



Experience the Difference!



HARRIS MEDICAL ASSOCIATES, LLC
1180 Satellite Blvd., Suite 200, Suwanee, GA 30024
Phone: (800) 980-2385 • Fax: (770) 495-0409

GENERAL INSTRUCTIONS

Harris Medical Associates, LLC must credential all providers prior to placement into any practice location. All information requested in this application is necessary to complete the credentialing process. This information is based on the standards for credentialing established by the National Committee for Quality Assurance (NCQA). Failure to provide the specific requested information will result in delay in verification and approval of your credentialing file.

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

- ▶ **Type or print legibly your responses.**
- ▶ **Note that modification to the wording or format of this application or agreement will invalidate it.**
- ▶ **All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments.**
- ▶ **Note that “See CV” is only acceptable for the education section of this application and only then if month/years are provided and complete address of each school or training facility is provided.**
- ▶ **Month/year must be provided in the work history section. Any gap of time greater than sixty (60) days during the five year period must be explained.**
- ▶ **If a particular section does not apply to you, write “n/a” in that section.**
- ▶ **Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.**
- ▶ **Please sign and provide a current date on the attestation and release pages of the application, the provider agreement and any other forms completed.**
- ▶ **After the application has been completed in its entirety, make a copy of the application to retain in your files or computer for future use. Attach all documentation shown on the next page to your application prior to mailing.**



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PHYSICIAN INITIAL CREDENTIALING CHECKLIST

- _____ **Completed Credentialing Application**
- _____ **Signed and Currently Dated Attestation and Release forms**
- _____ **Completed and signed attached W-9 form**
- _____ **Current Curriculum Vitae with Complete Professional History in Chronological order (month and year must be included)**
- _____ **Copy of Medical School Diploma and Training Certificate(s),**
- _____ **Current CME (list of CME activity for the past two years)**
- _____ **Copy of ECFMG Certificate (if applicable) and Copy of Certificate of Diplomate of National Board of Medical Examiners (if applicable)**
- _____ **Copy of Current Board Certificate or letter from Board(s) stating your status (if applicable)**
- _____ **Copy of All Current Active State License Wallet Card(s)**
- _____ **Copy of Federal DEA and State Controlled Substance Registrations or Certificate(s)**
- _____ **Copy of Any: BLS, ACLS, ATLS, PALS, APLS Certificate(s)**
- _____ **Certificate of Professional Liability Insurance Coverage or Declaration Page (Face Sheet) of Policy**
- _____ **Third party documentation for all Malpractice/Disciplinary Actions OR Completion of Appropriate Explanation Form Attached (if applicable)**
- _____ **Permanent Resident Card, Green Card or Visa Status (if applicable)**
- _____ **Note: All non United States citizens must provide a copy of their green card**
- _____ **Military Discharge Record -Form DD-214 (if applicable)**
- _____ **3 Written Letters of Recommendation From Providers Who Have Directly Observed You In Practice Within the Past Year. (Please ask them to specify the date they last observed you in practice - month/year)**
- _____ **Signed Provider Agreement**
- _____ **Recent Photograph**
- _____ **Copies of Current Immunization records and current TB test results (if available)**

Please return all of the above requested documents in the preferred following format:

SCAN and EMAIL to: Mark Stinnett VP Government Services: mstinnett@harrismedical.com

If no scan capability FAX to: Mark Stinnett at (770) 495-0409

If you have any questions or need further information, please call the Credentialing Department at (800) 980-2385 or (770) 497-9685.

THANK YOU FOR YOUR PROMPT RESPONSE!



HARRIS MEDICAL ASSOCIATES, LLC

PHYSICIAN INITIAL CREDENTIALING APPLICATION

Personal Information	Last Name Suffix((Jr, Sr, III) First Name Middle			Degree	Social Security Number	
	Home Address				Home Phone Number	
	City		State		Zip code	
	Office Address				Office Phone Number	
	City		State		Zip code	
	Citizenship		Birthplace	Date of Birth		Email address:
Education And Training	Medical School				Degree	
	Dates (From mm/yy To mm/yy)			City State		
	PGY1 (Internship) Training -- Facility Name				City	State
	Dates (From mm/yy To mm/yy)			Category of Training		
	Residency Training -- Facility Name				City	State
	Dates (From mm/yy To mm/yy)			Specialty		
	Fellowship Training -- Facility Name				City	State
	Dates (From mm/yy To mm/yy)			Specialty		
	Additional Training -- Facility Name				City	State
	Dates (From mm/yy To mm/yy)			Category of Training		
	Additional Training -- Facility Name				City	State
	Dates (From mm/yy To mm/yy)			Category of Training		
Board Certification	Specialty Board		Board Certified	Board Eligible	Date Certified	Certificate Number
			<input type="checkbox"/>	<input type="checkbox"/>		
	Specialty Board		Board Certified	Board Eligible	Date Certified	Certificate Number
		<input type="checkbox"/>	<input type="checkbox"/>			
Specialty Board		Board Certified	Board Eligible	Date Certified	Certificate Number	Recertification Date
		<input type="checkbox"/>	<input type="checkbox"/>			
Clinical Certification	BLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/>		ACLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/>		ATLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/>	
PALS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/>						
Federal Provider	Federal DEA Number		DEA Expiration Date	NPI Number	Medicare #/State: BC/BS #/State	Medicaid #/State Champus/Railroad #
Foreign Graduates	Do you have a permanent ECFMG Certificate? Yes <input type="checkbox"/> No <input type="checkbox"/>			ECFMG Certificate #r		Did you do a fifth Pathway? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Do you have a pending Social Service requirement Yes <input type="checkbox"/> No <input type="checkbox"/>			Did you take the FMGEMS? Yes <input type="checkbox"/> No <input type="checkbox"/>		



HARRIS MEDICAL ASSOCIATES, LLC APPLICATION Cont'd

Provider Name: _____

Licensing Exams Taken:	National Boards: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	FLEX: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	SPEX: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____
	USMLE: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____	State Boards: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____ State: _____	LMCC: Yes <input type="checkbox"/> No <input type="checkbox"/> Date Taken: _____

Please enter the information in the table below for all states in which you have held a medical license.

L I C E N S U R E

STATE	LICENSE NUMBER	LICENSE STATUS	DATE LICENSE GRANTED (MM/YY)	LICENSE EXPIRATION DATE (MM/DD/YY)	MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER	CONTROLLED SUBSTANCE PERMIT NUMBER
		Initial License <input type="checkbox"/> <input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					

Additional licenses listed on attached sheet

*Please list four **physician** references that are able to comment upon your **current (within the past year)** clinical and professional capabilities.*

R E F E R E N C E S

Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #



HARRIS MEDICAL ASSOCIATES, LLC

APPLICATION Cont'd

Provider Name: _____

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form and include any additional documentation if necessary.

Have any of the following ever been, or are currently in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.

1. Medical License in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Institutional affiliation / status? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. DEA Registration (federal or state programs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Professional society membership or fellowship / Board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Other Professional Registration / License <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Any professional sanction (e.g. government, administrative agency or other)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Clinical Privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Membership / Rights on any medical staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently using illegal drugs or legal drugs in an illegal manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? If yes, explain on the attached form	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a felony or misdemeanor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been denied professional liability insurance or denied renewal of an existing policy? If the answer to the above question is "YES" please attach a brief explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any malpractice claims, suits, settlements, or arbitration proceedings been made against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case on the attached Professional Liability Claims Information Form..

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Dismissed / Settled / Judgment / Pending)	Date of Incident (mm/yy)	Amount of Award or Settlement (if appropriate)
# 1					Summary Included <input type="checkbox"/>
# 2					Summary Included <input type="checkbox"/>
# 3					Summary Included <input type="checkbox"/>
# 4					Summary Included <input type="checkbox"/>

Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed below.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage

DISCIPLINARY ACTIONS

MALPRACTICE CLAIMS

HISTORY



HARRIS MEDICAL ASSOCIATES, LLC APPLICATION Cont'd

Please list all your practice locations and employment affiliations to cover at least the past five years of clinical practice. Please list month and year for all effective dates. Please provide a separate explanation of work gaps over 60 days in duration. If you desire that we do not contact these facilities, please check the appropriate box and attach a letter of explanation.

WORK HISTORY

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code

PREVIOUS LOCUM TENENS EXPERIENCE:

Please list all previous locum tenens experience in the spaces below. Use additional pages as necessary.

Name of Facility _____
 Address _____
 Phone # _____ FAX # _____
 Dates of Coverage: _____

Name of Facility _____
 Address _____
 Phone # _____ FAX # _____
 Dates of Coverage: _____

Name of Facility _____
 Address _____
 Phone # _____ FAX # _____
 Dates of Coverage: _____

Name of Facility _____
 Address _____
 Phone # _____ FAX # _____
 Dates of Coverage: _____

Name of Facility _____
 Address _____
 Phone # _____ FAX # _____
 Dates of Coverage: _____



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ATTESTATION AND SIGNATURE

I hereby affirm that the information provided by me on this application and attachments is true, complete and correct and that Harris Medical Associates, LLC (“Harris Medical”) will rely on the truthfulness of my statements in evaluating my potential as an independent contractor physician for locum tenens assignments or potential for referral for a permanent position. I further acknowledge that (a) the decision to offer me as a candidate is solely at the discretion of Harris Medical, (b) any information received from references or other agencies by Harris Medical may not be released to me without the consent of the reference or agency, and (c) I agree that I will not enter into an arrangement to provide temporary or permanent physician services with any individual, group or institution to whom I am referred by Harris Medical except through Harris Medical with the written consent of Harris Medical.

Applicant’s Signature: _____ **Date:** _____

Print Name: _____



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ATTACH RECENT PHOTO HERE

RELEASE AND WAIVER

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to Harris Medical Associates, LLC (“Harris Medical”) or its agents:

1. All hospitals at which I have held staff privileges, whether full or limited, temporary or permanent; and all hospitals at which I have received training.
2. All medical/osteopathic societies, educational institutions, specialty boards, and other medical/osteopathic organizations with which I have been associated.
3. All state or Canadian health care licensure boards, federal health agencies to include the National Practitioner Data Bank, and federal and state drug control agencies.
4. All licensed physicians, nurses or other health care professionals of any state, commonwealth, district, or Canadian province.
5. All agencies from which I currently have or previously have obtained malpractice insurance coverage.
6. All attorneys who have participated in civil or criminal actions in which I was named party that pertain to or directly affect my ability to obtain or retain a state medical license, obtain or retain clinical privileges and/or practice medicine.

I hereby release the above-named individuals and entities from all liability for the release of information to Harris Medical or its agents.

I further authorize Harris Medical or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirement for the granting of clinical privileges as an independent contractor or for licensure, and I further authorize them to release such information they now or may have in the future concerning me to any federal, state, county or local governmental entity or any hospital or other health care facility upon showing that the release of the information is vital to the health, safety, and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing Harris Medical or its agents to carry out its duties pursuant to my request for evaluation of my credentials for clinical privileges and/or a license to practice my profession.

Applicant’s Signature: _____ **Date:** _____

Print Name: _____



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PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential.

Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; For recredentialing, just complete separate forms for the past two (2) years. One case per sheet only (please photocopy first if additional sheets are needed)

PROVIDER'S NAME (required): _____

1. Claim filed by Name:

Name of Patient Involved: _____ Age: _____
 Month and Year of Occurrence: ____/____/____
 (event precipitating claim)
 Month and Year of Lawsuit: ____/____/____
 Insurance Carrier at Time: _____

2. What is/was your status: Primary Defendant: Co-defendant Other:
 Please Explain and list other Defendants:

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

Current Status: *(please check one)*

- Still pending: as of (date) ____/____/____
 Who is handling the defense of the case?
 Trial date set, awaiting trial? Trial Date: ____/____/____
 Settled out of court? Date: ____/____/____ Amount of Settlement: \$ _____
- Dismissed: Date: ____/____/____
- Defense Verdict: Date: ____/____/____
- Plaintiff Verdict: Date: ____/____/____
- Judgment Amount: \$ _____ Date: ____/____/____
 Amount Paid on your behalf (by you or carrier: \$ _____

This professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

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

Applicant's Signature: _____ **Date:** _____

Print Name: _____

