Form KAPER-1 (03/2007)0

Commonwealth of Kentucky

Instructions - Form KAPER-1 (03/2007), Part B, Section 1

A. Uniform Application for Evaluation (Credentialing) Form. Following is the form KAPER-1 (03/2007), Part B, Section 1, developed pursuant to KRS 304.17A-535(5) for evaluation (credentialing) of a health care provider. The form is available on the Web site of the Kentucky Office of Insurance (http://doi.ppr.ky.gov/kentucky). Prior to completing this form, a health care provider who desires initial evaluation (credentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete form KAPER-1 (03/2007), Part B, Section 1, and required attachments, as applicable and specified in item C of this instruction.

I. PERSONAL IDENTIFICATION DATA

Name: ____

Last	Suffix	First	Middle	Maiden Name	Degree

II. EDUCATIONAL DATA

(All periods of time must be accounted for from entrance into medical school to the present)

Please indicate if your name at any educational institution is different than the name listed on your application. ☐ **Yes** ☐ **No**
If YES, please identify other name(s): ____

A. Schools

Chairman/Chief of Service: ______________________________

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: ______________________________ ______________________________ ____________ / ____________
Type of Residency From (mm/yy) To (mm/yy)

Address: ______________________________

City/State/ZIP: ______________________________
City St ZIP ZIP+ Country

Phone: ______________________________ Fax: ______________________________

Chairman/Chief of Service: ______________________________

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: ______________________________ ______________________________ ____________ / ____________
Type of Residency From (mm/yy) To (mm/yy)

Address: ______________________________

City/State/ZIP: ______________________________
City St ZIP ZIP+ Country

Phone: ______________________________ Fax: ______________________________

Chairman/Chief of Service: ______________________________

Did you complete the residency? ☐ Yes ☐ No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

☐ Check if more than three residencies were begun or completed. Please supply the same information on a separate sheet and attach.

D. Fellowship and/or Other Postgraduate Training

Name: ______________________________ ______________________________ ____________ / ____________
Type of Fellowship From (mm/yy) To (mm/yy)

Address: ______________________________

City/State/ZIP: ______________________________
City St ZIP ZIP+ Country

Phone: ______________________________ Fax: ______________________________

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

☐ Yes ☐ No

Name: ______________________________ ______________________________ ____________ / ____________
Type of Fellowship From (mm/yy) To (mm/yy)

Address: ______________________________

City/State/ZIP: ______________________________
City St ZIP ZIP+ Country

Phone: ______________________________ Fax: ______________________________

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
<u>If YES, please explain on a separate sheet and attach.</u>

☐ Yes ☐ No

Name: ______________________________ ______________________________ ____________ / ____________
Type of Fellowship From (mm/yy) To (mm/yy)

Address: ____

City/State/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________________ Fax: ______________________________

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
<u>If YES, please explain on a separate sheet and attach.</u>

☐ Yes ☐ No

☐

IV. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

☐ CPR	☐ Yes	☐ No	Date of Expiration ____________
☐ ACLS	☐ Yes	☐ No	Date of Expiration ____________
☐ ATLS	☐ Yes	☐ No	Date of Expiration ____________
☐ PALS	☐ Yes	☐ No	Date of Expiration ____________
☐ NRP	☐ Yes	☐ No	Date of Expiration ____________

Please attach copies of all certificates.

V. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

	State:	License #:	Date Issued:	Expiration Date:	Status:		License Obtained by:	
KY State:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #2:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #3:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #4:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #5:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #6:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #7:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #8:	____	______	______	______	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

VI. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: ______________________ Expiration: ______________________

Federal DEA Certificate #: ______________________ Expiration: ______________________

VII. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: ____

Certificate #: ______________________ Expiration: ______________________

State: ____

Certificate #: ______________________ Expiration: ______________________

VIII. PROFESSIONAL LIABILITY DATA

(This application cannot be processed without proof of amount of professional liability)

Name of Carrier: ____

Address: ____

City: ______________________ State: ____________ ZIP: ____________

Policy #: ______________________ Amount of Coverage: ______________________

Date of Inception: ____________________ Date of Expiration: ____________________

Name of Agency: ____________________

☐ CLAIMS MADE ☐ OCCURRENCE (Check One)

Please list any other professional liability carriers you have used within the last five (5) years: ____________________

____

Answer the following questions as they apply:

1. Has your professional liability insurance coverage been terminated by action of the insurance company? ☐ Yes ☐ No
2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? ☐ Yes ☐ No
3. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? ☐ Yes ☐ No
4. Have any professional liability suits or claims been filed against you? ☐ Yes ☐ No
5. Have any professional liability suits or claims been filed against you which are presently pending? ☐ Yes ☐ No
6. Have any judgments or settlements been made against you in professional liability cases? ☐ Yes ☐ No
7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund? ☐ N/A ☐ Yes ☐ No
8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act? ☐ N/A ☐ Yes ☐ No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: ____________________

List the allegations: ____________________

____

Date of occurrence: ____________________

Name of institution involved (i.e., hospital): ____________________

Name and address of insurance carriers involved: ____________________

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: ____________________

The court case number: ____________________

The venue of the case (place where court case took place, such as County District Court or Circuit Court): ____________________

____

Allegations listed in complaint: ____________________

Date of incident leading to complaint: ____________________

Place of incident: ____________________

Name and address of malpractice insurance carrier: ____________________

____

Amount of jury award or amount awarded by the court: ____________________

IX. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)
2. If yes, list full name of certifying board and date which you obtained certification/recertification:
   ______________________________ Date: ______________
   ______________________________ Date: ______________
   ______________________________ Date: ______________
   ______________________________ Date: ______________
   ______________________________ Date: ______________
3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
   ______________________________ Date: ______________
4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: ______________
5. List date of next required recertification (if applicable): ______________
6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

X. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1. Are there any actions that have been initiated or are any pending against you by any state licensing board? ☐ Yes ☐ No
   ☐ Pending ☐ Resolved
2. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? ☐ Yes ☐ No
3. Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s). ☐ Yes ☐ No
4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ Yes ☐ No
5. Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed? ☐ Yes ☐ No
6. If applicable, is your federal and/or state narcotics registration certificate being challenged? ☐ Yes ☐ No
7. Have you been named as a defendant or convicted of a felony or misdemeanor? ☐ Yes ☐ No
8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility? ☐ Yes ☐ No
9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board? ☐ Yes ☐ No
10. Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility? ☐ Yes ☐ No
11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? ☐ Yes ☐ No

XI. PERSONAL HEALTH STATUS

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1. Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? ☐ Yes ☐ No
2. Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? ☐ Yes ☐ No
3. Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? ☐ Yes ☐ No

XII. PROFESSIONAL SOCIETIES

Membership in local, state, or national medical societies

Dates

Name: ____ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ____
City: ______________________________ State: ______________ ZIP: ______________

Name: ____ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ____
City: ______________________________ State: ______________ ZIP: ______________

Name: ____ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ____
City: ______________________________ State: ______________ ZIP: ______________

Name: ____ ____________ / ____________
From (mm/yy) To (mm/yy)
Address: ____
City: ______________________________ State: ______________ ZIP: ______________

1. I would like to use this application for membership in the ______________________ County Medical Society and the KMA. A separate dues statement will be sent.

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

B. Affiliations

List in chronological order all professional affiliations since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________

City/St/ZIP: ____
City St ZIP ZIP+ Country

Phone: ______________________ Fax: ______________________

Reason for leaving: ____

XIV. PEER REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, and ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: ____

Address: ____ Phone: ____________________

City/St/ZIP: ____ Country: __________________

Reference: ____

Address: ____ Phone: ____________________

ACKNOWLEDGEMENT STATEMENT

The following statement is required (by Medicare/Champus regulation) to be signed by each physician when he/she joins the Medical Staff. This must be signed and dated in the physician's own handwriting using his/her legal signature (initials are not accepted).

According to federal guidelines, stamped signatures and typed dates are not acceptable.

MEDICARE/CHAMPUS

"Notice to physicians: Medicare/Champus payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal law."

I certify that I have received the above statement.

Signature: ____ Date: ___________

Typed or Printed Name: ____