

Teachers Health Trust  
2950 East Rochelle  
Las Vegas, NV 89121



## **Teachers Health Trust**

### **Credentialing Application**

**Please complete the enclosed credentialing application or provide an application that you have used previously that contains the information requested. Please ensure that any copies used include an updated doctor's signature and date. This application must be typed or legibly printed. If more space is needed than provided, attach additional sheets.**

**PLEASE MAINTAIN A COPY OF YOUR COMPLETED APPLICATION FOR YOUR FILES.**

**Attach copies of the following documents:**

- Current Nevada Medical License**
- Current Federal DEA License**
- Current State Pharmacy License**
- Current Professional Liability Insurance**
- Copy of current Curriculum Vitae (include month/year) ECFMG Certificate (if foreign grad.)**
- Copy of W-9/EIN**
- Copy of CLIA Certification**

**Please allow at least sixty (60) days to process your application.**



### PHYSICIAN DATA

Name:		NPI:	
Other Name(s) Previously Used:		Physician Start Date:	
Physician Specialty (list all starting with primary):		Date of Birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Place of Birth:			
Citizenship:			

#### If not a US Citizen:

Visa Number:	Status:	Expiration Date:
Foreign Languages Spoken:		

### Local Residence

Complete Address:	
Telephone Number:	E-mail Address:
Date of Relocation to Nevada (if applicable):	

### PRIVATE AND OTHER PRACTICE INFORMATION

*List any private practice affiliations or other employment since completion of medical school.*

Practice Name	City and State	From (mm/dd/yy)	To (mm/dd/yy)

### PRACTICE INFORMATION

Tax ID:	NPI:	Medicaid:
Group/Practice Name (DBA):		
Date practice began/will begin:	Primary Specialty:	
List all additional Specialties (use additional pages if necessary):		



### Contact Information for Your Practice

Billing Address:	
Phone Number:	Fax Number:
Primary Contact:	
Practitioner's Beeper/Cell Number:	Answering Service Number:

Credentialing Address:	
Phone Number:	Fax Number:
Primary Contact:	E-Mail:

### Physical Locations and Phone Numbers of all Offices in Your Practice

*(If additional space is needed, you may copy this form or submit on a separate sheet of paper)*

- |          |      |
|----------|------|
| Address: |      |
| Phone:   | Fax: |
- |          |      |
|----------|------|
| Address: |      |
| Phone:   | Fax: |
- |          |      |
|----------|------|
| Address: |      |
| Phone:   | Fax: |
- |          |      |
|----------|------|
| Address: |      |
| Phone:   | Fax: |



**Location Information**

Are you currently accepting new patients into your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If no, explain:								
<b>Office Hours</b>								
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
From:								
To:								
Describe after-hours patient care operation:								
Any practice restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If yes, please explain:								
Office accessible to disabled pursuant to ADA Guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Languages, other than English, spoken in your office:								
Do you wish these languages to be listed in a provider directory? <input type="checkbox"/> Yes <input type="checkbox"/> No					Do you accept Medicare assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please indicate your primary location by circling its correspond number from the Physical Location on Page 3:					1	2	3	4

**PROFESSIONAL LICENSES**

*(Attach copies of license(s))*

*Nevada or Other State(s) in which you are currently practicing (must include number and expiration date)*

State:	Medical License Number:	Date Issued:	Date Expires:
NV			

**DEA AND STATE PHARMACY REGISTRATIONS**

*(Attach copies of certificates)*

Federal DEA Registration Number:	Date Expires:
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**State Pharmacy Registrations**

State:	State Pharmacy Number:	Date Expires:
NV		



## EDUCATION/TRAINING

### Medical/Dental Education

Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Degree Earned:	

### Internship

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	

### Internship

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	



### Residency

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	

### Other Residency

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	

### Fellowship

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	



### Fifth Pathway

*(Required to be completed by Non-USA Grads in Lieu of ECFMG Certification) Please attached a copy of certificate*

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	

### OTHER POST GRADUATE EDUCATION

*(List in chronological order and include copies of certificates)*

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	

Specialty:	
Facility Name:	
Mailing Address:	
Phone:	Fax:
From: Mo/Yr	To: Mo/Yr
Program Director:	



### BOARD CERTIFICATIONS

*(Attach copy of certificate(s))*

*Certification (this section pertains to specialty boards that are organized and recognized by the American Board of Medical Specialties or American Osteopathic Association)*

Name of Specialty Board:	
Mailing Address:	
Date of Certification:	Expiration Date:
If not certified, are you scheduled to take the exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of exam:

Name of Specialty Board:	
Mailing Address:	
Date of Certification:	Expiration Date:
If not certified, are you scheduled to take the exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of exam:

If you have ever failed any board examination, please indicate Board and date:
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### MILITARY SERVICE

*(Attach copy of discharge papers)*

Have you ever served or are you currently serving in the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Branch of Service:		
From:	To:	Type of Discharge:



### 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.

Hospital/Surgical Center	City/State	From	To	Type
Boulder City Hospital	Boulder City, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Centennial Hills Hospital Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Colorado River Medical Center	Needles, CA			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Desert Springs Hospital Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Dixie Regional Medical Center	St. George, UT			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Flamingo Surgery Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Goldring Surgical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Las Vegas Surgery Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Mountain View Hospital	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
North Vista Hospital	N Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Parkway Surgery Center	Henderson, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Plaza Surgical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Sahara Surgery Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Southern Hills Hospital	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Spring Valley Hospital Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
St Rose Dominican Hospital- De Lima	Henderson, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges



Hospital/Surgical Center	City/State	From	To	Type
St Rose Dominican Hospital-Siena	Henderson, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
St Rose Dominican Hospital-San.Martin	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Summerlin Hospital Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Sunrise Hospital and Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
University Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Valley Hospital Medical Center	Las Vegas, NV			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges
Valley View Medical Center	Bullhead City, AZ			<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges

### Additional Facilities

Hospital/Surgical Center:				
Mailing Address:				
City/State:				
Phone Number:		Fax Number:		Contact Person:
From:	To:	<input type="checkbox"/> Affiliation	<input type="checkbox"/> Membership	<input type="checkbox"/> Privileges

Hospital/Surgical Center:				
Mailing Address:				
City/State:				
Phone Number:		Fax Number:		Contact Person:
From:	To:	<input type="checkbox"/> Affiliation	<input type="checkbox"/> Membership	<input type="checkbox"/> Privileges



Hospital/Surgical Center:		
Mailing Address:		
City/State:		
Phone Number:	Fax Number:	Contact Person:
From:	To:	<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges

Hospital/Surgical Center:		
Mailing Address:		
City/State:		
Phone Number:	Fax Number:	Contact Person:
From:	To:	<input type="checkbox"/> Affiliation <input type="checkbox"/> Membership <input type="checkbox"/> Privileges



### PERSONAL LIABILITY (MALPRACTICE) INSURANCE

(Attach copy of present policy face sheet and ALL insurance carriers for the **past 5 years.**  
Attach additional sheets if necessary)

Present Carrier for Nevada Practice:		
Mailing Address:		
Telephone Number:		Fax Number:
Policy#:	Effective Date:	Expiration Date:
Amounts of Coverage- Minimum 1Mil/3Mil		
Occurrence/Claim:		Aggregate:

Previous Carrier:		
Mailing Address:		
Telephone Number:		Fax Number:
Policy#:	Effective Date:	Expiration Date:
Amounts of Coverage- Minimum 1Mil/3Mil		
Occurrence/Claim:		Aggregate:

Previous Carrier:		
Mailing Address:		
Telephone Number:		Fax Number:
Policy#:	Effective Date:	Expiration Date:
Amounts of Coverage- Minimum 1Mil/3Mil		
Occurrence/Claim:		Aggregate:



## STATEMENT OF UNDERSTANDING, AUTHORIZATION, CONSENT AND RELEASE

I understand that any misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership in the Teachers Health Trust's provider network. I also have had an opportunity to review the information submitted in support of this application. If during the process of credentialing, the Teachers Health Trust's provider network 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 recognize that as the applicant I bear the burden of demonstrating that I am qualified and remain qualified for the award of membership in accord with the criteria and standards required by the Teachers Health Trust's provider network, and I recognize that I have the burden of resolving any reasonable doubts about my qualifications for membership, participation and privileges.

In order to facilitate the evaluation of this application, I agree to meet and cooperate with the various officers, representatives and committees charged with responsibility for credentialing and peer review activities. Moreover, I consent to the communication and release of information and documents (including medical staff records and patient care records) among the specified medical centers, medical staffs and other entities which I have disclosed in this application and any and all other hospitals, medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurers, licensing authorities, specialty boards, health maintenance organizations, medical groups, ambulatory or outpatient care center, clinics, independent practice associations and any and all other sources that may be available for the purpose of evaluating my professional education, training, experience, character, conduct and judgment. In this regard, care shall be taken to safeguard the privacy of medical information and the confidentiality of medical staff information and medical records. I understand that the evaluation of credentials shall be accomplished in a professional manner, and that I will be afforded an appropriate review in the event that action on this application is adverse in accordance with the bylaws or rules pertaining to each organization.

I specifically authorize the transmission of this application and all supporting documentation, and all information collected during the credentialing process, to each employee of the Teachers Health Trust responsible for reviewing my application.

I therefore fully release from liability any person or entity, including any and all representatives of the Teachers Health Trust and any representative, agent or component thereof, that requests or provides information in connection with the evaluation of my application, credentials and practice, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. Moreover, I fully release from liability the Teachers Health Trust and any representative, agent or component thereof, and all other persons or entities participating in the evaluation of my credentials and practice from any and all liability for their actions and decisions, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. As part of this application, I pledge that if I am granted the requested membership, I will maintain an ethical practice in accord with applicable bylaws, and specifically that I will:

- A. Refrain from fee splitting or other inducements relating to patient referral
- B. Provide for the continuous care and supervision of my patients;
- C. Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;
- D. Abide by all applicable and generally recognized ethical principals applicable to my profession and to each and every healthcare entity to which I am applying; and,
- E. Maintain the confidentiality of patient information received by both paper and electronic means.

During the time that this application is being processed, I agree to update the application should there be any material change in the information provided which may affect the application or its outcome, and I specifically agree to notify the Teachers Health Trust immediately upon notification upon any significant change or any formally recommended change in licensure status, or any actual or formally recommended denial, suspension or revocation of privileges or membership or status by another healthcare entity, or cancellation or interruption of my professional liability insurance coverage.

I present this application and arrange for the submission of other information as part of this credentialing process in the expectation that the confidentiality and privacy of this information will be preserved and that this information and these materials will only be released and disclosed as part of current and future credentialing, peer review and quality assurance processes as described above.

I affirm that all information submitted by me in this application is true, current and complete and is furnished in good faith.

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Signature of Applicant

Printed Name

Date



## MALPRACTICE CLAIM INFORMATION WORKSHEET

**Please provide complete information since the date you first became licensed to practice.**

*Please duplicate this form and complete for EACH case in which you were named as a defendant. Also, for each case that has been settled or dismissed, supply all court/legal documentation.*

Practitioner Name: <input style="width: 600px; height: 20px;" type="text"/>		
Patient Name:		
Diagnosis:		
Your involvement in the case (attending, consulting, etc.):		
Allegations:		
Clinical Case Summary (Include additional pages or inserts if necessary):		
Patient outcome:		
Other pertinent details:		
Date of Incident:	Date filed:	Date closed:
Current Status of Case <b><i>must be noted</i></b> (dismissed, settled out of court, pending, other) NOTE: All Cases must include legal documentation:		
Settlement amount paid on your behalf, if any:		
Professional liability insurer involved:		
Name of Insurer:		
Address of Insurer:		
Policy Number:		

- I have no malpractice issues to disclose.
- I certify that I have disclosed all malpractice issues.

Name	Date
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Signature **Note: This form must be signed and dated whether or not you have any items to disclose**



## PRACTITIONER QUESTIONNAIRE

***If the answer to any of the following questions is YES, please give full details on a separate sheet of paper. (Date of occurrence, description of events, and current status along with all legal documentation)***

- A. *Has your license to practice medicine in any jurisdiction ever been denied, revoked, terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, 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 care facility or ambulatory surgery center or comparable facility, ever been denied, revoked, 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
- C. *Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute 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 relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute 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 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 your 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? If Yes, provide copies*  Yes  No



- J. Have you ever been denied professional liability insurance or has your policy ever been canceled?  Yes  No
- K. Have you ever been named in a complaint filed with a state medical board or society based on allegations of professional negligence or professional misconduct or have you ever received notice of an intent to commence litigation of that type? With regard to any such complaint or suit, has it resulted in a judgment, 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 including all legal documentation.**  Yes  No
- L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedures(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 investigations 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.**  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