Diversified Dental Services, Inc.

APPLICATION FOR PARTICIPATION

INITIAL CREDENTIALING APPLICATION

PERSONAL DATA

Name_____ Date of Birth_____

Other Name (s) Previously Used_____ Effective_____

Social Security Number_____ UPIN#_____ Medicaid_____

Medicare#_____ NPI Type 1 (Personal)_____ NPI Type 2 (Corporate)_____

Local Residence:_____

Address Phone

PROFESSIONAL LICENSES

Dental License #_____ Date Issued_____ Date Expires_____

Other State Licenses:

State Number Issue Date Expiration Date

_____

_____

_____

DEA REGISTRATION

Attach copy of certificate

Federal DEA Registration #_____ Date Expires_____

State Pharmacy (if applicable) #_____ Date Expires_____

Other State Pharmacy Licenses:

State Number Issue Date Expiration Date

_____

EDUCATION/TRAINING

DENTAL EDUCATION

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM: Mo/Yr TO: Mo/Yr Degree Earned

_____

Facility Name

_____

Mailing Address

_____

Phone FAX

_____

FROM: Mo/Yr TO: Mo/Yr Degree Earned

DENTAL EDUCATION (con't)

Internship/Residency (if applicable) Type_____(Specialty)

Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Degree Earned

OTHER POST GRADUATE EDUCATION

List in chronological order and include copies of certificates

Facility Name Specialty & Degree Awarded

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

HOSPITAL AND OTHER HEALTH CARE ENTITY MEMBERSHIPS

List ALL hospitals and surgical centers where you currently have or have had affiliation, membership and/or have been granted privileges. If you have withdrawn an application or you are no longer affiliated with a hospital or surgical center; provide an explanation on a separate page. If an explanation is attached, make sure the original entry is denoted. For any time period not covered by an affiliation or training, please provide a written explanation.

Hospital/Surgical Center

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Staff Category_____( ) Check here if explanation is attached

BOARD CERTIFICATIONS

Attach copies of certificate (s)

This section pertains to specialty boards that are organized and recognized by the American Dental Association.

Name of Specialty Board

Mailing Address

Date of Certification_____ Expiration Date_____

If **not** certified, indicate current status_____

If **not** certified, are you scheduled to take the exam? If so, when? _____

If you have ever failed a board examination, please indicate Board and date_____

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of dental school. For any time period **not** covered by an affiliation or training, please provide a written explanation.

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number FAX Number

PEER RECOMMENDATIONS

Criteria for peer references include: Local practitioners with your same level of licensure (e.g. MD/DO, DDS/DDS, DMD/DDS, DPM/DPM, APN/APN, PA/PA, RNFA/RNFA, etc.), personal knowledge of your current clinical abilities, ethical character and ability to work with others. Unacceptable references include relatives, current or pending professional partners/financial associates. Recommended peers: Hospital department chairs, practitioners in your specialty with whom you have worked a minimum of two of these peers should be of your same specialty. If this is not possible, please provide a written explanation.

Name _____Specialty_____
Address _____
Telephone _____ Fax _____

Name _____Specialty_____
Address _____
Telephone _____ Fax _____

Name _____Specialty_____
Address _____
Telephone _____ Fax _____

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Present Carrier_____

_____

Mailing Address

_____

Phone FAX

_____

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim $_____ Aggregate $_____

PRACTITIONER QUESTIONNARIE

If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status.

A. Has your license to practice medicine in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reason, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

C. Have your admitting or clinical privilege (s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

D. Have you ever voluntarily or involuntarily terminated, relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? ☐ **YES** ☐ **NO**

E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity ever been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

F. Have you ever voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? ☐ **YES** ☐ **NO**

G. Has membership or status in any state or local professional society or other comparable medical organization ever been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings or investigations toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs ever been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

I. Has a letter of concern or reprimand ever been issued to you? ☐ **YES** ☐ **NO**

J. Have you ever been denied professional liability insurance or has your policy ever been canceled? ☐ **YES** ☐ **NO**

K. (1) Have you ever been named in a complaint based on allegations or professional negligence or professional misconduct or have you ever received notice of an intent to commence litigation of that type? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case. ☐ **YES** ☐ **NO**

(2) With regard to any suit, has it resulted in a judgement, a settlement, or other final disposition, or is it still pending? Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case. ☐ **YES** ☐ **NO**

L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedure (s) or practicing portions of your specialty for which you are requesting privileges? ☐ **YES** ☐ **NO**

M. Has your specialty board certification or eligibility ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigation toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

N. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? ☐ **YES** ☐ **NO**

O. Have you ever been convicted of a criminal offense other than a minor traffic violation? ☐ YES ☐ NO

P. Are you now or have you **ever** been addicted to a controlled substance or alcohol? **If the answer to this question is yes, please provide the name, address and a full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. An organization may require that you complete a Health Status Form which provides the name an title of the individual/organization (counselor/diversion program/treating provider) who can advocate on behalf of your sobriety status.** ☐ YES ☐ NO

Q. Do you currently use illegal drugs? ☐ YES ☐ NO

R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care meeting the standards controlling the award of privileges and status that you seek? ☐ YES ☐ NO

S. Would you require an accommodation in order for you to exercise medical staff duties or the privileges requested safely and completely? ☐ YES ☐ NO

Required: Please explain any "no" answers to questions below.

T. Does your office utilize proper infection control and barrier techniques? ☐ YES ☐ NO

U. Does you office comply with OSHA requirements? ☐ YES ☐ NO

Question Explanation– Use this space to explain any "yes" answers to questions A-S and any "no" answers to questions T-U. (Attach additional sheet(s) if necessary)

MALPRACTICE CLAIM INFORMATION WORKSHEET

Please duplicate this form and complete for EACH case. Also, for each case that has been settled or dismissed, supply court documentation.

Practitioner Name_____

1. Patient Name_____
2. Diagnosis_____
3. Your involvement in the case (attending, consulting, etc.)_____

   _____
4. Allegation(s)_____

   _____
5. Clinical Case Summary (Include additional pages or inserts if necessary)

   _____

   _____
6. Patient Outcome_____

   _____
7. Other Pertinent Details_____

   _____
8. Date of Incident_____Date Filed_____Date Closed_____
9. Resolution of Case (dismissed, settled out of court, litigated, other)

   NOTE: All cases litigated must include legal documentation.

   _____

   _____
10. Settlement amount paid on you behalf, if any

    _____
11. Professional liability insurer involved:

    A. Name of Insurer_____B. Policy #_____

    B. Address of Insurer

       _____

       _____

Name:_____

Signature:_____**Date:**_____

☐ No claims to Report

Regardless of whether you have had any claims, this form must be signed and dated.

Authorization and Releases - Required

I authorize Diversified Dental Services (DDS) and its clients to obtain information from others including state licensing authorities, certification boards, professional liability insurance carriers (including claim histories and loss reports), hospitals, substance-abuse programs, and healthcare-related employers, about my qualifications, including without limitation, my professional competence and conduct. I further authorize, DDS and its clients, to release information on this form to their parent organizations, affiliates, subsidiaries, employees, and agents.

I consent to the release to DDS of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I release DDS, and any persons or entities providing information to DDS or evaluating the information received or provided on this form, from any and all liability, providing their acts were performed in good faith and without malice.

I understand I have the burden of providing adequate information to DDS to demonstrate my qualifications. I understand and agree that any misstatement or material omission on this form may constitute grounds for rejection of my application or dismissal as a member or participating provider with DDS or its client-sponsored networks. I understand and agree that it is my obligation to immediately notify DDS if any material changes occur in the information I have provided on this form. I understand that statements written on this form will be considered statements made by me, even if prepared by an employee, agent, or representative.

I understand that my misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership and privileges. I also understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application.

I attest that the information contained on this form is correct and complete.

Dentist's name (please print):_____

Dentist's signature (original signature only—no stamps):_____

Date:_____