**Section 965.APPENDIX B Uniform Health Care and Hospital Recredentials Form**

**STATE OF ILLINOIS**

**Uniform Health Care and Hospital Recredentials 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 plans that desire to recredential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

**INSTRUCTIONS**

This form is for recredentialing only. Other forms are required for credentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into 2 different Chapters, each containing various sections:

Chapter A: General and Practice Information

Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments that contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

*Any credentials data collected or obtained by the health care entity, health care plan, or hospital shall be confidential, as provided by law, and otherwise may not be redisclosed without written consent of the health care professional, except that in any proceeding to challenge credentialing or recredentialing, or in any judicial review, the claim of confidentiality shall not be invoked to deny a health care professional, health care entity, health care plan, or hospital access to or use of credentials data. Nothing in this* subsection *prevents a health care entity, health care plan, or hospital from disclosing any credentials data to its officers, directors, employees, agents, subcontractors, medical staff members, any committee of the health care entity, health care plan, or hospital involved in the credentialing process, or accreditation bodies or licensing agencies. However, any redisclosure of credentials data contrary to this* subsection *is prohibited.* (Section 15(h) of the Act)

**ATTACHMENTS**

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

Curriculum Vitae

**CONFIDENTIAL INFORMATION:**

All Current Professional Licenses

Current Federal DEA Licenses, If Applicable

Current State Controlled Substance Licenses, If Applicable

Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed Per Occurrence and In Aggregate

Current CLIA Certificate, If Applicable

Current W-9s, If Applicable

ECFMG Certificate, If Applicable

Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

**AFFIRMATION OF INFORMATION**

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Uniform Updating Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Applicant's Signature (or electronic signature) |  | Type or Print Name |  | Date |

**\*\*PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM.**

CHAPTER A:

**PRACTICE AND PROFESSIONAL INFORMATION**

**SECTION A. GENERAL INFORMATION**

|  |  |
| --- | --- |
| Name: |  |
|  | Last | First | MI | Degree  |
| List other names by which you have been known:  |  |
|  |  | Last | First | MI |
| If you have been known by other names, please explain why your name changed: |
|  |
| Birth Date: |  |  |  |
|  | (mm/dd/yy) |  |  |  |  |
| Sex: | [ ]  Male | [ ]  Female |  |  |  |
|  |  |  |  |  |
| U.S. Citizen? | [ ]  Yes | [ ]  No |  |  |
|  | If "no", do you have a legal right to reside permanently and work in the U.S.? | [ ]  Yes | [ ]  No |
|  | ***CONFIDENTIAL INFORMATION*** |  |  |
|  | Resident Visa No: |  |  |  |
|  | Medical Education Number: |  |  |
|  | Emergency Contact Person: |  |
|  |  | *Last* | *First* | *MI* |
|  | Telephone Number: | ( ) |  |
| Mailing Address: |  | Daytime Phone: | ( ) |
|  |  | Fax Number: | ( ) |
| *EMAIL Address:* |  |  |  |
| ***Check here if you have appended additional information for this section.*** ***[ ]***  |

CHAPTER A:

**SECTION B. PROFESSIONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Illinois Professional License Number:** | Unrestricted License? | [ ]  Yes | [ ]  No |
| If "no", please explain restriction(s) |  |
| **Current and Previous Professional Licenses in Other States** |
| State: |  | License # |  | Exp. Date: |  | (mm/dd/yy) |
| Unrestricted License? | [ ]  Yes | [ ]  No | If "no", please explain restriction(s) |  |
|  |
| State: |  | License # |  | Exp. Date: |  | (mm/dd/yy) |
| Unrestricted License? | [ ]  Yes | [ ]  No | If "no", please explain restriction(s) |  |
|  |
| State: |  | License # |  | Exp. Date: |  | (mm/dd/yy) |
| Unrestricted License? | [ ]  Yes | [ ]  No | If "no", please explain restriction(s) |  |
|  |
| **Check here if you have appended additional information for this section.** | [ ]  |
|  | ***CONFIDENTIAL INFORMATION*** |  |
|  | Current Federal DEA License Number: |  |  |
|  | DEA License Number Expiration Date: |  | Unrestricted License? | [ ]  Yes | [ ]  No |
|  |  | (mm/dd/yy) |  |  |
|  | If "no", please explain restriction(s): |  |
|  |  |
| **Check here if you have appended additional information for this section.** | [ ]  |
| **Current and Previous State Controlled Substance Numbers:** |
| *CONFIDENTIAL INFORMATION* |
| State: |  | CS License #: |  | Expiration Date: |  |
|  |  |  |  | (mm/dd/yy) |
| State: |  | CS License #: |  | Expiration Date: |  |
|  |  |  |  | (mm/dd/yy) |
| State: |  | CS License #: |  | Expiration Date: |  |
|  |  |  |  | (mm/dd/yy) |
| **Please identify all limitations related to the above Controlled Substances Numbers and explain limitations** |
|  |
|  |
| **Medicare Unique Provider ID# (UPIN):** |  |
| **National Provider Identification Number (NPI):** |  |
| **Medicaid ID#:** |  |
| **X-Ray Certification:** |
| State: |  | Certificate #: |  | Expiration Date: |  |
|  |  |  |  | (mm/dd/yy) |
| **Check here if you have appended additional information for this section.** | [ ]  |

**COMPLETE FOR EACH SPECIALTY**

|  |  |
| --- | --- |
| **Specialty I:** |  |
| Are you Board Certified in Specialty I? | [ ]  Yes | [ ]  No |
| If "yes", name of Certifying Board: |  |
| Date of Certification: |  | Date of Recertification (if applicable): |  |
|  | (mm/dd/yy) |  | (mm/dd/yy) |
| If "no", have you taken or are you scheduled to take the Specialty Boards Certification? |
| [ ]  Yes | [ ]  No |
| If Certifying Boards taken, give date: |  |  |
|  | (mm/dd/yy) |  |
| Certification Expiration Date, If Any: |  |  |
|  | (mm/dd/yy) |  |
| If not taken, date scheduled to take Specialty Boards: |  |  |
|  | (mm/dd/yy) |  |
| **Specialty/Subspecialty II:** |  |
| Are you Board Certified in Specialty II? | [ ]  Yes | [ ]  No |
| If "yes", name of Certifying Board: |  |
| Date of Certification: |  | Date of Recertification (if applicable): |  |
|  | (mm/dd/yy) |  | (mm/dd/yy) |
| If "no", have you taken or are you scheduled to take the Specialty Boards Certification? |
| [ ]  Yes | [ ]  No |
| If Certifying Boards taken, give date: |  |  |
|  | (mm/dd/yy) |  |
| Certification Expiration Date, If Any: |  |  |
|  | (mm/dd/yy) |  |
| If not taken, date scheduled to take Specialty Boards: |  |  |
|  | (mm/dd/yy) |  |
| **Specialty/Subspecialty III:** |  |
| Are you Board Certified in Specialty III? | [ ]  Yes | [ ]  No |
| If "yes", name of Certifying Board: |  |
| Date of Certification: |  | Date of Recertification (if applicable): |  |
|  | (mm/dd/yy) |  | (mm/dd/yy) |
| If "no", have you taken or are you scheduled to take the Specialty Boards Certification? |
| [ ]  Yes | [ ]  No |
| If Certifying Boards taken, give date: |  |  |
|  | (mm/dd/yy) |  |
| Certification Expiration Date, If Any: |  |  |
|  | (mm/dd/yy) |  |
| If not taken, date scheduled to take Specialty Boards: |  |  |
|  | (mm/dd/yy) |  |
| **Specialty/Subspecialty IV:** |  |
| Are you Board Certified in Specialty IV? | [ ]  Yes | [ ]  No |
| If "yes", name of Certifying Board: |  |
| Date of Certification: |  | Date of Recertification (if applicable): |  |
|  | (mm/dd/yy) |  | (mm/dd/yy) |
| If "no", have you taken or are you scheduled to take the Specialty Boards Certification? |
| [ ]  Yes | [ ]  No |
| If Certifying Boards taken, give date: |  |  |
|  | (mm/dd/yy) |  |
| Certification Expiration Date, If Any: |  |  |
|  | (mm/dd/yy) |  |
| If not taken, date scheduled to take Specialty Boards: |  |  |
|  | (mm/dd/yy) |  |
| **Check here if you have appended additional information for this section.** | [ ]  |

**CURRENT PROFESSIONAL LIABILITY INSURANCE**

***CONFIDENTIAL INFORMATION:***

|  |  |
| --- | --- |
| Carrier: |  |
| Address: |  |
|  | Street | City | State | Zip |
| Policy Number (last 4 digits): |  | Original Effect Date: |  | Expiration Date: |  |
|  |  |  | (mm/dd/yy) |  | (mm/dd/yy) |
| Policy Limits: | Per Occurrence: | $ |  | Aggregate: | $ |  |
| Retroactive Date: |  |  |
|  |  | (mm/dd/yy) |  |  |  |
| What type of coverage do you have? | [ ]  Claims Made | [ ]  Occurrence |
| Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage? |
| [ ]  | Yes | [ ]  | No |

**PROFESSIONAL LIABILITY ACTIONS**

**If you answer "yes" to any questions in this section, please complete FORM B. Please make copies of FORM B, if needed, and complete one for each "yes" answer.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Have any professional liability judgements ever been entered against you? | [ ]  | Yes | [ ]  | No |
| 2. | Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? | [ ]  | Yes | [ ]  | No |
| 3. | Are there any currently pending professional liability suits, actions, and/or claims filed against you? | [ ]  | Yes | [ ]  | No |

**LIABILITY INSURANCE**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have you ever had your professional liability insurance coverage canceled or non-renewed or had limits reduced? | [ ]  | Yes | [ ]  | No |

|  |
| --- |
| **MEMBERSHIP STATUS – USE FOR SECTIONS E, F AND G** |
| **Please use the following key to indicate Membership Status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgical Treatment Center Practice) below:** |
| A. | Active | F. | Active Provisional Staff | K. | Pending |
| B. | Courtesy | G. | Senior Staff | L. | Other (Specify) |
| C. | Consulting | H. | Associate |  |  |
| D. | Adjunct | I. | Provisional |  |  |
| E. | Suspended/ | J. | Affiliate |  |  |
|  | Terminated/ |  |  |  |  |
|  | Resigned |  |  |  |  |

**SECTION C. HOSPITAL MEMBERSHIP – CURRENT AND PENDING**

**Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending.** (Include additional sheets if more than three hospitals.)

|  |  |  |
| --- | --- | --- |
| **A.** | **Primary Hospital** |  |
|  | Hospital Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Membership Status (see above): |  | Dates: |  | To Present |
|  |  | From (mm/yy) |  |
|  | Department/Division: |  | Medical Staff Office Email: |  |
|  | Department Telephone #: | ( ) |  |
|  | Do you have admitting privileges at this hospital? | [ ]  Yes | [ ]  No |
|  | Any limitations in your area of specialty at this hospital?  |  |
|  |  |  |  |
| **B.** | **Other Hospital** |  |  |
|  | Hospital Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Membership Status (see above): |  | Dates: |  | To Present |
|  |  | From (mm/yy) |  |
|  | Department/Division: |  | Medical Staff Office Email: |  |
|  | Department Telephone #: | ( ) |  |
|  | Do you have admitting privileges at this hospital? | [ ]  Yes | [ ]  No |
|  | Any limitations in your area of specialty at this hospital?  |  |
|  |  |  |  |
| **C.** | **Other Hospital** |  |  |
|  | Hospital Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Membership Status (see above): |  | Dates: |  | To Present |
|  |  | From (mm/yy) |  |
|  | Department/Division: |  | Medical Staff Office Email: |  |
|  | Department Telephone #: | ( ) |  |
|  | Do you have admitting privileges at this hospital? | [ ]  Yes | [ ]  No |
|  | Any limitations in your area of specialty at this hospital?  |  |
| **Check here if you have appended additional information for this section** | [ ]  |

**SECTION D. AMBULATORY SURGICAL TREATMENT CENTER PRACTICE**

**Please list all ambulatory surgical treatment centers where you currently have clinical privileges. Use the Membership Status key listed prior to Section E.** (Include additional sheets if more than three ASTCs.)

|  |  |
| --- | --- |
| **A.** | **Primary Ambulatory Surgical Treatment Center** |
|  | ASTC Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Email: |  | Telephone #: | ( ) |
|  | Membership Status (see above): |  | Dates: |  |  |  |
|  |  | From (mm/yy) |  | To (mm/yy) |
| **B.** | **Other Ambulatory Surgical Treatment Center** |
|  | ASTC Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Email: |  | Telephone #: | ( ) |
|  | Membership Status (see above): |  | Dates: |  |  |  |
|  |  | From (mm/yy) |  | To (mm/yy) |
| **C.** | **Other Ambulatory Surgical Treatment Center** |
|  | ASTC Name: |  |
|  | Address: |  |
|  | Street | City | State | Zip |
|  | Email: |  | Telephone #: | ( ) |
|  | Membership Status (see above): |  | Dates: |  |  |  |
|  |  |  | From (mm/yy) |  | To (mm/yy) |
| **Check here if you have appended additional information for this section.** **[ ]**  |

**SECTION E. WORK HISTORY**

**List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service) in the past 4 years. 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 workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To Present |
|  |  | (mm/yy) |  |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To:  |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Previous workplace:** |  |
| Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Title or Professional Occupation: |  |
| Time in this employment: | From: |  | To: |  |
|  |  | (mm/yy) |  | (mm/yy) |
| **Check here if you have appended additional information for this section.** [ ]  |

**SECTION F. MEDICAL EDUCATION/CLINICAL TRAINING UPDATE**

**Please provide an update of your medical education and clinical training over the past four years. Do not duplicate internship, residency, and fellowship information previously reported.** (Attached additional sheets if necessary.)

|  |  |
| --- | --- |
| **FIRST UPDATE** |  |
|  | [ ]  Fellowship | [ ]  Residency | [ ]  Other |
| Institution Name:  |  |
| Department Chair or Program Director: |
|  |
| Last Name | First Name | MI | Degree |
| Mailing Address: |  |
|  | Street | City | State | Zip |
| Telephone Number: | ( ) | Email: |  |
| Dates attended: | From: |  | To: |  |
|  | mm/yy | mm/yy |  |  |
| Type of internship: | [ ]  Rotating | [ ]  Straight |
| If straight, please list specifically |  |
| Did you successfully complete this program?If no, please list specialty:  | [ ]  Yes | [ ]  No |
|  |
| Were you the subject of any disciplinary action during your attendance at this institution?  |
| (Attached an explanation of a "Yes" answer.) | [ ]  Yes | [ ]  No |
| **SECOND UPDATE** |
|  | [ ]  Fellowship | [ ]  Residency | [ ]  Other |
| Institution Name: |  |
| Department Chair and Program Director: |
|  |
| Last Name | First Name | MI | Degree |
| Mailing Address: |  |
|  | Street | City | State | Zip |
| Dates attended: | From: |  | To: |  |
|  | Mm/yy |  | Mm/yy |
| Types of internship: | [ ]  Rotating | [ ]  Straight: |
| If straight, please list specialty: |  |
| Did you successfully complete this program? | [ ]  Yes | [ ]  No |
|  |  |  |
| Were you the subject of any disciplinary action during your attendance |
| this institution? | [ ]  Yes | [ ]  No |
| (Attach an explanation of a "Yes" answer.) |
| **Check here if you have appended additional information for this section:** | [ ]  |

**SECTION G. PROFESSIONAL HISTORY: CONFIDENTIAL**

**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 questions, please complete FORM A. Please make copies of FORM A as needed and complete one form for each "yes" answer.**

**Adverse or Other Actions**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, cancelled and/or subject to probation, either voluntarily or involuntarily, or has your application for a license ever been withdrawn? | [ ]  | Yes | [ ]  | No |
| 2. | Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency that licenses providers? | [ ]  | Yes | [ ]  | No |
| 3. | Have you ever had your board certification rescinded or elected not to recertify, and/or failed to recertify? | [ ]  | Yes | [ ]  | No |
| 4. | Have you ever been examined by a Certifying Board but failed to pass? | [ ]  | Yes | [ ]  | No |
| 5. | Has any information pertaining to you, including malpractice judgements and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? | [ ]  | Yes | [ ]  | No |
| 6. | Has your federal DEA number and/or state associated Controlled Substances License been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? | [ ]  | Yes | [ ]  | No |
| 7. | Have your privileges at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, reduced, restricted, not renewed, denied, renewal, or has probation ever been imposed? | [ ]  | Yes | [ ]  | No |
| 8. | Has your membership at any hospital or other health care setting ever been suspended, revoked, voluntarily or involuntarily surrendered, not renewed, denied, or has probation ever been imposed? | [ ]  | Yes | [ ]  | No |
| 9. | Has your medical staff membership at any hospital or healthcare institution ever been voluntarily or involuntarily terminated? | [ ]  | Yes | [ ]  | No |
| 10. | Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ASTC privileges and/or your license? | [ ]  | Yes | [ ]  | No |
| 11. | Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs, or voluntarily withdrawn to avoid an investigation relating to those programs? | [ ]  | Yes | [ ]  | No |
| 12. | Have Medicare, Medicaid, CHAMPUS or PRO authorities, and/or any other third-party payors, brought charges against you for alleged inappropriate fees and/or quality-of-care issues? | [ ]  | Yes | [ ]  | No |
| 13. | Have you ever withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? | [ ]  | Yes | [ ]  | No |
| 14. | Has your authority to practice in any state been suspended, revoked, voluntarily or involuntarily surrendered, been subject to a consent order or stipulation order, not renewed, denied renewal, or has probation ever been imposed? | [ ]  | Yes | [ ]  | No |

**CRIMINAL ACTIONS**

**If you answer "yes" to any questions in this section, please complete FORM D. Please make copies of FORM D, if needed, and complete one for each "yes" answer**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | Have you ever been charged with or convicted of a felony or misdemeanor (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this State or any other state or country? | [ ]  | Yes | [ ]  | No |
| 2. | Have you ever been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? | [ ]  | Yes | [ ]  | No |

**MEDICAL CONDITION**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you currently have a physical illness or mental illness or disability that results in your inability to practice medicine with reasonable judgement, skill, and safety? (See Medical Practice Act – 225 ILCS60/22(a)) | [ ]  | Yes | [ ]  | No |
| **CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER** |
| **If you answer "yes" to any questions in this section, please complete FORM F. Please make copies of FORM F, if needed, and complete one for each "yes" answer.** |
| 1. | Do you currently overuse and/or abuse alcohol or any controlled substance(s)? | [ ]  | Yes | [ ]  | No |
| 2. | If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? | [ ]  | Yes | [ ]  | No |
| 3. | Are you currently participating in a supervised rehabilitation program and/or professional assistance program that monitors you for alcohol and/or substance use disorder? | [ ]  | Yes | [ ]  | No |
| **INVESTMENTS** |
| In the last 5 years have you and/or a member of your family ever purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgical center, and/or other business dealing with the provision of ancillary health services, equipment or supplies? | [ ]  | Yes | [ ]  | No |
| If "yes", please provide explanation: |  |
|  |
|  |
|  |

**SECTION H. PRIMARY SITE INFORMATION**

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

|  |  |
| --- | --- |
|  |  |
| **Primary Site** | Group/Business Name |
|  | Building Name |
|  | Office Address – Number and Street – Suite |
|  | City | County | State | Zip |
|  | ( ) |  |  |
|  | Main Telephone Number |  | Office Administrator –  | Last | First | MI |
|  |  |  | ( ) |  |  |
|  |  |  | Fax Number |  | E-Mail |
|  | ( ) |  | ( ) |
|  | Emergency Number |  | Answering Service |
|  | Are you currently accepting new patients at this location? [ ]  Yes [ ]  No |
|  | If "yes", describe any restrictions (e.g., appointment type, patient type): |
|  |  |
| Please provide the number of active patients enrolled with you at this site: |  |
| Please provide the number of patient visits you have at this site per year: |  |

|  |
| --- |
| **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.** |
|  | Special Skills of Practitioner: |  |
|  | Special Skills of Staff: |  |
|  | Languages Spoken by Practitioner: |  |
|  | Languages Written by Practitioner: |  |
|  | Languages Spoken by Staff: |  |
|  | Languages Written by Staff: |  |
| **Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.** |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION****:* Tax ID#: |  |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION****:* Tax ID#: |  |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION:*** Tax ID#: |  |

**SECTION I. ADDITIONAL SITE INFORMATION**

**Please provide the following information for each additional site at which you practice. If there is more than one additional site, copy and complete this section for each additional site.**

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

|  |  |
| --- | --- |
|  |  |
| **Primary Site** | Group/Business Name |
|  | Building Name |
|  | Office Address – Number and Street – Suite |
|  | City | County | State | Zip |
|  | ( ) |  |  |
|  | Main Telephone Number |  | Office Administrator –  | Last | First | MI |
|  |  |  | ( ) |  |  |
|  |  |  | Fax Number |  | E-Mail |
|  | ( ) |  | ( ) |
|  | Emergency Number |  | Answering Service |
|  | Are you currently accepting new patients at this location? [ ]  Yes [ ]  No |
|  | If "yes", describe any restrictions (e.g., appointment type, patient type): |
|  |  |
|  |  |
| Please provide the number of active patients enrolled with you at this site: |  |
| Please provide the number of patient visits you have at this site per year: |  |

|  |
| --- |
| **List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.** |
|  | Special Skills of Practitioner: |  |
|  | Special Skills of Staff: |  |
|  | Languages Spoken by Practitioner: |  |
|  | Languages Written by Practitioner: |  |
|  | Languages Spoken by Staff: |  |
|  | Languages Written by Staff: |  |

|  |
| --- |
| **Please provide the following information about physicians/practitioners who provide coverage for patients enrolled at this site when you are not available.** |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION****:* Tax ID#: |  |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION****:* Tax ID#: |  |
| Name: |  |
|  | Last | First | MI | Degree |
| Specialty: |  |
| Address: |  | Telephone: | ( ) |
|  | Street | City | State | Zip |  |
| Availability: | [ ]  Days | [ ]  Nights | [ ]  Weekends | [ ]  Holidays |

|  |  |
| --- | --- |
| ***CONFIDENTIAL INFORMATION****:* Tax ID#: |  |

|  |
| --- |
| End Uniform Health Care and Hospital Recredentials Form. |
| Attach Forms A-F As Required. |

**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.**

Applicant Name:

|  |
| --- |
|  |
| Last | First | MI |
| Indicate the number of ONE of the questions in Section I to which you answered "yes": |
| Question Number: |  |  |
|  |
| A. | Describe the circumstances surrounding this occurrence. Please include the date of the occurrence. |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| B. | Provide an explanation of any actions taken. Please include the date the action was taken. |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| C. | Provide the current status of the issue. |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| D. | If known: | Contact |  |  |
|  |  | Department/Committee: |  |
|  |  | Address: |  |
|  |  |  | Street | City | State | Zip |
|  |  | Telephone Number: | ( ) |
|  |  |  |  |  |
| **Signature** (or electronic signature)**:** |  | **Date:** |  |

**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.**

|  |  |
| --- | --- |
| Applicant Name: |  |
|  | Last | First | MI |
| A. | Plaintiff's Name: |  |
|  |  | Last | First | MI |
|  | If court case, Case Name & Case Number: |  |
|  |  |
| B. | Your Involvement in the Care (Attending, Consulting, Etc.) |  |
| C. | Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in  |
|  | Provider Practice Named in Suit, Etc.) |  |
| D. | Allegations, including Patient Outcome, If Available: |  |
|  |  |
|  |  |
|  |  |
| E. | Date of Incident (mm/yy) |  | F. | Date Filed (mm/yy) |  |
| G. | Date Case Closed (mm/yy): |  |  |
|  | Case Resolution: |
|  | [ ]  | Dismissed | [ ]  | Judgement | [ ]  | Arbitration | [ ]  | Other |
|  | [ ]  | Settlement Out of Court | [ ]  | Pending | [ ]  | Mediation |  |  |
| H. | Amount Paid on Your Behalf (if any): $ |  |  |
| I. | Professional Liability Insurer Name (if one was involved): |  |
| J. | Insurer Telephone Number: | ( ) | K. | Policy Number (last 4 digits): |  |
| L. | Insurer Address (Street, City, State, Zip Code): |  |
|  |  |
| **Signature** (or electronic 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.**

|  |  |
| --- | --- |
| Applicant Name: |  |
|  | Last | First | MI |
| A. | **History of Professional Liability Insurance (Please Check One)** |
|  | [ ]  | Cancelled Voluntarily | [ ]  Non-Renewed |
|  | [ ]  | Cancelled Involuntarily | [ ]  Application Denied |
| B. | Carrier Name: |  |
| C. | Carrier Telephone Number: | ( ) |
| D. | Policy Number (last 4 digits): |  |  |
| E. | Carrier Address: |  |
|  |  | Street | City | State | Zip |
| F. | Dates of Coverage: | From (mm/yy): |  | To (mm/yy): |  |
|  |  |  |
| G. | Circumstances Involved: |  |
|  |  |
| **Signature** (or electronic signature)**:** |  | **Date:** |  |

**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.**

|  |  |
| --- | --- |
| Applicant Name: |  |
|  | Last | First | MI |
| A. | Date of Incident (mm/yy): |  |  |
| B. | Date of Complaint or Conviction (mm/yy): |  |  |
| C. | Date of Resolution (mm/yy): |  |  |
| D. | Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): |  |
|  |  |
| E. | Allegations: |  |
|  |  |
|  |  |
|  |  |
| F. | Details of Incident: |  |
|  |  |
|  |  |
|  |  |
| G. | Actions Taken Against You: |  |
|  |  |
|  |  |
|  |  |
|  |  |
| H. | Current Status of Situation: |  |
|  |  |
|  |  |
| I. | Medical Practice Privileges Affected as a Result of This Situation: |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Signature** (or electronic signature)**:** |  | **Date:** |  |

**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.**

|  |  |
| --- | --- |
| Applicant Name: |  |
|  | Last | First | MI |
| A. | Describe this medical condition: |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| B. | To what extent does this current condition affect your current ability to practice  |
|  | medicine in your specialty area or to perform a full range of clinical activities? |
|  |  |
|  |  |
|  |  |
|  |  |
| C. | Provide the name and address of your personal physician/health care provider who can provide information about your health condition. |
|  | **Name** | **Telephone Number** |
|  |  |  | ( ) |
|  | Last | First | MI | Degree |  |  |
|  |  |  | ( ) |
|  | Last | First | MI | Degree |  |  |
|  |
| **Signature** (or electronic signature)**:** |  | **Date:** |  |

**FORM F – CHEMICAL SUBSTANCES OR ALCOHOL USE DISORDER**

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

|  |  |
| --- | --- |
| Applicant Name: |  |
|  | Last | First | MI |
| Describe the substance(s) you use: |  |
|  |
| A. | To what extent does, or could, your use of this (these) substance(s) affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities? |
|  |  |
|  |  |
|  |  |
| B. | Monitored by State Board Mandate (Name and Address) |
|  |  |  |
|  |  |  |
|  |  |
| C. | Monitored Voluntarily (Name and Address) |
|  |  |  |
|  |  |  |
|  |  |
| D. | Other information about the current status of your use of substances: |
|  |  |
|  |  |
| E. | Abstinent since (mm/yy): |  |  |
|  |  |
| F. | Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice. |
|  | Name: |  |
|  |  | Last | First | MI | Degree |
|  | Address: |  |
|  | Street | City | State | Zip |
|  |  |
|  | Telephone Number: | ( ) |  |
| **Signature** (or electronic signature)**:** |  | **Date:** |  |

(Source: Amended at 48 Ill. Reg. 12398, effective August 1, 2024)