STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care pl

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

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FedeOA5LCONFIDENTIAL INFORMATIOR

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION B. PROFESSIONAL INFORMATION

☐ ☐

Current and Previous Professional License(s) in Other States

State:

Medicare Unique Provider ID# (UPIN)_____

National Provider Identification Number (NPI):_____

Medicaid ID#:_____

X-Ray Certification: _____ _____ _____

Check here if you have appended additional information for this section: ☐

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

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☐ ☐

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

☐ ☐

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application

MEDICAL/PROFESSIONAL SCHOOL

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INTERNSHIP

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FIRST RESIDENCY

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SECOND RESIDENCY

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(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

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_____ _____

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TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

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C. Other Hospital

Check here if you have appended additional information for this section: ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E.

A. Hospital Name:

B. Hospital Name:

C. Hospital Name:

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: _____

_____

_____ _____

_____

_____ **to Present**

Previous work place: _____

_____

_____ _____

_____

_____ **to:** _____

Previous work place: _____

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Previous work place: _____

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Previous work place: _____

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Previous work place: _____

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_____ **to:** _____

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. Name

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

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PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

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LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

☐ ☐

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

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☐ ☐

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

☐ ☐

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

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INVESTMENTS

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If Yes, please provide explanation _____

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CHAPTER B:
BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

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_____ _____ _____

_____ _____

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If yes _____

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☐ ☐

If yes _____

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_____

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient

Please provide the following regarding your practice at this site:

Please check all procedures you perform at this site:

☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

_____

_____

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Is this practice site handicapped accessible

☐ ☐ ☐ ☐

Does this site employ paraprofessionals for direct patient care? ☐ ☐

If yes

☐

Lab Service at this site? ☐ ☐

If yes, ☐ ☐ ☐

☐ ☐

If yes, _____

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site #

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If yes _____

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If yes _____

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Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient

Please provide the following regarding your practice at this site:

Please check all procedures you perform at this site:

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Lab Service at this site? ☐ ☐

If yes, ☐ ☐ ☐

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Signature: _____ **Date:** _____

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Signature: _____ **Date:** _____