

## Kodiak Area Native Association Provider Application

All blanks must be completed. (Please do not indicate see resume) If a particular section is not applicable please mark N/A in the blank. Please print legibly in ink or type. Please attach a CV, copies of all the current state licenses, DEA license, professional school diploma, and board certification.

<b>Provider Information</b>			
First Name	Middle	Last	Degree
Current Mailing Address		Physical Address	
City, State, Zip		City, State, Zip	
Alaskan Mailing Address		Other name(s) known by	
City, State, Zip		Primary/Secondary Specialty	
Date of Birth	Birth City, State, Country	Citizenship	Social Security Number
UPIN/NPI (Medicare Provider Number)	DSHS Number	L&I Number	
Phone Number (     )	Pager Number (     )	Email	

<b>Peer References</b>	
List three professional references, preferably from your specialty area, not including relatives, current or pending partners or associates in practice, if possible, include at least one member from the Medical Staff of each facility at which you have privileges. References must be from individuals who through recent observation are directly familiar with your work.	
Name	Title
Address	Phone (     )
City, State, Zip	

Name	Title
Address	Phone (     )
City, State, Zip	

Name	Title
Address	Phone (     )
City, State, Zip	

## Education

<b>Education</b>	
Name of Undergraduate Institution	Degree Received
Address	Graduation Date (mm/yy)
City, State, Zip	

Name of Medical/Professional Institution		Degree Received
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Status	Reason for leaving

Name of Internship/PGYI Institution		Program Director
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Phone (    )	Type/Specialty

Name of Residency Institution		Program Director	
Address	From (mm/yy) To (mm/yy)	Successfully completed?	
City, State, Zip	Phone (    )	Type/Specialty	
Was Medicare billed during your residency for resident surgical assistant or any other services? ____ Yes ____ No _____ Provider Number			

Name of Fellowship Institution		Program Director	
Address	From (mm/yy) To (mm/yy)	Successfully completed?	
City, State, Zip	Phone (    )	Course of Study	

Name of Preceptorship Institution	Department Chair	Training
Address		From (mm/yy) To (mm/yy)

Name of Faculty/Teaching Appointments	Faculty Director	Position
Address		

## Work History

Account for all periods since graduation from medical/professional school. Use additional sheets if needed.

Name of Practice/Employer		Legal Business Name of Practice/Employer	
Address		Contact Name	Phone Number (    )
City, State, Zip		From (mm/yy) To (mm/yy)	Fax Number (    )
Medicare # used at this location	Medicare Carrier/Intermediary Name	Medicaid # used at this location	CLIA (lab) # used at this location
Were you a participating _____ or a non-participating _____ Medicare provider in this practice?			

Name of Practice/Employer		Legal Business Name of Practice/ Employer	
Address		Contact Name	Phone Number (    )
City, State, Zip		From (mm/yy) To (mm/yy)	Fax Number (    )
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City, State, Zip	From (mm/yy) To (mm/yy)	Fax Number (    )	
Medicare # used at this location	Medicare Carrier/Intermediary Name	Medicaid # used at this location	CLIA (lab) # used at this location
Were you a participating _____ or a non-participating _____ Medicare provider in this practice?			

<b>Hospital Affiliations</b>		
Name of Institution		Department
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Status	Reason for leaving

Name of Institution		Department
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Status	Reason For leaving

Name of Institution		Department
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Status	Reason For leaving

Name of Institution		Department
Address		From (mm/yy) To (mm/yy)
City, State, Zip	Status	Reason For leaving

<b>Hospital Applications in Progress</b>		
Name of Institution		Department
Address		Date Submitted
City, State, Zip	Status	Reason for leaving

<b>Professional Affiliations</b>		
Organization	From (mm/yy) To (mm/yy)	Membership Status
Organization	From (mm/yy) To (mm/yy)	Membership Status
Organization	From (mm/yy) To (mm/yy)	Membership Status

## Professional Licensure, Registrations and Certifications

State Licenses		
State	License Number	Year Obtained/Year Relinquished/Reason
State	License Number	Year Obtained/Year Relinquished/Reason

Drug Enforcement Administration	
DEA Number	Expiration Date

Board Certification				
Issuing Board/State	Specialty	Number	Date Certified/Recertified	Exp. Date
Issuing Board/State	Specialty	Number	Date Certified/Recertified	Exp. Date
If you are not board certified, does your specialty have board certification? ____ Yes ____ No If you are not board certified, do you intend to be certified? ____ Yes ____ No _____ Date of Board Testing				

Blue Cross of Washington and Alaska		
Alaska	Practice Name	Number
Washington	Practice Name	Number

Other Certifications (ACLS, PALS, Radiology, etc.) (Attach Certificate if applicable)		
Type	Number	Exp. Date
Type	Number	Exp. Date

## Professional Liability

(List current and all policies held in the last 10 years.)

Company	Policy Number
Address	From (mm/yy) To (mm/yy)
City, State, Zip	Per Claim Amount \$ _____ Aggregate Amount \$ _____

Company	Policy Number
Address	From (mm/yy) To (mm/yy)
City, State, Zip	Per Claim Amount \$ _____ Aggregate Amount \$ _____

## Disclosure Questionnaire

If you answer **YES** to any of the following questions, please provide details on a separate page. Include a copy of any order or settlement where applicable. If you attach additional sheets, sign and date each sheet.

### 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	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 in an HMO, PPO, IPA, PHO or other entity	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 substance (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, and professional association or education training institution?

3. Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions.

4. Have you ever been the subject of any reports to a state, federal, national databank, or state licensing or disciplinary entity?

### 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?

a.) Do you have such notice of any such anticipated charges?

b.) Are you currently under governmental investigation?

## Disclosure Questionnaire Continued

If you answer **YES** to any of the following questions, please provide details on a separate page. Include a copy of any order or settlement where applicable.

### AFFIRMATION OF ABILITIES

1. Do you presently use any drugs illegally?
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 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.
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?

### 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?
2. Have you or your insurance carriers 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?
3. Are there any such claims being asserted against you now?
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)?
5. Are any of the privileges that you are requesting not covered by your current malpractice coverage?

### Attestation

I certify the information in this entire application is complete, accurate and current, it is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or immediate dismissal from the Kodiak Area Native Association (KANA) if I have been employed I further understand that this is an application for employment and that no employment contract is being offered. A photocopy of this application has the same force and effect as the original.

I hereby authorize KANA to investigate my past and present work, character, and education records to ascertain any and all information, which may be pertinent to my employment qualifications. I release from all liability or responsibility all persons and corporations requesting or supplying such information.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_