Form KAPER-1 (03/2007)

Part B, Section 2

For Health Care Providers Desiring Reappointment for Health Care Facility Privileges

Commonwealth of Kentucky

Instructions - Form KAPER-1 (03/2007) Part B, Section 2

A. Uniform Application for Re-evaluation (Recredentialing) Form. Following is the form KAPER-1 (03/2007), Part B, Section 2 developed pursuant to KRS 304.17A-535(5) for re-evaluation (recredentialing) of health care providers. 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 re-evaluation (recredentialing) 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 2 and required attachments as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the provider, who desires re-evaluation (recredentialing) by a hospital or health care facility, requesting consideration of the complete form KAPER-1 (03/2007), Part B, Section 2 and required attachments as applicable and specified in item C of this instruction, may be required.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (03/2007), Part B, Section 2 in the following order:

1.

I. PERSONAL IDENTIFICATION DATA

Name: _____
Last Suffix First Middle Maiden Name Degree

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____
_____ L1m(____)6(____)6axc_____A5P(13())]TJ 0.06 T)Tj 0.#g5 Ta53

II. TEACHING APPOINTMENTS

Name: _____ _____ _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____

III. 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.

IV. 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.

V. 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: _____

VI. 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: _____

VII. PROFESSIONAL LIABILITY DATA

Answer the following questions as they apply to the last two (2) years:

VIII. 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: _____

XI. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all <u>professional employment</u> 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: ______________________

B. Affiliations

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: _____

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