Community Health of Central Washington

PRE-APPLICATION FOR PROVIDERS

The information contained on this application will be used to query the National Practitioner Data Bank, perform state patrol criminal background checks, check state licenses, verify education and training, etc. By completing this form, you authorize Community Health of Central Washington to perform these verifications.

PERSONAL INFORMATION	
Name:	Specialty:
Other Name(s) Used:	Clinic Applying At:
Address:	Date of Birth: (mo/day/year)
City, State, Zip:	Social Security #: - -
Are you legally able to work for any employer in the U.S.? ☐ YES ☐ NO If "NO" please explain:	If you are working under a VISA are there any restrictions? ☐ YES ☐ NO If "YES" please explain:
How did you hear of this opening?	

EDUCATION		
Name of Professional School:	Location of Professional School: (city, state)	
Date Graduated: (mo/day/year)	Degree:	Completed: ☐ YES ☐ NO

RESIDENCY/OTHER TRAINING		
Name of Residency Training Program:	Location of Residency Program: (city, state)	
Date Graduated: (mo/day/year)	Specialty:	Completed: ☐ YES ☐ NO
Name of Other Post-Graduate Training Program:	Location of Program: (city, state)	
Date Graduated: (mo/day/year)	Degree:	Completed ☐ YES ☐ NO

BOARD CERTIFICATION			
Board Certified? ☐ YES ☐ NO	Board Eligible? ☐ YES ☐ NO	Name of Board:	Board Date: (mo/day/year) Expiration Date: (mo/day/year)

LICENSES			
License Number		State	Expiration Date
License Number		State	Expiration Date
License Number		State	Expiration Date

DEA REGISTRATION

Please return via email or regular mail to: Mari Guess, Recruiting Manager
~ Email: mari.guess@chcw.org
CHCW – 501 S 5th Ave., Yakima, WA 98902

DEA Registration Number		DEA Expiration Date (mo/day/year)

PEER REFERENCES			
List **three** professional references, from your specialty area, not including relatives, who have worked with you in the past **two** years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director.			
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	

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Please answer all of the following questions. If your answer to any of the following questions is "yes"; please provide details in the space below or on a separate sheet. If you attach additional sheets, please sign and date each sheet.

A.	**PROFESSIONAL SANCTIONS**		
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a. License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b. Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c. Specialty or subspecialty board certification	YES ☐	NO ☐
	d. Membership on any hospital medical staff	YES ☐	NO ☐
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g. Professional society membership or fellowship	YES ☐	NO ☐
	h. Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO ☐
	i. Academic Appointment	YES ☐	NO ☐
	j. Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	YES ☐	NO ☐
B.	**CRIMINAL HISTORY**		
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	YES ☐	NO ☐
	a. Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b. Are you currently under governmental investigation?	YES ☐	NO ☐
C.	**AFFIRMATION OF ABILITIES**		
1.	Do you presently use any drugs illegally?	YES ☐	NO ☐
2.	Do you have, or have you had in the last two years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. _____ If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance. _____	YES ☐	NO ☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY**		
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?	YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?	YES ☐	NO ☐

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ADVERSE ACTIONS
Please explain any adverse license sanctions, malpractice events, clinical privilege denials, criminal history or any type of investigation or discipline related to your practice below or on an attached sheet. _____

I warrant that all the statements made on this form and on any attached information sheets are true and correct. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date: _____

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