _____ ❑ ❑ *If more, please submit on separate page and attach to the application*
Appeal level Reviewers must be Board Certified. (M.D.'s / D.O.'s must be certified by ABMS or ABOS) **Please list ALL specialties in which you are Board Certified and submit a copy of your Board Certification for each specialty.**	Specialty Board Certified? Board Eligible? Name of Board: Expiration Date: 1. _____ ❑ Yes ❑ Yes _____ _____ 2. _____ ❑ Yes ❑ Yes _____ _____ 3. _____ ❑ Yes ❑ Yes _____ _____ 4. _____ ❑ Yes ❑ Yes _____ _____
Major Professional Activity (focus within your specialty)	Age Groups: ❑ Adult ❑ Pediatric ❑ Teen Anatomical Specialties: Treatment Specialties (i.e. arthritis, joint replacement):
Briefly name your professional achievements (suitable for including in a summary of experience)	
Patient Care History: Please answer all four questions.	1) Do you currently provide direct patient care? ❑ Yes ❑ No _____ **# hours per week** 2) Do you have at least 5 years full-time equivalent (37.5-40 hrs/wk) experience in providing direct patient care? ❑ Yes ❑ No 3) Indicate month/year when direct patient care began. _____/_____ ***Please provide details in your CV.*** Ended (if applicable) _____/_____ 4) What other activity do you engage in that you consider "active practice": _____ **# hours per week** _____
Organizations for which you currently provide utilization review services:	
List any areas which may pose a conflict of interest for you in the performance of reviews for PRN:	

Are there any past, present or pending actions against your professional license? Include: Malpractice Suits, Investigations of Wrongdoing, Disciplinary Actions such as Reprimands, Probation, License Limitations, Suspensions or Revocations, Fines or Penalties, including OIG and SAM compliance	❑ No ❑ Yes If Yes, please provide a full explanation on Page 3 and attach copies of any legal documents related to the incident(s), including but not limited to the initial complaint or charges, findings and orders.
Have you ever been under investigation or convicted of a felony, including tax evasion?	❑ No ❑ Yes If yes, please provide an explanation on a separate sheet.
Hospital Affiliation(s)	Name Medical Staff Status Address
Professional Reference #1: **References must currently not be related to you by family or current/pending professional partnership/financial arrangement (Not an Associate.)**	Name: Specialty: Phone Street Address: FAX #: City State, Zip:
Professional Reference #2:	Name: Specialty: Phone Street Address: FAX #: City State, Zip:

Please mail or fax your completed application with copies of the following documents to the Credentialing Department. To expedite processing of your application, please fax all documents to: (602) 944-2028.

1. Curriculum Vitae (Work History for past 5 years in month/year to month/year format. Please explain any gaps in excess of 6 months)
2. Medical or Professional License(s) **for all states in which you are licensed**
3. Board Certification(s) **for all specialties in which you are board certified**

NOTICE: You have the right, upon request, to review information we have obtained to evaluate your credentialing application, attestation or CV. You also have the right to correct erroneous information and to receive the status of your credentialing or re-credentialing application upon request.. For further details regarding your rights please refer to the separate Physician Orientation Manual, under the heading: "Reviewer Rights".

Submission of false information or omission of information requested is grounds for suspension of reviewer privileges.

CERTIFICATION - By signing below, I certify/attest to the following:

1) No physical, mental, or substance abuse problems exist that could, without reasonable accommodation, affect my professional judgment or impede my ability to participate in utilization review activities.
2) That Physicians' Review Network is authorized to investigate and evaluate my application, and consult with any person, organization, or entity that has, or could have, any information, data, or documents regarding my background, competence and credentials.
3) That any individual, organization or entity providing information regarding my background, competence and credentials is authorized to release such information to Physicians' Review Network and I release from liability Physicians Review Network and any individual, organization or entity for any act or omission related to the collection or release of information provided in good faith.
4) That the information contained in this application and supporting documents is true, complete, and accurate to the best of my knowledge.

DATE: _____

Reviewer Signature (Will be used as electronic signature, Please stay within box)

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CONFIDENTAL INFORMATION REPORT

If you answered "Yes" to the question on page 2 regarding past or present actions against your professional license, please copy and complete the following form for <u>each</u> incident reported. Please attach any legal documents available. ***PLEASE PRINT***

Month / Year of Incident _____ County/State Recorded _____

Summary describing nature of incident (complaint, allegation) _____

_____

_____

_____

_____

_____

_____

_____

What was your response to the allegation(s)? _____

_____

_____

_____

_____

_____

_____

Disposition of Claim: ☐ Dropped ☐ Dismissed ☐ Pending ☐ Settled, Amount: _____

☐ With prejudice ☐ Without prejudice

☐ Verdict for you, Amount: _____ ☐ Verdict for plaintiff, Amount: _____

Reviewer Signature: _____ Date: _____