

### **Credentialing Application Checklist**

IN ORDER TO PROCEED CONTRACT COORDINATORS MUST HAVE THE FOLLOWING COMPLETED DOCUMENTS

### If provider is in CAQH please submit per practitioner:

- Completed W-9, at least one if all practitioners share same tax ID
- □ CAQH Provider Data Form, FULLY COMPLETED
- Exhibit 3 Participating Provider Attestation (in the Agreement/Contract) each practitioner must complete one)
- □ Completed and signed Ownership and Disclosure Form

### If provider is not in CAQH please submit per practitioner:

- Completed W-9, at least one if all practitioners share same tax ID
- □ Attached CAQH Practitioner Application, FULLY COMPLETED
- Exhibit 3 Participating Provider Attestation (in the Agreement/Contract) each practitioner must complete one)

□ Signed and Dated Copy of Practitioner Application with signed and dated Provider Statement to Release Information signed within the last 120 days from submission

- □ Copy of Declaration Page of Professional Liability Policy
- Copy of ECFMG Certificate (if applicable)
- Completed and signed Ownership and Disclosure Form

### If Hospital or Ancillary (Hospitals and Ancillaries are not in CAQH):

If practitioners are included in the contract follow instructions above for items submitted for practitioners in addition to what is required for Hospital/Ancillary/Facility listed below.

- D Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Hospital/Ancillary Provider)
- □ Copy of Vermont State Operational License
- Copy of other applicable State/Federal Licensures (i.e. CLIA, DEA, Pharmacy, or Department of Health)
- □ Copy of accreditation(e.g. Joint Commission)
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- □ Copy of the most recent Site Evaluation Results by a governmental agency. If most current survey is not within the last three years, please provide a written explanation.
- □ Completed W-9



### **Credentialing Application Checklist Continued**

IN ORDER TO PROCEED CONTRACT COORDINATORS MUST HAVE THE FOLLOWING COMPLETED DOCUMENTS

| If provider is approved by Centurion for delegated credentialing:  |
|--|
| Delegation Agreement (comes from Negotiator)   |
| Credentialing Policy & Procedure   |
| Sub-delegation Agreement(s) (If applicable)  |
| □ Spreadsheet of delegated group using the Delegated File Layout_062012 NH   |
| Exhibit 3 Participating Provider Attestation (in the Agreement/Contract) only need one copy from the delegated entity  |
| Copies of individual credentialing files will need to be provided as part of the pre-delegation audit  |
| If provider is not doing delegated credentialing, but is willing to submit a roster:   |
| Note: A roster does not speed our credentialing, but does speed our ability to load them into our systems  |
| All materials from the sections above as appropriate, plus   |
| □ Spreadsheet of delegated group using the Delegated File Layout_062012 NH filling out as much information as they are willing to provide.   |
| <ul> <li>For groups less than 20 the practitioner names, NPI(need to define)</li> <li>For groups 20 or larger the more they fill out the faster we can load them into our systems</li> </ul> |

### Please send all completed materials to:

Mail: Centurion c/o Lisa Rossics Centene Plaza 7700 Forsyth Blvd. Clayton, MO Fax: 877-668-2077 Email: Irossics@centene.com



the next generation in correctional healthcare

### **CAQH Provider Data Form**

For Credentialing Purposes

| Date:  |                            |                |                       |                         | Are you regis    | stered with CA        | QH? Yes No             |       |
|--|----------------------------|----------------|-----------------------|-------------------------|------------------|-----------------------|------------------------|-------|
| If Yes, CAQH Provider ID:  |                            |                |                       |                         | Individual NF    | P <u> </u> :          |                        |       |
| Last Name:   |                            |                | Firs                  | st Name:                |                  |                       | Middle Initial:        |       |
| Date of Birth:   | Social Sec                 | urity:         |                       |                         | N                | Nedicaid ID #:        |                        |       |
| Provider Type (MD, DO, PhD,                                      | LCSW, LPC, e               | etc.):         | Are you a in an offic |                         |                  | ovider not prac<br>No | ticing                 |       |
| Tax ID:  |                            |                | Group Bill            | ing NPI:                |                  |                       |                        |       |
| Practice Name:   |                            |                |                       |                         | E-Mail Addre     | ess:                  |                        |       |
| Primary Office Street Address:                                   |                            |                |                       |                         |                  | Suite #:              |                        |       |
| Primary Office City:   |                            |                |                       | State:                  | Cour             | nty:                  | Zip:                   |       |
| Primary Telephone:   |                            |                |                       |                         | Primary Fax:     |                       |                        |       |
| Credentialing Contact Informat                                   | ion:                       |                |                       |                         |                  |                       |                        |       |
| Specialty:   |                            |                | Applying              | As:                     | Specialist       |                       |                        |       |
|  |                            |                |                       |                         | Primary Care I   | Physician             |                        |       |
| If PCP, are you accepting new                                    | patients?                  | What gender of | or age rest           | rictions d              | o you have?      |                       |                        |       |
| 🗅 Yes 🛛 No   |                            | Gender: 🛛 No   | Restrictio            | ons 🛛 🖬 F               | emale Only       | □ Male Only           |                        |       |
| Yes, existing patients or  | lly                        | Age: 🛛 No Re   | estrictions           | 🗅 Age                   | Limits: Lowes    | st Age Hi             | ighest Age             |       |
| Are you board certified?<br>Yes No                               | lf Yes, boa                | rd name:       |                       |                         |                  | Exp.                  | Date:                  |       |
| Please list any medical related testing, MRI, etc.:              | organizations              | you have owner | ship with,            | e.g., labo              | pratory, home l  | health agency,        | radiology facility, mo | obile |
|  |                            |                |                       |                         |                  |                       |                        |       |
| If you provide direct laboratory information. Attach a copy of y |                            |                |                       |                         | vide Clinical La | aboratory Inform      | nation Act (CLIA)      |       |
| Do you have a CLIA<br>Certificate? Yes No                        | Do you have<br>waiver? Yes |                | Type of \$            | Service P               | Provided:        |                       |                        |       |
| Certificate Number:<br>Certificate Expiration Date:              |                            |                |                       | CLIA Name:<br>Tax ID #: |                  |                       |                        |       |

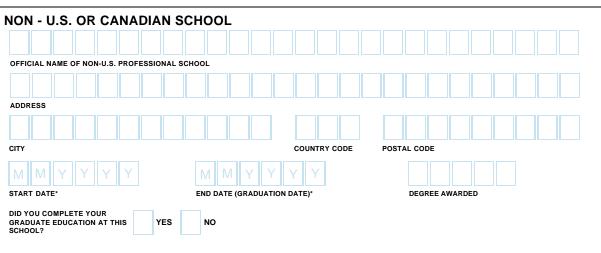
Note: If you have already completed your application with CAQH, please ensure that you have authorized Centurion to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Centurion to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Centurion.

# **Provider Application**

| CORRECT NUMBERS AND LETTERS  | BC123 CORRECT X INCORRECT SARKS SINCORRECT COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.   |           |
|--|---|-----------|
| Instructions<br>Read all instructions<br>carefully prior to<br>submitting your<br>application.   | <ul> <li>Tips to avoid processing delays <ol> <li>Complete only this application and its supplemental forms. Do not use another provider's application.</li> <li>Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.</li> <li>Print legibly and inside the boxes provided based upon the examples given above.</li> <li>Do not enter more than 1 character per box. If necessary, write outside the provided spaces.</li> <li>Complete all sections that are applicable to you.</li> <li>Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 3</li> </ol> </li> <li>NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left b</li> </ul> |           |
| SECTION 1  | Personal Information and Professional IDs   |           |
| Provider Type  | Code list is found on page 36. Enter the associated 3-digit code in the space provided.* DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SET (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.  | , NURSE   |
| Name<br>Do not use nicknames<br>or initials, unless they<br>are part of your legal<br>name.  | LAST NAME*  SUFFIX FIRST NAME*  HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE  | (JR, III) |
|  |   | (JR, III) |
|  | OTHER FIRST NAME OTHER MIDDLE NAME       M     D     D     Y     Y     Y       DATE STARTED USING OTHER NAME     DATE STOPPED USING OTHER NAME  |           |
| General<br>Information   | GENDER* MALE FEMALE DATE OF BIRTH* M M D D Y Y Y Y  |           |
| Only enter a Foreign<br>National Identification<br>Number if you do not<br>have a SSN. Do not<br>enter National Provider<br>Identification (NPI)<br>Number here. | CITY OF BIRTH STATE OF COUNTRY OF BIRTH   |           |
| Code lists are found on pages 36-43. Enter the associated 3-digit code   | SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN)  | )F ISSUE  |
| in the space provided.   | ENTER ALL NON-ENGLISH<br>LANGUAGES YOU SPEAK<br>LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE   |           |
| Home Address   | NUMBER STREET APT NUMBER  |           |
|  | CITY STATE ZIP CODE   |           |
| <b>NOTE:</b> CAQH will use<br>this method for<br>application follow-up.  | E-MAIL  |           |
| L  | 3076  |           |

| Section 1   | * REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND RE<br>Personal Information and Professional IDs. (Contin  |  |
|---|--|--|
|   | Personal Information and Professional IDs (Contin  |  |
| Professional<br>IDs<br>Include all state<br>licenses, DEA<br>Registration and State<br>Controlled Dangerous   | FEDERAL DEA NUMBER   | M M D D Y Y Y Y<br>DEA ISSUE DATE<br>M M D D Y Y Y Y<br>DEA EXPIRATION DATE  |
| Substance (CDS)<br>certification numbers.<br>Provide all current and<br>previous licenses/<br>certifications.   | CDS STATE OF REGISTRATION  | M M D D Y Y Y Y<br>CDS ISSUE DATE<br>M M D D Y Y Y Y<br>CDS EXPIRATION DATE  |
| Non-licensed<br>professionals should<br>enter certification/<br>registration number in<br>the space provided for<br>license number.<br>If you have additional | STATE LICENSE NUMBER  IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO   | LICENSE ISSUING STATE  MMDDYYYYY  LICENSE ISSUE DATE  MMDDYYYYY  LICENSE EXPIRATION DATE   |
| Professional IDs to<br>report, use the<br>Professional IDs<br>Supplemental Form on<br>page 19.  | Code list is found on page 36;<br>use license status codes. Enter<br>3-digit code in space provided.<br>LICENSE STATUS CODE  | Code list is found on page 36;<br>use provider type codes. Enter<br>3-digit code in space provided.  |
|   | STATE LICENSE NUMBER<br>IF THIS IS A STATE LICENSE, ARE YOU<br>CURRENTLY PRACTICING IN THIS STATE? YES NO<br>Code list is found on page 36;<br>use license status codes. Enter<br>3-digit code in space provided.  | LICENSE ISSUING STATE $M M D D Y Y Y Y$ LICENSE ISSUE DATE $M M D D Y Y Y Y$ LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided. |
|   | LICENSE STATUS CODE LICENSE TYPE   |  |
| Other ID<br>Numbers<br>If you have additional<br>Professional IDs to<br>report, use the<br>Professional IDs<br>Supplemental Form on<br>page 19.               | ARE YOU A PART-<br>ICIPATING MEDICARE<br>PROVIDER?*<br>ARE YOU A PART-<br>ICIPATING MEDICAID<br>PROVIDER?*<br>MEDICAID NUMBER<br>MEDICAID NUMBER<br>MEDICAID NUMBER<br>MEDICAID NUMBER<br>WORKERS COMPENSATION NUMBER<br>ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)<br>ECIMA STATES STATE |  |
| L   | . 3077   |  |

| I   |   |   |
|---|---|---|
| Section 2   | Education and Training  | ĺ |
| Undergraduate   | UNDERGRADUATE SCHOOL  |   |
| School(s)<br>Provide the appropriate<br>information for the<br>school that issued your<br>undergraduate degree<br>and all schools | OFFICIAL NAME OF UNDERGRADUATE SCHOOL   |   |
| attended.   | ADDRESS   |   |
| Drefessional  | CITY STATE ZIP/POSTAL CODE  |   |
| Professional<br>School(s)   |   |   |
| Provide the appropriate<br>information for the<br>school that issued your<br>professional degree.                                 | COUNTRY CODE     TELEPHONE     FAX       M     M     Y     Y     Y       START DATE     END DATE (GRADUATION DATE)     DEGREE AWARDED |   |
| Fifth Pathway Graduates<br>please complete the<br>following sections: U.S.<br>School that issued your                             | DID YOU COMPLETE YOUR<br>UNDERGRADUATE EDUCATION YES NO<br>AT THIS SCHOOL?  |   |
| certificate, the Non-U.S.<br>School where you<br>attended, and the Fifth<br>Pathway institution<br>where you completed            | GRADUATE TYPE*:   | - |
| your training on<br>Supplemental Page 20.   | U.S. OR CANADIAN SCHOOL   | • |
| Code lists are found on pages 36-43. Enter the associated 3-digit code  | SCHOOL CODE (U.S./<br>CANADIAN ONLY) NAME OF U.S./<br>CANADIAN SCHOOL:  |   |
| in the space provided.  |   |   |
| lf you have additional<br>Undergraduate or  | START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED  |   |
| Professional Schools to<br>report, use the<br>Education Supplemental<br>Form on page 20.  | DID YOU COMPLETE YOUR<br>GRADUATE EDUCATION AT THIS YES NO<br>SCHOOL?   | _ |
|   | NON - U.S. OR CANADIAN SCHOOL   |   |



3078

| 2   | Educati                      | on a    | nd Trai                  | ning   | ) (Co   | ontinue  | ed)     |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|---|------------------------------|---------|--------------------------|--------|---------|----------|---------|-----|--------|-----|---|------|---|-----|-------|-------|-----|---|---|--------|--------|-------------------|
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
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| g<br>u  |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   | SC     |        | CODE (I<br>ED MED |
| e one   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        | CHOOL  |                   |
| stitution.  | INSTITUTION/H                | IOSPITA | L NAME (USE              | вотн   | LINES   | IF REQUI | RED)    |     |        |     |   |      |   |     |       |       |     | _ |   |        |        |                   |
| dditional   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
| e training<br>e the   | NUMBER                       |         |                          | STRE   | ET      |          |         |     |        |     |   |      |   |     |       |       |     |   | S | UITE/B | UILDIN | G                 |
| l Training<br>e 21.   |                              |         |                          |        |         |          |         |     |        |     | Г |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
| n on the<br>I   | CITY                         |         |                          |        |         |          |         |     |        |     | S | TATE |   | ZIP | /POS1 | TAL C | ODE |   |   |        |        |                   |
| / Work  |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       | -   |   |   | -      |        |                   |
|   | COUNTRY CO                   | DE      |                          |        | Т       | ELEPHON  | E       |     |        |     |   |      |   | FAX |       |       |     |   |   |        |        |                   |
| e (3)   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | DID YOU COM<br>INSTITUTION?  | PLETE   | THIS TRAININ             | S PRO  | GRAM    | AT THIS  | YES     |     | NO     |     |   |      |   |     |       |       |     |   |   |        |        |                   |
| bry Gap Form on<br>33 any training<br>s) of three (3)<br>ths or greater, or<br>gap(s) of a shorter<br>tion if required by<br>organization for<br>h you are being<br>entialed.<br>e lists are found on<br>s 36-43. Enter the<br>ciated 3-digit code<br>e space provided. | (IF NOT, PLEA                | SE USE  | THE SPACE E              | ELOW   | то ех   | PLAIN.)  |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | List each                    |         | INTERNSHIP/<br>RESIDENCY |        | FELL    | .OWSHIP  | OTHER   | N   | 1      |     |   |      | Y |     | Μ     | Μ     | Y   | Y | Y | Y      |        |                   |
|   | department<br>separately, if |         | RESIDENCI                |        |         |          |         |     | ART DA |     |   |      |   |     |       | DATE  |     |   |   |        |        |                   |
|   | applicable.                  |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
| s   | List                         |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | Internship/                  | DEPA    | RTMENT/SPE               | SIALTY | ' (DO N | OT ABBRE | EVIATE) |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | Residency,<br>Fellowship     |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | and Other<br>programs        | NAME    | OF DIRECTO               | R      |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | separately.                  |         | INTERNSHIP/              |        | 1       |          |         |     |        |     |   |      |   | 1   |       |       |     |   |   |        | 1      |                   |
|   |                              |         | RESIDENCY                |        | FELL    | OWSHIP   | OTHER   | N   |        | ΙΙΥ | Y | Ý    | Y |     | Μ     | M     | Y   | Y | Y | Y      |        |                   |
|   |                              |         |                          |        |         |          |         | ST  | ART DA | TE  |   | _    | _ |     | END   | DATE  | _   | _ |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              | DEPA    | RTMENT/SPE               | IALTY  | ' (DO N | OT ABBRE | EVIATE) |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       | 1     |     |   |   | 1      |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              | NAME    | OF DIRECTO               | R      | _       |          |         |     | _      | _   |   |      |   | _   |       |       | _   |   |   |        |        |                   |
|   |                              |         | INTERNSHIP/<br>RESIDENCY |        | FELL    | OWSHIP   | OTHER   | Ν   | 1      | ΙY  | Y | ' Y  | Y |     | Μ     | M     | Y   | Υ | Υ | Υ      |        |                   |
|   |                              |         | REGIDENCI                |        |         |          |         | STA | ART DA |     |   |      |   |     | END   | DATE  |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        | 11     |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              | DEPA    | RTMENT/SPE               | CIALTY | ' (DO N | OT ABBRE | EVIATE) |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              | NAME    | OF DIRECTO               | R      |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   |                              | •       |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |
|   | 1                            |         |                          |        |         |          |         |     |        |     |   |      |   |     |       |       |     |   |   |        |        |                   |

| RD<br>IFIED?            | YES   | NO   |   | CER  | IN UT I  |  |  |  |   |  |   |   |  |  |  |  |   |   |   |   |  |  |  | _  |
|-------------------------|---|--|---|--|--|--|--|--|---|--|---|---|--|--|--|--|---|---|---|---|--|--|--|--|
| TFIED?                  | YES   | NO   |   |  | INITIA<br>TIFICATIO<br>DA  | DN 🚺   | Ν  | 1  |   |  |   |   |  | (  | E  | DO YO<br>BE LIS<br>HE DI<br>JNDEF  | TED I   | ORY   | I   | Ю   |  | YES  |  | NO   |
| RD                      |   | NO   |   |  | TIFICATIO<br>DA<br>PLICABL   | те 🛛 🚺   | I  | 1  |   | )<br>Y   |   |   |  | (  |  | SPECI  |   |   | I   | РО  |  | YES  |  | NC   |
| E                       |   |  |   | EXPIRA<br>(IF AF   | TION DAT   | re<br>E) Ⅳ   | N  | 1  | D   |  |   |   |  | (  |  |  |   |   | F   | os  |  | YES  |  | NC   |
| T<br>RD<br>IFIED<br>ECT | EXAM  |  |   |  |  |  |  |  |   | IT FOR   | AN  |   |  |  |  |  |   |   |   |   |  |  |  |  |
| CER                     | TIFYING   | BOARD C  | ODE   |  |  | N  | 1  | /  |   |  |   |   | r  | r  |  |  |   |   |   |   |  |  |  |  |
|                         |   |  |   |  |  |  |  |  | D EXA   | M, PL  | EASE  | USE T   | HE   |  |  |  |   |   |   |   |  |  |  |  |
|                         |   |  |   |  |  |  |  |  |   |  |   |   |  |  |  |  |   |   |   |   |  |  |  |  |
|                         |   |  |   |  |  |  |  |  |   |  |   |   |  |  |  |  |   |   |   |   |  |  |  |  |
|                         |   |  |   |  |  |  |  |  |   |  |   |   |  |  |  | DO   |   |   |   |   |  |  |  |  |
|                         |   |  |   |  | ERTIFICA   | TION<br>DATE   | Μ  | Μ  | D   | D  | Y   | Υ   | Υ  | Υ  |  | BE<br>THE<br>UND   | LISTE<br>DIRE<br>DER T  | D IN<br>CTOR<br>HIS   |   | нмс   |  |  |  |  |
| RTIFIED?                | YE  | S NC   | C   | -  | APPLICA  | BLE)   | M  | М  | D   | D  | Y   | Y   | Y  | Y  |  |  |   |   |   |   |  |  | L  |  |
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| NOT<br>ARD<br>RTIFIED   | EXA   | AM, RESULT   | гs  |  |  |  |  |  |   | SIT F  | OR AN   | I   |  |  |  |  |   |   |   |   |  |  |  |  |
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YES       NO       RECERTIFICATION DATE       M       D       Y       Y       Y         NOT       ARD       EXPIRATION DATE       M       D       Y       Y       Y         ILECT       ILAVE TAKEN       EXAM, RESULTS       INTEND TO SIT FOR AN       A A         EXAM       PENDING FOR       M       D       Y       Y       Y         OC       EXAM, RESULTS       EXAM ON       INTEND       A A         DE       M       D       Y       Y       Y         OC       EXAM, R | D       EXAM, RESULTS       Image: Centifying Board Code         Centifying Board code       M <td< td=""><td>D       EXAM, RESULTS       ID NOT INTEND         GET       ID NOT INTEND FOR       ID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE       ID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE       ID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE       ID NOT INTEND TO TAKE A CERTIFICATION         ECIALTY       INITIAL       M M D D Y Y Y         ECIALTY       CERTIFICATION         ARD       RECERTIFICATION         ARD       EXPIRATION DATE         (IF APPLICABLE)       M M D D Y Y Y         NOT       EXAM ON         ARD       EXPIRATION DATE         M M D D Y Y Y       Y         OC       INTEND TO SIT FOR AN         EXAM RESULTS       INTEND TO SIT FOR AN         EXAM ON       I DO NOT INTEND         CERTIFYING BOARD CODE       M M D D Y Y Y Y         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE</td><td>D       EXAM, RESULTS       IDU NOT INTEND TO ARE         PENDING FOR       M       M       D       Y       Y       Y         CERTIFYING BOARD CODE       M       M       D       Y       Y       Y       Y         DU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE       CERTIFYING BOARD CODE       M       M       D       Y       Y       Y         DU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE       CERTIFYING BOARD EXAM, OTHERWISE LEAVE THE SPACE BLANK.       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ECIALTY       CERTIFYING CERTIFICATION DATE         Date       M M D D Y Y Y Y         BE LISTED IN<br>THE DRECTORY<br>UNDER THIS         ARD       EXAM RESULTS         RTIFYING       EXAM RESULTS         VES       NO         RECERTIFICATION<br>DATE       M M D D Y Y Y         M M D D Y Y Y       POS         VIDICATED TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE | D       EXAM, RESULTS       EXAM ON       A CERTIFYING BOARD CARE         GT       IDD NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE         DUINDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFICATION M M D D Y Y Y         BE LISTED IN THE DIRECTORY         UNDER THIS         SPECIALTY         VES         NO         RECERTIFICATION M M D D Y Y Y         DO Y Y YS         PPO         VES         NOT         RTIFYING         EXAM ON         RTIFYING BOARD CODE         NOT         INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE |

F

| Section 3   | Professio                          | onal / M    | Nedio     | cal S  | Spe    | cial | ty l  | nfoi  | ma     | tion  | ) (Co | ontin | ued)                               | 1        |      |    |     |         |     |       |       |      |   |
|---|------------------------------------|-------------|-----------|--------|--------|------|-------|-------|--------|-------|-------|-------|------------------------------------|----------|------|----|-----|---------|-----|-------|-------|------|---|
| ertifications   | Do you hold th                     | ne followin | ig certif | icatio | ns? If | yes, | provi | de ex | pirati | on da | ates. |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           | EXPIF  | RATIO  |      | =     |       |        |       |       |       |                                    |          |      |    | EXF | PIRATIO |     | ΓE    |       |      |   |
|   | BASIC LIFE<br>SUPPORT?*            | YES         | NO        | Μ      | Μ      | D    | D     | Y     | Y      | Y     | Y     | SL    | DV LIFE<br>JPPOR1<br>B?*           |          | YES  | NO | M   | M       | D   | D     | Y     | Υ    | Υ |
|   | CPR?*                              | YES         | NO        | Μ      | М      | D    | D     | Y     | Y      | Y     | Y     | LI    | DV TRA<br>FE<br>JPPOR <sup>-</sup> |          | YES  | NO | M   | M       | D   | D     | Y     | Y    | Y |
|   | ADV<br>CARDIAC<br>LIFE SPT?*       | YES         | NO        | М      | М      | D    | D     | Y     | Y      | Y     | Y     | PE    | EDIATR<br>DVANCI                   | IC<br>ED | YES  | NO | M   | M       | I D | D     | Y     | Υ    | Y |
|   | NEONATAL<br>ADVANCED<br>LIFE SPT?* | YES         | NO        | М      | М      | D    | D     | Υ     | Y      | Y     | Υ     | LI    | FE SPT                             | e.       | L    |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| Practice<br>nterests                                      |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| rovide additional<br>reas of professional                 |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| ractice interest,<br>ctivities, procedures,<br>agnoses or |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| opulations.   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| rimary  |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| Credentialing   | LAST NAME                          |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
|   |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| E THE OFFICE  | FIRST NAME                         |             | -         | _      |        |      |       |       |        |       |       |       |                                    |          | <br> |    |     |         | 1   |       |       |      | N |
| DDRESS OF THE<br>RIMARY PRACTICE<br>DCATION AS THE        |                                    |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |
| REDENTIALING<br>FORMATION.                                | NUMBER                             |             |           | STRE   | =1     |      |       |       |        |       |       |       |                                    |          |      |    |     |         | 1   | SUITE | BUILI | JING |   |
|   | CITY                               |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    | STA | TE      |     | ZIP ( | ODE   |      |   |
| NOTE:   |                                    | -           |           | ]_[    |        |      |       |       |        |       |       |       |                                    | _        |      |    |     |         |     |       |       |      |   |
| Even if you checked<br>he boxes above,                    | TELEPHONE                          |             | 1(        |        |        |      |       |       | FAX    |       |       |       | نــــال<br>ـــــ                   |          | <br> | /I |     |         |     |       |       |      |   |
| please provide the<br>e-mail address, if                  | E-MAIL ADDRES                      |             |           |        |        |      |       |       |        |       |       |       |                                    |          |      |    |     |         |     |       |       |      |   |

\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

| Section 4  | Practice                                  | Loca     | ation   | Info    | rmat            | ion               |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
|--|---|----------|---------|---------|-----------------|-------------------|----------------------------|--------|----------------|--------|----------------|------------------|---------------|----------------|------|-----|----------------|-----------------|----------------|-----------------|-------------|--------|---------|-------|-------------------|----|
| Primary<br>Breaties                                | NOTE: IF YOU<br>CREDENTIALI               | INDICAT  | ED THA  | T YOU   | PRACT<br>N ABO\ | ICE EX<br>/E. SEC | CLUS                       | SIVELY | ( WITH<br>Y BE | IIN TH | IE INF<br>BLAN | PATIEN<br>IK. YO | IT SE<br>U MA | tting<br>Y pro | ON F | AGE | 1, YO<br>SECTI | U ARE<br>ON 5   | E ONL<br>ON P/ | Y REG<br>AGE 1' | UIREI<br>1. | о то с | OMPL    | ETE T | HE                |    |
| Practice<br>Location                               | CURRENTLY<br>PRACTICING A<br>THIS ADDRESS |          | YES     | 1       | NO              | YOUF              | D, WHA<br>R EXPI<br>RT DAT | ECTED  | M              | Μ      | D              | D                | Υ             | Υ              | Υ    | Y   |                |                 |                |                 |             |        |         |       |                   |    |
| If you have additional<br>practice locations, use  |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | ٦  |
| the Supplemental<br>Practice Location              | PHYSICIAN GR                              | OUP / PR | ACTICE  | NAME T  | O APPE          | AR IN C           | DIRECT                     | TORY   | (DO NO         | ОТ АВ  | BREVI          | ATE)*            |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| Information Form on pages 25-29.                   |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | 1  |
| pageo 20 201                                       | GROUP / CORF                              | PORATE N | IAME AS | IT APPI | EARS O          | N W-9, I          | IF DIFI                    | FEREN  | IT FRC         | М АВ   | OVE (I         | о пот            | АВВ           | REVIA          | TE)  |     |                |                 |                |                 |             |        |         |       |                   | _  |
| <b>NOTE:</b> "General<br>Correspondence" refers    |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| to any correspondence<br>that might be sent to the | NUMBER*                                   |          |         | STR     | REET*           |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 | 1           | SUIT   | E/BUILI | DING  |                   | _  |
| provider that does not solely relate to creden-    |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| tialing or billing information.                    | CITY*<br>SEND GENERA                      |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                | 1    | 1 1 |                |                 | STA            | TE*             |             | ZIP C  | ODE*    |       |                   | 7  |
| <b>TIP</b> Your Individual Tax                     | CORRESPON-<br>DENCE HERE?                 | •        | YES     |         | NO              | TELEPH            |                            |        |                |        |                | -                |               |                |      |     | AX             |                 |                |                 |             |        |         |       |                   |    |
| ID is assumed to be<br>your Primary Tax ID         |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | ٦  |
| unless you specify otherwise to the right.         | OFFICE E-MAIL                             | ADDRES   | S       |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
|  |   |          |         |         |                 |                   |                            |        |                |        | _              |                  | -             |                |      |     |                | PRIMA<br>TAX ID |                |                 | USE<br>TAX  |        | DUAL    |       | USE GRO<br>TAX ID | າມ |
|  | INDIVIDUAL TA                             | AX ID    |         |         |                 |                   |                            | GROU   | IP TAX         | ID     |                |                  |               |                |      |     |                | (ONE (          | ONLY)          | •               |             |        |         |       |                   |    |
| Office Manager                                     |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | 7  |
| or Business<br>Office Staff                        | LAST NAME*                                |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| Contact  |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | ٦  |
| List each contact                                  | FIRST NAME*                               |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       | M.I.              | _  |
| separately. You may use the check boxes            |   | -        |         | -       |                 |                   |                            |        |                |        |                | -                |               |                | -    |     |                |                 |                |                 |             |        |         |       |                   |    |
| below for convenience.<br>Do not write             | TELEPHONE*                                |          |         |         |                 |                   |                            |        | FAX            |        |                |                  |               |                |      |     |                |                 | <br>           |                 |             |        |         |       |                   | _  |
| instructions like "see<br>above". These            |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| responses will be<br>rejected and will             | E-MAIL ADDRE                              | SS       |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| require follow-up.                                 |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | _  |
| Billing Contact                                    |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| CHECK HERE TO                                      | LAST NAME*                                |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   | -  |
| USE OFFICE<br>MANAGER AND<br>OFFICE ADDRESS        |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       | M.I.              |    |
| AS BILLING<br>INFORMATION                          | FIRST NAME*                               |          |         |         | _               |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                | -               |             |        |         |       | WI.I.             | ٦  |
|  | NUMBER*                                   |          |         | STR     | REET*           |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             | SUITE  | BUILC   |       |                   |    |
|  |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                | 1               |                |                 | 1           |        |         |       |                   | ٦  |
| NOTE:  | CITY*                                     |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 | ST             | ATE*            |             | ZIP C  | ODE*    |       |                   |    |
| Even if you checked the box above, please          |   | _        |         | -       |                 |                   |                            |        |                |        |                | _                |               |                | 1-   |     |                |                 |                |                 |             |        |         |       |                   |    |
| provide the<br>E-mail Address of the               | TELEPHONE*                                |          |         |         |                 |                   |                            |        | FAX            |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
| Billing Contact.                                   |   |          |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
|  | E-MAIL ADDRE                              | SS       |         |         |                 |                   |                            |        |                |        |                |                  |               |                |      |     |                |                 |                |                 |             |        |         |       |                   |    |
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| NOTE:       TURMBER*       STREET       SUTERBULLDING         Final Address of the<br>Payee Contact.       OTY       STATE*       ZB CODE*         F-mail Address of the<br>Payee Contact.       FAX       FAX         Contact.       E-MAIL ADDRESS       E-MAIL ADDRESS         Office Hours       (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)       E-NO       AVER NOUNDAY         Intersonation       State*       Payee       Sature Address       Sature Address         NOTE:       (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)       Sature Address       Sature Address         NOTE:       USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)       Sature Address       Sature Address         NOTE:       USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)       Sature Address       Sature Address         NOTE:       USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)       Sature Address       Sature Address         NOTE:       USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOURS       Sature Address       Sature Address         NOTE:       USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOURS       Sature Address       Sature Address         Open Practice<br>Status       NOT Partiel NET NOT THE NEAREST WALF Address NTO THE NEAREST NOT AT HE NOURE ADDRESS       Sature Address NTO Address       Sature NOURE BACK OFFICE TELEPHONE<br>MASTER USE NTO AT HEN P  | Section 4                    | Practice Lo   | cation          | Infor   | matic    | on (Co   | ontin | ued)       |              |            |         |         |         |        |       |        |      |        |      |              |
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| NOTE:<br>Even I you checked<br>provide the<br>Famil Address of the<br>Payee Contact.<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:<br>TELEPHONE:   |                              | FIRST NAME*   |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      | м            |
| NOTE:<br>Eval Jou checked<br>the box shove, please<br>privide the<br>E-mail Address of the<br>Payee Contact.<br>E-mail Address of the<br>E-mail Address   |                              |   |                 |         |          |          |       |            |              |            |         | 1       |         |        |       |        |      |        |      |              |
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|  | NOTE:                        |   |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| provide the<br>Payee Contact.<br>E-mail Address of the<br>E-mail Address of th  |                              | CITY*   |                 |         |          |          |       |            |              |            |         |         |         |        | STATE |        | ZIP  | CODE*  |      |              |
| Payee Contact.  E-MAIL ADDRESS   | provide the                  |   |                 | -       |          |          |       |            |              |            | -       |         |         |        |       |        |      |        |      |              |
| Office Hours     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HALM FORMAT AND ROUND TO THE SATURDAY     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND THE PRACTICE?'     (USE HALM FORMAT AND ROUND TO THE NEAREST HALF-HOURS BACK OFFICE TELEPHONE     (USE HALM FORMAT AND THE PRACTICE?'     (USE HALM FORMAT AND ROUND TO ALL PRACTICE HALF FORMAT AND ROUND AND A CCEPT NEW PATIENTS?'     (USE AND ROUND AND A CCEPT NEW PATIENTS?'     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS WITH PHYSICIAN REFERRAL?''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS?''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS?''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS WITH PHYSICIAN REFERRAL?''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS?''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS'''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS'''     (USE AND ROUND AND A CCEPT NEW MEDICAND PATIENTS'''   |                              | TELEPHONE*  |                 |         |          | _        |       | FAX        | _            |            | _       |         |         |        |       |        | _    |        |      |              |
| Diffice Hours       (USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)         Image: transmitter of the state of the s   | ►                            |   |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| START       A-MM<br>P-PM       END       A-AM<br>P-PM       START       A-AM<br>P-PM       END       A-AM<br>P-PM         MONDAY       IUESDAY       IUESDAY       IUESDAY       Saturbay       Saturbay       IUESDAY         TUESDAY       IUESDAY       IUESDAY       Saturbay       Saturbay       IUESDAY       IUESDAY         24/7 PHONE COVERAGE?"       IF YES       VOICE MALL WITH<br>INSTRUCTIONS TO CALL       WOICE MALL WITH<br>INSTRUCTIONS TO CALL       VOICE MALL       AFTER HOURS BACK OFFICE TELEPHONE         24/7 PHONE COVERAGE?"       IF YES       NO       ARSWERING SERVICE       VOICE MALL WITH<br>INSTRUCTIONS OF CALL       VOICE MALL       VOICE MALL       AFTER HOURS BACK OFFICE TELEPHONE         Ublished under any<br>ircumstances.       VES       NO       ARSWERING SERVICE       VOICE MALL       WITH OTHER<br>INSTRUCTIONS       AFTER HOURS BACK OFFICE TELEPHONE         Oppen Practice<br>Status       Accept New PATIENTS INTO THIS PRACTICE?"       YES       NO       Accept New PATIENTS?"       YES         Accept New PATIENTS WITH CHANGE OF PAYOR?"       YES       NO       Accept New MEDICARE PATIENTS?"       YES         Accept New PATIENTS WITH CHANGE OF PAYOR?"       YES       NO       Accept New MEDICARE PATIENTS?"       YES         Accept New PATIENTS WITH PHYSICIAN REFERRAL?"       YES       NO       Ac   |                              | E-MAIL ADDRESS  |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| START       A+M<br>P+PM       END       A+AM<br>P+PM       START       A+AM<br>P+PM       END       A+AM<br>P+PM         MONDAY       MONDAY       FRDAY       FRDAY       FRDAY       FRDAY         MONDAY       TUESDAY       SaturDay       SaturDay       SaturDay         MONDAY       THURBDAY       SaturDay       SunDay       SaturDay         24/7 PHONE COVERAGE?*       IF YES       VOICE MAIL WITH<br>NOTIFICURNITIONER       VOICE MAIL WITH<br>NOTIFICURNITIONER       AFTER HOURS BACK OFFICE TELEPHONE         24/7 PHONE COVERAGE?*       IF YES       NO       AREWERING SERVICE       VOICE MAIL WITH<br>NISTRUCTIONS       AFTER HOURS BACK OFFICE TELEPHONE         2018bined under any<br>incurnistances.       VES       NO       AREWERING SERVICE       AFTER HOURS BACK OFFICE TELEPHONE         2018bined under any<br>incurnistances.       VES       NO       ACCEPT NEW PATIENTS INTO THIS PRACTICE?*       VES       NO       ACCEPT ALL NEW PATIENTS?*       VES         2010bined under any<br>incurnistances.       Accept new patients into this practice?*       VES       NO       Accept new patients?*       VES         2011       Accept new patients with change of PAYOR?*       YES       NO       Accept new medical patients?*       YES         2012       Accept new patients with change of PAYOR?*       YES   | fice Hours                   | USE HHMM FOR  | MAT AND         | ROUN    | р то ті  | HE NEA   | REST  | HALF-H     | OUR)         |            |         |         |         |        |       |        |      |        |      |              |
| IOTE:<br>Inter hours back office<br>Plephone will be used<br>n/ by the health plan<br>d will not be<br>ublished under any<br>incumstances.<br>Dpen Practice<br>Status<br>Accept new patients into this practice?<br>Accept new patients with change of payor?<br>YES NO ACCEPT NEW MEDICARE PATIENTS?<br>YES NO ACCEPT NEW MEDICAR   |                              |   | START           |         |          |          | END   |            | A=AM<br>P=PM |            |         | ST      | ART     |        |       |        | EN   | D      |      | A=AM<br>P=PM |
| Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours back office       Inter hours back office         Inter hours back office       Inter hours back office       Inter hours<   |                              | MONDAY  |                 |         |          |          |       |            |              | FRIDAY     |         |         |         |        |       |        |      |        |      |              |
| IOTE:<br>Ither hours back office<br>alsephone will be used<br>ind will not be<br>ublished under any<br>ircumstances.<br>Deen Practice<br>Status Accept New Patients into this practice? Yes No Accept AlL New Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Accept New Patients with Physician REFERAL? Yes No Accept New Medical Patients? Yes Yes No Accept New Medical Patients? Yes Accept New Medical Patients?   |                              |   |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| Inter hours back office slephone will be used in be what he halt he hal  |                              | TUESDAY   |                 |         |          |          |       |            |              | SATURDAY   |         |         |         |        |       |        |      |        |      |              |
| NOTE:       thursback office         iter hours back office       lephone coverage?*       if yes         answering       voice Mail with         ind will not be       with ot be         ubitsbad under any       ves         Ves       No         Asswering       voice Mail with         instructions to call       with other         outstances.       asswering         Open Practice       accept new patients into this practice?*         Status       accept existing patients with change of payor?*       yes         Accept new patients with physician referral?*       yes       No         accept new patients with physician referral?*       yes       No         accept new patients with physician referral?*       yes       No         accept new patients with physician referral?*       yes       No       accept new medicaid patients?*         accept new patients with physician referral?*       yes       No       accept new medicaid patients?*       yes         accept new patients with physician referral?*       yes       No       accept new medicaid patients?*       yes         accept new patients       gender limitations       accept new medicaid patients?*       yes       no         accept new patients       maximum   |                              |   |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| After hours back office<br>elephone will be used<br>inly by the health plain<br>will not be<br>published under any<br>sitrumstances.       If YES       IF YES       AFTER HOURS BACK OFFICE TELEPHONE         24/7 PHONE COVERAGE?       IF YES       VOICE MAIL WITH<br>INSTRUCTIONS TO CALL<br>WITH OTHER<br>INSTRUCTIONS       VOICE MAIL WITH<br>WITH OTHER<br>INSTRUCTIONS       AFTER HOURS BACK OFFICE TELEPHONE         Open Practice<br>Status       ACCEPT NEW PATIENTS INTO THIS PRACTICE?*       YES       NO       ACCEPT ALL NEW PATIENTS?*       YES         ACCEPT NEW PATIENTS WITH CHANGE OF PAYOR?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         IF ANY OF THE<br>BOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)       GENDER LIMITATIONS       AGE LIMITATIONS       LIST OTHER LIMITATIONS         YES       NO       IF YES       MALE       MALE       MALE       MALE       MALE         YES       NO       IF YES       MALE       MALE       MAXIMUM       MAXIMUM       MAXIMUM   |                              | WEDNESDAY   |                 |         |          |          |       |            |              | SUNDAY     |         |         |         |        |       |        |      |        |      |              |
| elephone will be used<br>only by the health plan<br>and will not be<br>published under any<br>irrcumstances.<br>Open Practice<br>Status<br>Accept new patients into this practice?' YES NO Accept All New Patients?' YES<br>Accept new patients with change of Payor?' YES NO Accept new medicaid patients?' YES<br>Accept new patients with physician referral?' YES NO Accept new medicaid patients?' YES<br>Accept new patients with physician referral?' YES NO Accept new medicaid patients?' YES<br>IF ANY OF THE<br>ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY<br>YES NO IF YES<br>NO YES<br>NO YES<br>NO IF YES<br>NO YES<br>NO YES<br>NO IF YES<br>NO YES  |                              | THURSDAY  |                 |         |          |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| Implementation       Imple   | elephone will be used        | 24/7 PHONE COVERA   | GE?* IF         | VES     |          |          |       |            |              |            |         |         | AFTER   | HOUR   | SBACK | OFFICE |      | HONE   |      |              |
| ACCEPT NEW PATIENTS INTO THIS PRACTICE?*       YES       NO       ACCEPT ALL NEW PATIENTS?*       YES         ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         ACCEPT NEW PATIENTS WITH CHANGE OF PAYOR?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         IF ANY OF THE<br>ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)       GENDER LIMITATIONS       AGE LIMITATIONS       LIST OTHER LIMITATIONS         ARE THERE ANY<br>PRACTICE LIMITATIONS?*       GENDER LIMITATIONS       AGE LIMITATIONS       LIST OTHER LIMITATIONS         YES       NO       IF YES       MALE       NONE       MINIMUM<br>AGE       MAXIMUM   | and will not be              |   |                 | AN      | SWERING  |          |       |            |              |            |         |         |         | nook   |       |        |      |        |      |              |
| Status       ACCEPT NEW PATIENTS INTO THIS PRACTICE?*       100       ACCEPT NEW PATIENTS?*       YES         ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*       YES       NO       ACCEPT NEW MEDICARE PATIENTS?*       YES         IF ANY OF THE<br>ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)       GENDER LIMITATIONS       AGE LIMITATIONS       LIST OTHER LIMITATIONS         ARE THERE ANY<br>PRACTICE LIMITATIONS?*       GENDER LIMITATIONS       AGE LIMITATIONS       LIST OTHER LIMITATIONS         YES       NO       IF YES       MALE<br>ONLY       NONE       MINIMUM<br>AGE       MAXIMUM  |                              |   |                 | SEF     | RVICE    |          |       |            |              |            |         |         |         |        |       |        |      |        |      |              |
| ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO ACCEPT NEW MEDICAID PATIENTS?* YES  | ircumstances.                |   |                 | IS PRAC | TICE?*   |          |       | ſES        | NO           | ACCE       | PT ALL  | NEW P   | ATIEN   | rs?*   |       |        |      |        | YES  |              |
| IF ANY OF THE<br>ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY<br>PRACTICE LIMITATIONS?*<br>VES<br>NO<br>IF YES<br>NO<br>IF YES<br>FEMALE<br>MALE<br>ONLY<br>FEMALE<br>MALE<br>MAXIMUM  | bircumstances. Open Practice | ACCEPT NEW PATIEN   | NTS INTO TH     |         |          |          |       | (F.O.      | NO           | ACCE       | PT NEW  | / MEDIO | CARE P  | ATIEN  | rs?*  |        |      |        | YES  |              |
| ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY<br>PRACTICE LIMITATIONS?*<br>VES NO IF YES<br>IF YES<br>NO IF YES<br>FEMALE<br>MALE<br>ONLY<br>FEMALE<br>MAXIMUM   | circumstances. Open Practice |   |                 | ГН СНАМ | IGE OF P | AYOR?*   |       |            |              |            |         |         |         |        |       |        |      |        | YES  |              |
| EXPLAIN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY<br>PRACTICE LIMITATIONS?*<br>VES NO IF YES<br>FEMALE<br>NONE MALE<br>FEMALE<br>MALE<br>ONLY<br>NONE MALE<br>MAXIMUM   | ircumstances. Dpen Practice  | ACCEPT EXISTING PA  | ATIENTS WI      |         |          |          | Н     |            | NO           | ACCE       | EPT NEW | / MEDIO | CAID PA | ATIENT | S?*   |        |      |        |      |              |
| ARE THERE ANY<br>PRACTICE LIMITATIONS?*  | ircumstances. Dpen Practice  | ACCEPT EXISTING PA<br>ACCEPT NEW PATIEN   | ATIENTS WIT     |         |          |          | Н     |            | NO           | ACCE       | EPT NEW | / MEDIC | CAID PA | ATIENT | S?*   |        |      |        |      |              |
| PRACTICE LIMITATIONS?*     MALE<br>ONLY     NONE     MINIMUM<br>AGE       YES     NO     IF YES  | Dpen Practice                | ACCEPT EXISTING PA<br>ACCEPT NEW PATIEN<br>IF ANY OF THE<br>ABOVE INFORMATIO<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH  | ATIENTS WITH PH |         |          |          | Н     |            | NO           | ACCE       | PT NEW  |         |         |        | S?*   |        |      |        |      |              |
| YES NO IF YES ONLY AGE AGE AGE   | ircumstances. Dpen Practice  | ACCEPT EXISTING PA<br>ACCEPT NEW PATIEN<br>IF ANY OF THE<br>ABOVE INFORMATIO<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)  | ATIENTS WITH PH |         |          | RAL?*    |       | /ES        |              |            |         |         |         |        |       |        |      |        |      |              |
|  | Dpen Practice                | ACCEPT EXISTING PA<br>ACCEPT NEW PATIEN<br>IF ANY OF THE<br>ABOVE INFORMATIO<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY                         | ATIENTS WITH PH |         |          | RAL?*    |       | res        |              | IMITATIONS | LIST    |         |         |        |       |        |      |        |      |              |
| ONLY AGE   | Dpen Practice                | ACCEPT EXISTING PA<br>ACCEPT NEW PATIEN<br>IF ANY OF THE<br>ABOVE INFORMATION<br>VARIES BY PLAN,<br>EXPLAIN (USE BOTH<br>LINES IF REQUIRED)<br>ARE THERE ANY<br>PRACTICE LIMITATION | ATIENTS WITH PH |         | N REFERF | RAL?*    |       | res        |              |            | LIST    |         |         |        |       |        |      |        |      |              |

| tion 4                 | Practice Location Information (Continued)  |                    |                                  |
|------------------------|--|--------------------|----------------------------------|
| I-Level<br>actitioners | DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN<br>ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*<br>(IF YES, PLEASE PROVIDE THE INFORMATION BELOW) | YES NO             |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER LAST NAME   |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER FIRST NAME  |                    | M.I. PRACTITIONER TYPE (E.G., P/ |
|                        |  |                    | CNP, NF                          |
|                        | PRACTITIONER LICENSE / CERTIFICATE NUMBER  | PRACTITIONER STATE |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER LAST NAME   |                    |                                  |
|                        |  |                    |                                  |
| -                      | PRACTITIONER FIRST NAME  |                    | M.I. PRACTITIONER TYPE (E.G., PA |
|                        |  |                    | CNP, NF                          |
|                        | PRACTITIONER LICENSE / CERTIFICATE NUMBER  | PRACTITIONER STATE |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER LAST NAME   |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER FIRST NAME  |                    | M.I. PRACTITIONER TYPE (E.G., PA |
|                        |  |                    | ČNP, N                           |
|                        | PRACTITIONER LICENSE / CERTIFICATE NUMBER  | PRACTITIONER STATE |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER LAST NAME   |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER FIRST NAME  |                    | M.I. PRACTITIONER TYPE (E.G., PA |
|                        |  |                    | ČNP, NF                          |
|                        | PRACTITIONER LICENSE / CERTIFICATE NUMBER  | PRACTITIONER STATE |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER LAST NAME   |                    |                                  |
|                        |  |                    |                                  |
|                        | PRACTITIONER FIRST NAME  |                    | M.I. PRACTITIONER TYPE (E.G., P. |
|                        |  |                    | CNP, NF                          |
|                        | PRACTITIONER LICENSE / CERTIFICATE NUMBER  | PRACTITIONER STATE |                                  |
|                        |  |                    |                                  |
|                        |  |                    |                                  |

|   |   |             |           |                                     |   |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     | I  |    |
|---|---|-------------|-----------|-------------------------------------|---|-----------------|--------|---------|--------------|------------------|----------|-------|------------|-----------------|-----------------|-------------------------|-------|-------|----|-----|----|----|
| Section 4   | * REQUIRED RESPO  |             |           |                                     |   |                 | AYS A  | ND REC  | QUIRE F      | -OLLOW-          | UP.      |       |            |                 |                 |                         |       |       |    |     |    | ī  |
| Languages   |   |             |           |                                     | Jonunu                                  | <del>.</del> u) |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    | 1  |
| Code lists are found on<br>pages 37. Enter the<br>associated 3-digit code<br>in the space provided. | NON-ENGLISH LANG<br>SPOKEN BY OFFICE<br>INTERPRETERS<br>AVAILABLE?* |             |           | NGUAGE CODI<br>LANGUAC<br>INTERPRI  | GES<br>ETED                             | GUAGE           |        | [       |              | GE CODE          |          | LANGU |            |                 |                 | ANGL                    |       |       |    |     |    |    |
| Accessibilities   | DOES THIS OFFICE  | IEET ADA A  | CCESSIBIL | ITY REQUIREN                        |   | YES             |        | NO      | ANGUA        | GE CODE          |          | LANGU | AGEC       | ODE             | I               | ANGU                    | JAGE  | CODE  |    |     |    | -  |
|   | DOES THIS SITE OF<br>ACCESS FOR THE F                               |             | APPED     |                                     | DES THIS SI<br>ERVICES FO               |                 |        |         |              | YES              | NC       | D     | ACC<br>PUB | ESSIE<br>LIC TR | BLE BY<br>RANSP | ORTA                    | FION? | *     | YE | 6   | NO |    |
|   | BUILDING?*  | YES         | NO        |                                     | TEXT TEL                                | EPHON           | Υ (ΤΤΥ | )*      |              | YES              | N        | 0     |            | E               | BUS*            |                         |       |       | YE | 6   | NO |    |
|   | PARKING?*   | YES         | NO        |                                     | AMERICA                                 | N SIGN          | LANG   | JAGE*   |              | YES              | N        | 0     |            | 5               | SUBWA           | Y*                      |       |       | YE | 3   | NO |    |
|   | RESTROOM?*  | YES         | NO        |                                     | MENTAL/                                 |                 | AL IMP | AIRMEN' | T            | YES              | N        | 0     |            | F               | REGIO           | NAL TF                  | RAIN* |       | YE | 6   | NO |    |
|   | OTHER HANDICAPP   | ED ACCESS   |           |                                     | OTHER DIS                               | ABILITY         | SERV   | ICES    |              |                  |          |       | оті        | IER T           | RANSP           | ORTA                    | TION  | ACCES | s  |     |    |    |
| Services  | Does this locatior  | n provide a | ny of the | following ser                       | vices?                                  |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    | -  |
|   | LABORATORY<br>SERVICES?   | YES         | NO        | CERTIFYIN                           | OVIDE ACCE<br>IG PROGRAM<br>, COLA, MLE | N               | G/     |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   | RADIOLOGY<br>SERVICES?  | YES         | NO        |                                     | OVIDE X-RA<br>TION TYPE                 | Y               |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    | _  |
|   | EKGS?   | YES         | NO        | ALLERGY                             | IS?                                     | YES             |        | NO      | ALLE<br>TEST | RGY SKIN<br>ING? | N        | YES   | 6          | NO              |                 | ROUT<br>GYNE<br>(PELV   | COLO  |       |    | YES |    | NO |
|   | DRAWING<br>BLOOD?   | YES         | NO        | AGE<br>APPROPRI<br>IMMUNIZA         |   | YES             |        | NO      | FLEX         | IBLE<br>OIDOSCO  | PY?      | YES   | 6          | NO              |                 | TYMP.<br>Y/ AUI<br>SCRE | DIOME | TRY   |    | YES |    | NO |
|   | ASTHMA<br>TREATMENT?<br>PULMONARY                                   | YES         | NO        | OSTEOPAT<br>MANIPULA                |   | YES             |        | NO      |              | DRATION          | I/       | YES   | 5          | NO              |                 | CARD<br>STRE            |       | ST?   |    | YES |    | NO |
|   | FUNCTION<br>TESTING?  | YES         | NO        | PHYSICAL<br>THERAPY?                | ?                                       | YES             |        | NO      | CARE<br>LACE | E OF MINC        | DR<br>S? | YES   | 6          | NO              |                 |                         |       |       |    |     |    | _  |
|   | IS ANESTHESIA<br>ADMINISTERED IN<br>YOUR OFFICE?                    | YES         | NO        | IF YES, WH<br>CLASS/CA<br>DO YOU US | TEGORY                                  |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   | IF YES, WHO<br>ADMINISTERS IT?                                      | LAST NAME   |           |                                     |   |                 |        |         |              |                  |          | FIRS  |            | E               |                 |                         |       |       |    |     | ]  |    |
|   | TYPE OF PRACTICE<br>(SELECT ONE ONLY)                               |             | SOLO F    | PRACTICE                            |   | SIN             | GLE SI | PECIALI | Y GRO        | UP               |          | MUL   | TI-SPE     | CIALT           | ry gro          | DUP                     |       |       |    |     |    |    |
|   | ADDITIONAL OFFICE   | E PROCEDUR  | RES PROVI | DED (INCLUDI                        | NG SURGIC                               | AL PRO          | CEDUR  | ES)     |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   |   |             |           |                                     |   |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   |   |             |           |                                     |   |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   |   |             |           |                                     |   |                 |        |         |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |
|   |   |             |           |                                     |   | 30              | )8(    | 5       |              |                  |          |       |            |                 |                 |                         |       |       |    |     |    |    |

| Section 4                                       | * REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.   |      |                                      |
|---|---|------|--------------------------------------|
| Section 4                                       | Practice Location Information (Continued)   |      |                                      |
| Partners/<br>Associates                         | LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE   |      |                                      |
|   |   |      |                                      |
| Code lists are found on pages 36-43. Enter the  |   |      | SPECIALTY CODE COVERING<br>COLLEAGUE |
| associated 3-digit code in the space provided.  |   |      | (Y/N)?                               |
| If you have additional                          | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| partners/associates at THIS location, use the   |   |      |                                      |
| Partner/Associate                               |   |      | SPECIALTY CODE COVERING              |
| Supplemental Form on page 23. Photocopy as      |   |      | COLLEAGUE<br>(Y/N)?                  |
| necessary. Be certain<br>to check "Primary      | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| Location" at the top of the page.               |   |      |                                      |
|   |   |      |                                      |
|   |   |      | SPECIALTY CODE COVERING<br>COLLEAGUE |
|   |   |      | (Y/N)?                               |
|   | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| Covering  | LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE   |      |                                      |
| Colleagues                                      |   |      |                                      |
| Code lists are found on                         |   |      | SPECIALTY CODE                       |
| pages 36-43. Enter the associated 3-digit code  |   |      |                                      |
| in the space provided.                          | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| If you have additional<br>covering colleagues   |   |      | FROMDER TIPE (CODE PG 30)            |
| that are not partners at THIS location, use the |   |      |                                      |
| Covering Colleagues<br>Supplemental Form on     |   |      | SPECIALTY CODE                       |
| page 24. Photocopy as                           |   |      |                                      |
| necessary. Be certain<br>to check "Primary      | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| Location" at the top of the page.               |   |      |                                      |
|   |   |      |                                      |
|   |   |      | SPECIALTY CODE                       |
|   |   |      |                                      |
|   | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)           |
| Section 5                                       | Hospital Affiliations   |      |                                      |
| Admitting<br>Arrangements                       | DO YOU HAVE<br>HOSPITAL<br>PRIVILEGES?* YES VESTICATION OF ADMIT PATIENTS, WHAT<br>TYPE OF ADMITTING ARRANGEMENTS DO<br>YOU HAVE? |      |                                      |
|   |   |      |                                      |
|   |   |      |                                      |
|   |   |      |                                      |
|   |   |      |                                      |
|   |   |      |                                      |
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| I   |   |      | I                                    |
|   | . 3087  |      |                                      |

| Hospital Privileges reprivatives Privileges reprivatives Privileges Privilege   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      | ied)   | ntinu  | Cor   | ns (   | atio    | ffili  | al A   | spit  | Ho    | tion 5                            |
|--|-----|----------|-------|-------|-------|-------|----------|------|-------|-----|----|---|-----|-------|-----|--------|-------|------|-------|--------|------|--------|--------|-------|--------|---------|--------|--------|-------|-------|-----------------------------------|
| rivileges<br>applicable, list all<br>applicable, list all<br>applicable, list all<br>bit oppicable, list all<br>bit oppicable, list all<br>bit oppicable, list all<br>all all all all all all all all all all  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      | .04)   |        | 001   |        |         |        |        |       |       |                                   |
| Applicability list all<br>many hospital, their<br>recurrent<br>fundiogation debi-<br>running of additional<br>soppital Privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>imm on page 30.4<br>P Be cortain your<br>mission processings<br>or or while the privileges that the privileges<br>mission processings<br>or or while the privilege that the privileges<br>mission processings<br>or or while the privileges that the privileges<br>mission processing the privileges<br>mission processings<br>or or while the privileges that the privileges<br>mission processings<br>or the privileges that the privileges<br>mission processings<br>or or while the privileges that the privileges<br>mission processings<br>or or while the privileges that the privileges<br>mission processing the privileges<br>mission proc                                  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
| Hard hospital, the current listions, followed by wooks diffialtons in onedgeal order: no onedgeal order: no one addition of the hospital h   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        | _     |      |       |        |      |        |        |       |        |         |        | IAME   |       | HOSP  | icable, list all                  |
| Idelong, followed by<br>onclogical order.       NUMERE       STREET       SUITEBULD         Wows affiliations<br>(ory  |     |          | ٦٢    |       |       |       |          |      |       |     |    |   | Г   |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       | y hospital, then                  |
| Inclogical order:<br>20 Devalues uses<br>Supplemental<br>page 33.<br>Use contain your<br>ission prage 33.<br>Use contain your<br>ission provides that the the the the the the the the the th   | ING | UILDING  | ITE/B | SUIT  | 1     |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        | т      | STREE |        |         |        |        | BER   | NUME  | ions, followed by                 |
| u have additional<br>Supplemental<br>n on page 30:<br>Be certain your<br>ission parcentage<br>up to 100% for<br>https://www.commental<br>perartitent Director's FIRST NAME<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>TELEPHONE TATUS<br>TELEPHONE TATUS<br>Department Director's FIRST NAME<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>Department Director's FIRST NAME<br>Department Director's FIRST NAME<br>NUMBER STRUCTURE<br>DEPartment Director's FIRST NAME<br>Department D                                   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
| DEPARTMENT DIRECTOR'S FIRST NAME  DEPART   |     | DE       | РСО   | ZIP   |       | E     | STAT     |      | -     |     |    |   |     |       |     |        |       |      |       | -      |      |        |        |       |        |         |        |        |       | CITY  | have additional                   |
| Be certain your<br>ssion percentage<br>por 100% for S LAST NAME<br>DEPARTMENT DIRECTOR'S LAST NAME<br>DEPARTMENT DIRECTOR'S LAST NAME<br>AFFILIATION START DATE<br>AFFILIATION START DATE<br>AFFILIATION START DATE<br>NUMBER<br>STREET<br>DEPARTMENT DIRECTOR'S LAST NAME<br>NUMBER<br>STREET<br>DEPARTMENT NAME<br>DEPARTMENT   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       | (    | FAX   |        |      |        |        |       |        |         |        | E      | PHON  | TELE  | al privileges, use<br>Ipplemental |
| Be certain your<br>ission percentages<br>provide you will precedence in the provide provide the provide th   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       | on page 30.                       |
| Be certain your<br>sistion percentages<br>up to 100% for<br>enhospitals.<br>Dervice this<br>to correct this<br>to correc |     |          |       | 1     |       |       | _        | _    | -     |     |    |   |     |       |     | _      | _     | _    |       |        |      |        |        |       |        |         | ME     | NT NAI | RTME  | DEPA  |                                   |
| Be certain your<br>ission percentages<br>up to 100% for<br>ent hospitals.  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        | ME    | STNA   | P'S I / | ECTO   |        | DTME  |       |                                   |
| Be certain your<br>ission percentages<br>phyliceges?  VES NO ARE PRIVILEGES AFFILIATION START DATE AFFILIATION START DATE OF YOUR TOTAL ANNUAL<br>ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) OTHER HOSPITAL OTHER HOSPITAL OTHER HOSPITAL OTHER PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) OTHER HOSPITAL OTHER HOSPITAL OTHER HOSPITAL STREET SUTERPUIL DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME OEPARTMENT DIRECTOR'S FIRST NAME OEPARTMENT DIRECTOR'S FIRST NAME OEPARTMENT DIRECTOR'S FIRST NAME OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE OF YOUR TOTAL ANNUAL ADMISSION YEAR OF YOUR TO   |     |          |       | 1     |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         | Lero   |        |       |       |                                   |
| Be certain your<br>ission percentages<br>per to 100% for torta. Annual.<br>Application stratt date a felulation end date<br>of your torta. Annual.<br>Admitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>a domitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>a domitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>a domitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>a domitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>a domitting Privilege status (e.g. none, Full unrestricted, Provisional, temporary)<br>other hospital.<br>Department name<br>Department pirectors s first name<br>Department pirector   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     | _      | _     |      |       |        |      | _      |        | ME    | RST N  | R'S FI  | ЕСТО   | NT DIR | RTME  | DEPA  |                                   |
| Be certain your<br>siston percentages<br>up to 100% for<br>ent hospitals.<br>ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)<br>OTHER HOSPITAL<br>TOTHER HOSPITAL<br>HOSPITAL NAME<br>NUMBER<br>STREET<br>SUITE/BUILD<br>CITY<br>STATE<br>TELEPHONE<br>DEPARTMENT DIRECTOR'S FIRST NAME<br>DEPARTMENT DIRECTOR'S FIN   | YES | YE       | S     | .EGES |       | RE F  | <b>b</b> | NC   |       | ES  | YE |   | TED |       |     |        |       | Y    | Y     | Υ      | Y    | М      | Μ      |       | Y      | Y       | Y      | Y      | М     | Μ     |                                   |
| up to 100% for<br>ent hospitals<br>admitting PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)<br>OTHER HOSPITAL<br>OTHER HOSPITAL<br>HOSPITAL NAME<br>UNIMEER STREET<br>SUITE/BUILD<br>CITY<br>STATE ZIP CODE<br>TELEPHONE<br>DEPARTMENT DIRECTOR'S LAST NAME<br>DEPARTMENT DIRECTOR'S FIRST NAME   |     |          | _     |       | L     |       |          | тот  | OUR ' |     | 0  | _ |     |       |     | _      |       | _    |       | D DATE | N EN | ΙΑΤΙΟ  | AFFII  |       |        | TE      | RT DAT | N STAR | IATIO | AFFIL |                                   |
| ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)  OTHER HOSPITAL  HOSPITAL NAME  UNMBER STREET  SUITE/BUILD  OTY  STATE ZIP CODE  TELEPHONE  FAX  DEPARTMENT DIRECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  DIRECTOR'S FIRST NA   |     |          | E     | TAGE  |       | T PEF | WHA      | ONS, | SSIO  | DMI | A  |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       | o to 100% for                     |
| HOSPITAL NAME   HOSPITAL NAME   NUMBER   STREET SUITE/BUILD CITY STATE ZIP CODE TELEPHONE FAX DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME M M Y Y Y Y FULL, UNRESTRICTED YES NO ARE PRIVILEGES? AFFILIATION START DATE OF YOUR TOTAL ANNUAL ADMISsions, WHAT PERCENTAGE OF YOUR TOTAL ANNUAL ADMISsions, WHAT PERCENTAGE  |     |          |       |       |       |       |          |      |       |     |    |   |     |       | RY) | IPOR.  | L, TE | SION | PROVI | ICTED, | ESTR | . UNRI | , FULI | NONE  | S (E.G | STATU   |        |        |       |       | wise, you will                    |
| NUMBER STREET   CITY STATE ZIP CODE TELEPHONE FAX DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME OF YOUR TOTAL ANNUAL   |     |          | 7     |       |       |       |          |      |       |     |    |   |     |       |     | _      | _     | _    |       |        |      | _      | _      |       |        |         | TAL    | OSPI   | ER H  | отн   |                                   |
| NUMBER STREET   CITY STATE ZIP CODE CITY STATE ZIP CODE FAX DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME OF YOUR TOTAL ANNUAL   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
| CITY STATE ZIP CODE<br>TELEPHONE FAX<br>DEPARTMENT DIRECTOR'S LAST NAME<br>DEPARTMENT DIRECTOR'S LAST NAME<br>DEPARTMENT DIRECTOR'S FIRST NAME<br>DEPARTMENT DIRECTOR'S FIRST NAME<br>DEPARTMENT DIRECTOR'S FIRST NAME<br>DEPARTMENT DIRECTOR'S FIRST NAME<br>M M Y Y Y Y Y FULL UNRESTRICTED YES NO ARE PRIVILEGES<br>AFFILIATION START DATE OF YOUR TOTAL ANNUAL<br>ADMISSIONS, WHAT PERCENTAGE  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       | nosr  |                                   |
| TELEPHONE FAX   DEPARTMENT NAME DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT DERCENTAGE OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE   | ING | JUILDING | ITE/B | SUIT  |       |       |          |      |       |     |    |   |     |       |     |        | _     |      |       |        |      |        | т      | TREE  | :      |         |        |        | BER   | NUME  |                                   |
| TELEPHONE FAX   DEPARTMENT NAME   DEPARTMENT DIRECTOR'S LAST NAME   DEPARTMENT DIRECTOR'S FIRST NAME   DEPARTMENT DIRECTOR'S FIRST NAME   M Y   Y Y   PRIVILEGES?   AFFILIATION START DATE   OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  |     |          |       |       | ]     |       |          |      | 1     |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
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| DEPARTMENT NAME DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME DEPARTMENT DIRECTOR'S FIRST NAME AFFILIATION START DATE AFFILIATION START DATE OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  |     |          |       |       |       |       |          |      |       |     |    | - |     |       |     | -      |       |      |       |        |      |        |        | -     |        |         | -      |        |       |       |                                   |
| DEPARTMENT DIRECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  AFFILIATION START DATE  AFFILIATION START DATE  OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  TO THIS HOSPITAL?   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       | (    | FAX   | _      |      |        |        |       |        |         |        | E      | рнол  | TELE  |                                   |
| DEPARTMENT DIRECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  AFFILIATION START DATE  OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE  TO THIS HOSPITAL?   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
| DEPARTMENT DIRECTOR'S FIRST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  AFFILIATION START DATE  AFFILIATION END DATE  OF YOUR TOTAL ANNUAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?   |     |          |       |       |       |       | _        |      |       |     |    |   |     |       |     |        | _     |      |       |        |      | _      |        |       |        |         | ME     | NT NAI | RTME  | DEPA  |                                   |
| DEPARTMENT DIRECTOR'S FIRST NAME  DEPARTMENT DIRECTOR'S FIRST NAME  AFFILIATION START DATE  AFFILIATION END DATE  OF YOUR TOTAL ANNUAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?   |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        | ME    | ST NA  | R'S LA  | ЕСТО   |        | RTME  | DEPA  |                                   |
| M       M       Y  |     |          |       | 1     |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |
| AFFILIATION START DATE AFFILIATION END DATE OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        | ME    | RST NA | R'S FII | ЕСТО   | NT DIR | RTME  | DEPA  |                                   |
| AFFILIATION START DATE AFFILIATION END DATE OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL?  | YES | YE       | s     | .EGES | RIVIL | ARE F | <b>c</b> | NC   |       | ES  | YE |   | TED | STRIC |     | ULL, I |       | Y    | Y     | Y      | Y    | М      | М      |       | Y      | Y       | Y      | Y      | Μ     | М     |                                   |
| ADMISSIONS, WHAT PERCENTAGE<br>IS TO THIS HOSPITAL?  |     |          |       | (17   | JRAR  | EMP   |          |      |       |     |    |   |     | ſ     | GES | RIVIL  |       |      |       | D DATE | N EN | IATIO  | AFFII  |       |        | TE      | RT DAT | N STAR | IATIO |       |                                   |
|  |     |          | E     | TAGE  |       | T PEF | WHA      | ONS, | SSIO  |     | A  |   |     |       | RY) | IPOR   | L. TE | SION | PROVI | ICTED. | ESTR | . UNRI | . FULI | NONE  | S (E.G | STATU   | EGE S  | PRIVIL | TTING | ADMI  |                                   |
| PLEASE EXPLAIN<br>TERMINATED AFFILIATION   |     |          |       |       |       |       |          |      |       |     |    |   |     |       | ,   |        |       |      |       |        |      |        | , -    |       |        |         |        | PLAIN  | SE EX | PLEA  |                                   |
|  |     |          |       |       |       |       |          |      |       |     |    |   |     |       |     |        |       |      |       |        |      |        |        |       |        |         |        |        |       |       |                                   |

| Section 6  | Professional Liability I  | nsur  | anc   | e C  | arri | er |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
|--|---|-------|-------|------|------|----|------|--------|------|-------|--------|-------|------|-------|-------|-------------|------------|------|---------|--------|-------|-----|------|
| Professional   |   |       |       |      | 1    |    | 1    | 1      |      |       |        |       |      |       |       |             |            | 9515 | -INSUI  | 2502*  |       | YES |      |
| Liability  | CARRIER OR SELF-INSURED NAME*                                   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            | JELF | -111301 | (ED :  |       | 113 |      |
| Insurance<br>Carrier                                   |   |       |       |      | -    |    | 1    | 1      |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Garrier  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| IMPORTANT<br>IF YOU DO NOT                             | NUMBER* STR   | EE I* |       |      |      |    |      |        |      |       |        |       |      | _     | Г     | _           |            |      | SUITE   | BUILC  | JING  |     |      |
| CARRY MALPRACTICE                                      |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| INSURANCE, CHECK<br>THIS BOX AND SKIP<br>THIS SECTION. | CITY*   |       |       |      |      |    |      | 1      | _    |       |        |       |      |       |       | STAT        |            |      | ZIP (   | CODE*  | _     |     |      |
|  | ΜΜΥΥΥΥΥ   | Μ     | Μ     | Y    | Y    | Y  | Y    |        | Μ    | Μ     | Y      | Y     | Y    | Y     |       | PE O<br>VER | GE?*       |      | INDI    | IDUAL  | •     | SH  | ARED |
|  | ORIGINAL EFFECTIVE DATE*  | EFFE  | CTIVE | DATE | *    |    |      |        | EXPI | RATIO | N DATE |       |      |       | 1     |             |            |      |         |        |       |     |      |
|  | DO YOU HAVE UNLIMITED COVERAGE<br>WITH THIS INSURANCE CARRIER?* |       | YES   |      | NO   |    |      |        |      |       |        |       |      |       | \$    |             |            |      |         |        |       |     |      |
|  |   |       | 1     | _    |      |    | АМО  | JNT OF | COVE | RAGE  | PER    | OCCUF | RENG | E     | AN    | IOUN        | IT OF      | COVE | RAGE    | AGGRE  | GATE  | :   |      |
|  | POLICY INCLUDES TAIL COVERAGE?                                  |       | YES   |      | NO   |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
|  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       | _           |            |      |         |        |       |     |      |
|  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
|  | POLICY NUMBER*  |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Professional   |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            | SELF | -INSU   | RED?   |       | YES |      |
| Liability<br>Insurance                                 | CARRIER OR SELF-INSURED NAME                                    |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Carrier  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| List other current,<br>future, or previous             | NUMBER* STR   | EET*  |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      | SUITE   | /BUILC | DING  |     |      |
| carrier(s) if current                                  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| carrier is less than ten (10) years.                   | CITY*   |       |       |      |      |    |      |        |      |       |        |       |      |       | L     | STA         | ſE*        |      | ZIP (   | CODE*  |       |     |      |
| NOTE: A longer period                                  | ммүүүү  | Μ     | М     | Y    | Y    | Y  | Y    | 1      | М    | М     | Y      | Y     | Y    | Y     |       |             | F<br>\GE?* |      | INDI    |        | _     | SH  | ARED |
| may be required by<br>your healthcare entity.          | ORIGINAL EFFECTIVE DATE*  |       | CTIVE | DATE | *    |    |      | 1      |      | RATIO |        |       |      |       | 00    | VERA        | AGE ?      |      | 1       |        |       |     |      |
| If you have additional                                 | DO YOU HAVE UNLIMITED COVERAGE                                  |       |       |      | ]    |    |      |        |      |       |        |       |      |       | ] ¢[  |             |            |      |         |        |       |     |      |
| Insurance, use the                                     | WITH THIS INSURANCE CARRIER?                                    |       | YES   |      | NO   | 4  |      | JNT OF |      | PAGE  |        | ,     |      | `E    | Ψ     |             |            | COVE | AGE     | AGGRE  | GATI  |     |      |
| Supplemental<br>Insurance Form on                      | POLICY INCLUDES TAIL COVERAGE?                                  |       | YES   |      | NO   |    | Amov |        | 0011 |       |        |       |      |       | -     | 1001        |            | 0012 |         | HOOKE  | .0411 |     |      |
| page 31.   | FOLICT INCLUDES TAIL COVERAGE?                                  |       | 123   |      | NO   |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
|  |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
|  | POLICY NUMBER*  |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Section 7  | Work History and Refe   | rence | es    |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Military   | Are you currently on active military                            |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Duty   | duty or military reserve?*                                      |       | YE    | S    | NC   | )  |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Work History   | WORK HISTORY  |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| Include a chronological work history for the           |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| past 10 years.   | PRACTICE / EMPLOYER NAME  |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| A longer period may be                                 |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |
| required by your<br>healthcare entity.                 | NUMBER STR  | EET   |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      | SUIT    | E/BUIL | DING  |     |      |
| If you have additional                                 |   |       |       |      |      |    |      |        |      | 1     |        |       |      |       |       |             |            |      |         |        |       |     |      |
| work history, use the<br>Supplemental Work             | СІТҮ  |       | 1     | 1    |      | 1  |      |        | 1    |       | STATI  | <br>E |      | ZIP/P | OSTAL | сор         | 1 <b> </b> |      |         | 1      |       |     |      |
| History Form on page                                   |   |       |       |      |      |    |      |        |      |       |        |       |      |       |       |             |            |      |         |        |       |     |      |

| on 7                           | Work H       | istory  | / and                 | Refe   | renc | es (         | Cont         | tinu | ed)   |     |              |   |      |   |      |       |       |   |           |         |    |   |
|--------------------------------|--------------|---------|-----------------------|--------|------|--------------|--------------|------|-------|-----|--------------|---|------|---|------|-------|-------|---|-----------|---------|----|---|
| History                        |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
| st current                     |              | -       |                       | -      |      |              |              |      |       |     | -            |   |      |   |      |       |       |   |           |         |    |   |
| s. Those<br>e listed in        | TELEPHONE    |         |                       |        |      |              |              |      | FAX   |     |              |   |      |   |      |       |       |   |           |         |    |   |
| 4.                             |              |         | Μ                     | ЛУ     |      | $\mathbf{v}$ | $\mathbf{V}$ |      | М     | М   | $\mathbf{v}$ |   |      |   |      |       |       |   |           |         |    |   |
| a chronological                |              |         |                       |        |      |              |              |      |       |     |              |   | ·    |   |      |       |       |   |           |         |    |   |
| tory for the                   | COUNTRY CO   |         | START D               |        |      |              |              |      | END I | AIE |              |   |      |   |      |       |       |   |           |         |    |   |
| years.                         | REASON FOR   | DEPART  | JRE (IF AP            | PLICAB | LE)  |              |              | _    |       |     |              |   |      |   |      |       |       |   |           | —       | _  |   |
| period may be                  |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
| by your<br>re entity           |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
| ve additional<br>tory, use the |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
| ental Work                     | WORK HIS     | TORY    |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
| Form on page                   |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | PRACTICE / E | MPLOYE  | R NAME                |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | NUMBER       |         |                       | STR    | EET  |              |              |      |       |     |              |   | _    |   | _    |       |       |   | SUITE     | /BUILDI | NG | _ |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | CITY         |         |                       |        |      |              |              |      |       |     |              |   | STAT | E | ZIP/ | POSTA | L COD | E |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              | -       |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | TELEPHONE    |         |                       |        |      |              |              |      | FAX   |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         | Μ                     | ЛУ     | Y    | Y            | Y            |      | М     | М   | Y            | Y | Y    | Y |      |       |       |   |           |         |    |   |
|                                | COUNTRY CO   | DE      | START D               | ATE    |      |              |              |      | END I | ATE |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | REASON FOR   |         |                       |        |      |              |              |      | LIL   | A12 |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | REASONTOR    |         |                       | LICAD  | ,    |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              | 1 |      |   |      |       |       |   |           |         |    | _ |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              | TODY    |                       |        |      |              |              |      |       |     |              |   |      |   | <br> |       |       |   | <br>      |         |    |   |
|                                | WORK HIS     | IURT    |                       |        |      |              |              | _    |       |     |              | _ | _    | _ | <br> | _     |       |   | <br>,     | r       |    | _ |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | PRACTICE / E | MPLOYE  | R NAME                | _      |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | NUMBER       |         |                       | STRI   | EET  |              |              | _    |       |     |              |   |      |   | -    | _     |       |   | <br>SUITE | /BUILDI | NG | _ |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | CITY         |         | <u>مما المحمدا ال</u> |        |      |              |              |      |       |     |              |   | STAT | Έ | ZIP/ | POSTA | l cod | E |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | TELEPHONE    |         |                       |        |      |              |              |      | FAX   |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         | M                     | ИX     | Y    | Y            | Y            |      | Μ     | Μ   | Y            | Y | Y    | Y |      |       |       |   |           |         |    |   |
|                                | COUNTRY CO   | DE      | START D               | ATE    |      |              |              |      | END I | ATE |              |   |      |   |      |       |       |   |           |         |    |   |
|                                | REASON FOR   | DEPARTI | URE (IF AP            | PLICAB | LE)  |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        | _,   |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |
|                                |              |         | 1                     |        |      |              |              |      |       |     |              | 1 | 1    |   |      |       |       |   |           |         |    |   |
|                                |              | 11      |                       |        |      |              |              |      |       |     |              |   |      |   |      |       |       |   |           |         |    |   |

| Section 7                                 | Work Histo                          | ory and R                     | eferei               | nces    | (Co             | ntinu            | led)     |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|---|-------------------------------------|-------------------------------|----------------------|---------|-----------------|------------------|----------|--------|--------|----------------|-------|-----------------|--------|----------------|-------------------|----------------|---------------|-------------------|-----------------|---------------|---------|--------|
| Saps in<br>Professional /                 | PLEASE EXPLAIN A<br>LONGER THAN THR | NY TIME PERIO<br>EE MONTHS IN | DS OR GA<br>DURATION | N OR OF | RAININ<br>A SHO | G OR W<br>RTER I | ORK HIST | ORY TH | IAT HA | VE OC<br>BY TH | CURRE | ED SIN<br>ANIZ/ | ICE GE | RADUA<br>FOR W | TION F<br>/HICH Y | ROM I<br>'OU A | PROF<br>RE BE | ESSION<br>EING CI | IAL SC<br>REDEN | HOOL<br>TIALE | AND A   | RE     |
| Vork History                              | GAP START DATE                      | MM                            | YY                   | Y       | Y               | GAP              | END DATE | Μ      | Μ      | Y              | Y     | Y               | Y      |                |                   |                |               |                   |                 |               |         |        |
| you have additional                       |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ofessional / work<br>story gaps, use the  |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                | _             |                   |                 |               |         |        |
| upplemental<br>rofessional Work           |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| istory Gaps Form on age 33.               |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| rofessional                               |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                | _             |                   |                 |               |         |        |
| eferences                                 |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ovide three                               | LAST NAME*                          |                               |                      | _       |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   | Г               |               |         |        |
| ofessional references<br>whom you are not |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ated or are not                           | FIRST NAME*                         |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   | PROV            | /IDER         | TYPE (( | CODE P |
| artners in your<br>actice.                |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ode lists are found on                    | NUMBER*                             |                               | STREET*              |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               | A                 | PT/SU           | ITE/BU        | JILDING | i      |
| ages 36-43. Enter the                     |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| sociated 3-digit code<br>r provider type. | CITY*                               |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   | STAT           | E*            |                   | ZIP CO          | DE*           |         |        |
|   | _                                   |                               | _                    |         |                 |                  |          |        | _      |                |       | <u> </u>        |        |                |                   |                |               |                   |                 |               |         |        |
| OTE:<br>ou are required to                | TELEPHONE                           |                               |                      |         |                 |                  | FAX      |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ovide exactly 3<br>ferences. Your         |                                     |                               |                      | _       |                 |                  |          | _      |        |                | _     |                 |        |                |                   |                | _             |                   | _               | _             | _       | _      |
| plication will not be                     |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| omplete without this<br>formation.        | LAST NAME*                          |                               |                      | _       |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| ease check with<br>edentialing entity for | FIRST NAME*                         |                               |                      |         |                 |                  |          | _      |        |                |       |                 |        |                |                   |                |               |                   | PRO             | VIDER         | TYPE (  | CODE F |
| ny special<br>equirements.                |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
| quirements.                               | NUMBER*                             |                               | STREET*              |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               | ۸                 | PT/SU           | ITE/BU        | JILDING | i      |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   | CITY*                               |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   | STAT           | E*            |                   | ZIP CO          | DE*           |         |        |
|   | -                                   |                               | _                    |         |                 |                  |          |        | _      |                |       | _               |        |                |                   |                |               |                   |                 |               |         |        |
|   | TELEPHONE                           |                               |                      |         |                 |                  | FAX      |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   |                                     |                               |                      | _       | _               |                  |          | _      |        |                |       |                 | _      |                |                   | _              | _             |                   | _               | _             | _       | _      |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   | LAST NAME*                          |                               |                      |         | _               |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         | _      |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   | FIRST NAME*                         |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   | PRO             | VIDER         | TYPE (  | CODE   |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   | NUMBER*                             |                               | STREET*              |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               | A                 | PT/SU           | ITE/BU        | JILDING | i      |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   | CITY*                               |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   | STAT           | E*            |                   | ZIP CO          | DE*           |         |        |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       | ٦.              |        |                |                   |                |               |                   |                 |               |         |        |
|   | TELEPHONE                           |                               |                      |         |                 |                  | FAX      |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         |        |
|   |                                     |                               |                      |         |                 |                  |          |        |        |                |       |                 |        |                |                   |                |               |                   |                 |               |         | 1      |

| •   | * REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.  |
|---|--|
| Section 8   | Disclosure Questions   |
| Disclosure  | LICENSURE  |
| Questions   | 1. YES NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-  |
| Answer all questions.<br>For any "Yes"                                | ditions or limitations by any state or professional licensing, registration or certification board?*   |
| response, provide an explanation on the                               | 2. YES NO Has there been any challenge to your licensure, registration or certification?*  |
| Supplemental<br>Disclosure Question                                   | HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS   |
| Explanation Form on   | Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever  |
| page 34.  | 3. YES NO been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings   |
| Allied Health<br>Providers  | toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*  |
| If you are an Allied  | 4. YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?*   |
| Health Provider and<br>you do not believe a<br>question is applicable | 5. YES NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*  |
| to you, you should answer the question                                | EDUCATION, TRAINING AND BOARD CERTIFICATION  |
| "NO".   | Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, resi-   |
|   | 6. YES NO dency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*   |
|   | 7. YES NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*   |
|   | 8. YES NO Have any of your board certifications or eligibility ever been revoked?*   |
|   | 9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*  |
|   | DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION   |
|   | 10. YES NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*  |
|   | MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION   |
|   | 11. YES NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*                |
|   | OTHER SANCTIONS OR INVESTIGATIONS  |
|   | 12. YES NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-<br>tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant   |
|   | in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*  |
|   | 13. YES NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*   |
|   | 14. YES NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*   |
|   | 15. YES NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*                                       |
|   | 16. YES NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health-care facility of any military agency?* |
|   | PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY  |
|   | 17. YES NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*   |
|   | 18. YES NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*   |

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\* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

| Section 8  | Disclosure Questions (Continued)  |
|--|---|
| Disclosure<br>Questions  | MALPRACTICE CLAIMS HISTORY  |
| Answer all questions.<br>For any "Yes"<br>response, provide an         | 19. YES NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?*   |
| explanation on the   | CRIMINAL/CIVIL HISTORY  |
| Supplemental<br>Disclosure Question<br>Explanation Form on<br>page 34. | 20. YES NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*   |
| IMPORTANT<br>If you answered "Yes"<br>to <b>question #19</b> , you     | 21. YES In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*   |
| must complete the<br>Supplemental<br>Malpractice Claims                | 22. YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?*  |
| Explanation Form on<br>page 35 for each<br>malpractice claim.          | Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.   |
|  | ABILITY TO PERFORM JOB  |
|  | 23. YES NO Are you currently engaged in the illegal use of drugs?*<br>("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on<br>one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of applica-<br>tion, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of<br>drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22.<br>It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses author-<br>ized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of<br>prescription controlled substances.) |
|  | 24. YES NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*  |
|  | 25. YES NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*  |
|  | 26. YES NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*  |

## Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employ-ees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity. I agree that information obtained in accordance with th

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

| Signature*                      | Name (print)* |  |
|---------------------------------|---------------|--|
| M M D D Y Y Y Y<br>DATE SIGNED* |               |  |
|                                 |               |  |
|                                 | 3094          |  |

### Professional IDs Supplemental Form

| Section 1   | Personal Information and Professional IDs   |   |  |
|---|---|---|--|
| Professional<br>IDs<br>Include all additional<br>state licenses, DEA<br>Registration and State<br>Controlled Dangerous  | FEDERAL DEA NUMBER  | M M D D Y Y Y<br>DEA ISSUE DATE<br>M M D D Y Y Y<br>DEA EXPIRATION DATE                                       | Y  |
| Substance (CDS)<br>certification numbers.<br>Provide all current and<br>previous licenses/<br>certifications.<br>If you need to report<br>additional Professional | FEDERAL DEA NUMBER  | M M D D Y Y Y<br>DEA ISSUE DATE<br>M M D D Y Y Y<br>DEA EXPIRATION DATE                                       | Y  |
| IDs, photocopy this<br>page as needed and<br>submit as instructed.  | CDS CERTIFICATE NUMBER  | M M D D Y Y Y<br>CDS ISSUE DATE<br>M M D D Y Y Y<br>CDS EXPIRATION DATE                                       | Y  |
|   | CDS CERTIFICATE NUMBER  | M M D D Y Y Y<br>CDS ISSUE DATE<br>M M D D Y Y Y<br>CDS EXPIRATION DATE                                       | Y  |
|   | STATE LICENSE NUMBER<br>IF THIS IS A STATE LICENSE, ARE YOU<br>CURRENTLY PRACTICING IN THIS STATE? YES NO                   | M   | IDDYYYYY       SISSUE DATE       IDDYYYYY       IDDYYYYY       IDDYYYYY       IDDYYYYY       IDDYYYYY       IDDYYYYY       IDDYYYYY       IDDYYYY       IDDYYYY       IDDYYYY       IDDYYY       IDDYYY       IDDYYY       IDDYYY       IDDYYY       IDDYYY       IDDYY       IDYY       IDDYY |
|   | Code list is found on page 36;<br>use license status codes. Enter<br>3-digit code in space provided.<br>LICENSE STATUS CODE | Code list is found on page 36;<br>use provider type codes. Enter<br>3-digit code in space provided.<br>E TYPE |  |
|   | STATE LICENSE NUMBER  | LICENSE ISSUING STATE   | IDDYYYYY<br>ISSUE DATE   |
|   | IF THIS IS A STATE LICENSE, ARE YOU<br>CURRENTLY PRACTICING IN THIS STATE? YES NO<br>Code list is found on page 36;         | LICENSE   | DDYYYYY<br>EXPIRATION DATE   |
|   | use license status codes. Enter<br>3-digit code in space provided.<br>LICENSE STATUS CODE                                   | use provider type codes. Enter<br>3-digit code in space provided.   |  |
|   |   |   |  |

## Other Relevant Education Supplemental Form

|  | * REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. |
|--|---|
| Section 2                                    | Education and Training  |
| Fifth Pathway                                | FIFTH PATHWAY GRADUATES ONLY  |
| Education                                    |   |
|  | INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE) |
|  |   |
|  |   |
|  | ADDRESS   |
|  |   |
|  | CITY STATE ZIP CODE   |
|  |   |
|  | TELEPHONE FAX   |
|  |   |
|  | EDUCATION AT THIS SCHOOL?   |
|  | START DATE END DATE (GRADUATION DATE)   |
| Other Relevant                               |   |
| Education                                    | INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)                               |
| If you need to report                        |   |
| additional Education, photocopy this page as |   |
| needed and submit as                         | NUMBER STREET SUITE/BUILDING  |
| instructed.                                  |   |
|  | CITY STATE ZIP/POSTAL CODE  |
|  |   |
|  | TELEPHONE FAX   |
|  |   |
|  | COUNTRY CODE START DATE END DATE (GRADUATION DATE) DEGREE AWARDED                   |
|  |   |
|  | EDUCATION AT THIS SCHOOL?   |
|  |   |
|  |   |
|  | INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)                               |
|  |   |
|  | NUMBER     STREET     SUITE/BUILDING  |
|  |   |
|  | CITY STATE ZIP/POSTAL CODE  |
|  |   |
|  |   |
|  | TELEPHONE FAX   |
|  | M M Y Y Y Y M M Y Y Y Y   |
|  | COUNTRY CODE     START DATE     END DATE (GRADUATION DATE)     DEGREE AWARDED       |
|  | DID YOU COMPLETE YOUR<br>EDUCATION AT THIS SCHOOL? YES NO                           |
|  |   |

## Other Training Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

| Section 2  | Educatio                                  | on a   | and T            | rain           | ing     |        | ,       |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|--|---|--------|------------------|----------------|---------|--------|---------|--------|------|-------|---|------|--------|---|---|------|---|---|-----|------|-------|------|---|---|---|------|------|------------------------|------------------|-----------------|
| Training   |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      | Т                      |                  |                 |
| List all postgraduate<br>training programs you<br>attended. Use one    |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      | AFFI | OOL (<br>LIATE<br>OOL) | CODE (<br>ED MED | (E.G.,<br>DICAL |
| section per institution.   | INSTITUTION /                             | HOSPI  | TAL NA           | NE (US         | Е ВОТН  | H LINE | SIFR    | EQUIR  | ED)  |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   | _    |      |                        |                  |                 |
| If you need to report additional Training,                             | NUMBER                                    |        |                  |                | STREE   | T      |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   | S | UITE | BUII | DING                   |                  |                 |
| photocopy this page as<br>needed and submit as                         |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   | 1 | Г   |      |       |      |   | Т |   |      |      |                        |                  |                 |
| instructed.  | СІТҮ                                      |        |                  |                |         |        |         |        |      |       |   |      |        |   | 5 | STAT | E |   | ZIP | /POS | FAL C | CODI | = |   |   |      |      |                        |                  |                 |
| Code lists are found on pages 36-43. Enter the associated 3-digit code |   |        |                  |                |         |        |         |        | -    |       |   |      | ]-[    |   |   |      |   |   |     |      |       | -    |   |   |   | 7-   |      |                        |                  |                 |
| in the space provided.   | COUNTRY CO                                | DE     |                  |                |         | TE     | ELEPH   | ONE    |      |       |   |      |        |   |   |      |   |   | FAX |      |       |      |   |   |   |      |      |                        |                  |                 |
|  | DID YOU COMP                              |        |                  |                |         |        |         |        |      | YES   |   | NC   | 0      |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  | (IF NOT, PLEAS                            | SE USE | E THE SP         | ACE BE         | ELOW I  | IO EXI | PLAIN.) | )      |      |       | _ | -    |        |   | - |      |   |   |     | -    |       |      |   | _ |   |      |      | 1—                     |                  | 1               |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   | Т |      |   |   | Т   |      |       |      |   |   |   |      |      |                        |                  | 1               |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  | List each<br>department<br>separately, if |        | INTERN<br>RESIDI | ISHIP/<br>ENCY |         | FELL   | owshi   | P      |      | OTHER |   | M    | M      | Υ |   | Y    | Y | Υ |     | M    |       |      | Y | Υ | Y |      | Y    |                        |                  |                 |
|  | applicable.                               |        |                  |                |         |        |         |        |      |       |   |      |        |   | Г | Т    |   |   |     |      |       |      |   |   |   | Т    |      |                        |                  |                 |
|  | List<br>Internship/                       | DEP    | ARTMEN           | T/SPEC         | IALTY ( | (DO NO | ОТ АВЕ  | BREVIA | ATE) |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  | Residency,<br>Fellowship                  |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   | Г    |      |                        |                  |                 |
|  | and Other<br>programs                     | NAM    | E OF DIF         | RECTOR         | ۲       |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  | separately.                               |        | INTERN           |                |         | FELL   | owshi   | P      |      | OTHER | 2 | М    | М      | Y | 5 | Y    | Y | Y |     | М    | N     | 1    | Y | Y | Y |      | Y    |                        |                  |                 |
|  |   |        |                  |                |         |        |         |        |      |       |   | STAR | T DATE |   | _ |      |   |   |     | END  | DAT   | E    |   |   |   |      |      |                        |                  | _               |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  |   | DEP    | ARTMEN           | T/SPEC         | IALTY ( | (DO NO | ОТ АВЕ  | BREVI  | ATE) |       |   | _    |        |   |   |      |   | _ |     |      |       | _    | _ |   |   |      |      |                        |                  | _               |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   | L    |      |                        |                  |                 |
|  |   | NAM    |                  |                | 2       |        |         | _      |      |       |   |      |        |   | _ | _    | _ | _ |     | _    | _     | _    | _ |   |   |      | _    |                        |                  |                 |
|  |   |        | INTERN           | ENCY           |         | FELL   | owshi   | P      |      | OTHER |   |      | М      | Y |   | Y    | Y | Y |     | M    |       |      | Y | Y | Y |      | Y    |                        |                  |                 |
|  |   |        |                  |                |         |        |         |        |      |       | : | STAR | f date |   |   | -    |   | _ |     | END  | DAT   | E    | _ |   |   |      | _    |                        |                  | _               |
|  |   | DEP    | ARTMEN           | T/SPEC         | IALTY ( | (DO NO | ОТ АВЕ  | BREVIA | ATE) |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |
|  |   |        |                  |                |         |        |         |        |      |       |   |      |        |   | Г |      |   |   |     |      |       |      |   |   |   | Г    |      |                        |                  |                 |
|  |   | NAM    | E OF DIF         | RECTOR         | 2       |        |         |        |      |       |   |      |        |   |   |      |   |   |     |      |       |      |   |   |   |      |      |                        |                  |                 |

## Additional Specialty Supplemental Form

| Section 3   | Profe                                   | ssion   | al /                         | Meg     | dical   | Spec               | alty                       | Info   | rmat            | ion    |         |         |       |   |   |                                  |        |          |                   |     |   |    |
|---|---|---------|------------------------------|---------|---------|--------------------|----------------------------|--------|-----------------|--------|---------|---------|-------|---|---|----------------------------------|--------|----------|-------------------|-----|---|----|
| dditional<br>pecialty   | SPECIALTY<br>CODE                       |         |                              |         |         | CERT               | INITIA<br>IFICATIO<br>DAT  | NM     | Μ               | D      | Y       | Υ       | Y     | Y |   | DO YO<br>BE LIS<br>THE D<br>UNDE | STED I | N<br>ORY | HMO               | YES |   | NC |
| de lists are found on ges 36-43. Enter the  | BOARD<br>CERTIFIED?                     | YE      | s                            | NO      |         | RECERT             | IFICATIC<br>DAT<br>PLICABL | re M   | Μ               | D      | Y       | Υ       | Υ     | Υ |   | SPEC                             | IALTY  | ?        | PPO               | YES |   | NC |
| sociated 3-digit code<br>he space provided.   | CERTIFYING<br>BOARD<br>CODE             |         |                              |         |         | EXPIRAT<br>(IF APF | ION DAT                    | E)     | Μ               | DI     | Y       | Υ       | Υ     | Υ |   |                                  |        |          | POS               | YES |   | N  |
|   | IF NOT<br>BOARD<br>CERTIFIED            | EXA     | VE TAP<br>M, Res<br>NDING P  | SULTS   |         |                    |                            |        | I INTEN<br>EXAM |        | T FOR A | N       |       |   |   |                                  |        |          | ) TO TA<br>OARD E |     |   |    |
|   | (SELECT<br>ONE)                         |         |                              |         |         |                    |                            | Μ      | М               | D      | Y       | Υ       | Υ     | Y |   |                                  |        |          |                   |     |   |    |
|   | IF YOU INDIC                            |         | ΑΤ ΥΟΙ                       |         | ИОТ ІМТ |                    |                            |        |                 | RD EXA | M, PLE  | ASE USE | E THE |   |   |                                  |        |          |                   |     |   |    |
|   | FOLLOWING                               | SPACE T | O EXPL                       | _AIN, C | THERW   | VISE LEAV          | 'E THE S                   | PACE B | LANK.           | 1      |         |         |       |   | 1 | 1                                |        |          |                   |     |   | _  |
|   |   |         |                              |         |         |                    |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     |   |    |
|   |   |         |                              |         |         |                    |                            |        |                 |        |         |         |       |   | ] | ]                                |        |          |                   |     |   |    |
|   |   |         |                              |         |         |                    |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     |   |    |
| lditional<br>ecialty  | SPECIALTY<br>CODE                       |         |                              |         |         | CERT               | INITIA<br>IFICATIO<br>DAT  | N M    | Μ               | D      | Y       | Y       | Υ     | Y |   | DO YO<br>BE LIS<br>THE D         | STED I | N<br>ORY | HMO               | YES |   | NC |
| le lists are found on<br>es 36-43. Enter the  | BOARD<br>CERTIFIED?                     | YE      | s                            | NO      |         | RECERT             | IFICATIC<br>DA1<br>LICABL  | re M   | Μ               | D      | ) Y     | Υ       | Y     | Y |   | UNDE                             |        |          | PPO               | YES |   | N  |
| ociated 3-digit code<br>ne space provided.  | CERTIFYING<br>BOARD<br>CODE             |         |                              |         |         | EXPIRAT            |                            | E      | Μ               | D      | ) Y     | Υ       | Y     | Y |   |                                  |        |          | POS               | YES |   | N  |
| bu need to report<br>itional Specialties,<br>tocopy this page as<br>ded and submit as | IF NOT<br>BOARD<br>CERTIFIED<br>(SELECT | EXA     | VE TAP<br>AM, RES<br>NDING P | SULTS   |         |                    |                            |        | I INTER<br>EXAM |        | T FOR A | N       |       |   |   |                                  |        |          | O TO TA<br>OARD E |     |   |    |
| tructed.  | ONE)                                    |         |                              |         |         |                    |                            | Μ      | М               | D      | Y       | Y       | Υ     | Y |   |                                  |        |          |                   |     |   |    |
|   | IF YOU INDIC<br>FOLLOWING               |         | ΑΤ ΥΟΙ                       |         | иот імт |                    |                            |        |                 | RD EX  | M, PLE  | ASE USE | E THE |   |   |                                  |        |          |                   |     |   |    |
|   |   |         |                              |         |         | -                  |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     |   |    |
|   |   |         |                              |         |         |                    |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     |   |    |
|   |   |         |                              |         |         |                    |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     |   | ٦  |
|   |   |         |                              |         | (       |                    |                            |        |                 |        |         |         |       |   |   |                                  |        |          |                   |     | _ | _  |

## Partners/Associates Supplemental Form

| Section 4  | Practice Location Information   |         |                    |                                 |
|--|---|---------|--------------------|---------------------------------|
| Partner/<br>Associates   | SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PRO | /IDERS. |                    |                                 |
| Use this page to<br>report additional<br>partners/associates at                            | ► LOCATION # PRIMARY PRACTICE PRACTICE NAME   |         |                    |                                 |
| the designated<br>practice location.   | PRACTICE ADDRESS  |         |                    |                                 |
| IMPORTANT  |   |         |                    |                                 |
| In the box provided,<br>indicate to which<br>practice location this                        |   |         |                    | COVERING<br>COLLEAGUE<br>(Y/N)? |
| page belongs.  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | E PG 36)                        |
| Check "Covering<br>Colleague?" if he/she<br>provides coverage for<br>you at THIS location. |   |         |                    | COVERING                        |
| Code lists are found<br>on pages 36-43. Enter  |   | M.I.    |                    | COLLEAGUE<br>(Y/N)?<br>E PG 36) |
| the associated 3-digit code in the space   |   | 1       |                    |                                 |
| provided.<br>If you need to report<br>additional   |   |         |                    | COVERING<br>COLLEAGUE           |
| partners/associates,<br>photocopy this page<br>as needed and submit                        | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | (Y/N)?<br>E PG 36)              |
| as instructed.   |   |         |                    |                                 |
|  |   |         |                    | COVERING<br>COLLEAGUE<br>(Y/N)? |
|  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD |                                 |
|  |   |         |                    |                                 |
|  |   |         |                    | COVERING<br>COLLEAGUE<br>(Y/N)? |
|  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | E PG 36)                        |
|  |   |         |                    |                                 |
|  |   |         |                    |                                 |
|  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | (Y/N)?                          |
|  |   |         |                    |                                 |
|  |   |         | SPECIALTY CODE     | COVERING                        |
|  |   |         |                    | COLLEAGUE<br>(Y/N)?             |
|  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | E PG 36)                        |
|  |   |         |                    |                                 |
|  |   |         |                    | COVERING<br>COLLEAGUE           |
|  | FIRST NAME  | M.I.    | PROVIDER TYPE (COD | (Y/N)?<br>E PG 36)              |
| •  |   |         |                    | ,                               |
|  | 3098  |         |                    |                                 |

## Covering Colleagues Supplemental Form

| Section 4  | Practice Location Information   |                               |
|--|---|-------------------------------|
| Covering<br>Colleagues   | <b>SPECIFY PRACTICE LOCATION</b> INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS. |                               |
| Include all colleagues<br>providing regular<br>coverage and his/her                                    | ► LOCATION # PRIMARY PRACTICE PRACTICE NAME   |                               |
| specialty, including if  | PRACTICE ADDRESS  |                               |
| he/she is a partner in<br>one or more of your<br>practice locations.                                   |   |                               |
| IMPORTANT  |   | SPECIALTY CODE                |
| In the box provided,<br>indicate to which<br>practice location this<br>page belongs.                   | FIRST NAME M.   | I. PROVIDER TYPE (CODE PG 36) |
| Code lists are found on<br>pages 36-43. Enter the<br>associated 3-digit code<br>in the space provided. |   | SPECIALTY CODE                |
| If you need to report<br>additional Covering   | FIRST NAME  | PROVIDER TYPE (CODE PG 36)    |
| Colleagues, photocopy<br>this page as needed<br>and submit as<br>instructed.                           |   | SPECIALTY CODE                |
|  | FIRST NAME  | I. PROVIDER TYPE (CODE PG 36) |
|  |   | SPECIALTY CODE                |
|  | FIRST NAME M.   | PROVIDER TYPE (CODE PG 36)    |
|  |   | SPECIALTY CODE                |
|  | FIRST NAME M.   | I. PROVIDER TYPE (CODE PG 36) |
|  |   | SPECIALTY CODE                |
|  | FIRST NAME M.   | PROVIDER TYPE (CODE PG 36)    |
|  | LAST NAME   | SPECIALTY CODE                |
|  | FIRST NAME  | PROVIDER TYPE (CODE PG 36)    |
|  |   | SPECIALTY CODE                |
|  | FIRST NAME  | PROVIDER TYPE (CODE PG 36)    |
|  | 3099  |                               |

| Section 4  | Practice Lo                                  | cation I      | nforma      | tion ·    | - Page                           | e 1 of   | f 5    |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
|--|--|---------------|-------------|-----------|----------------------------------|----------|--------|--------|-------|-------|-------|-----|---|----|------------------|-------------|-----|-----|--------|--------|------|-----|------|
| Additional<br>Practice   |  | on∗ #         |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| Location   | CURRENTLY<br>PRACTICING AT<br>THIS ADDRESS?* | YES           | NO          | YOUF      | , WHAT IS<br>R EXPECT<br>T DATE? |          | М      | D      | D     | Υ     | Υ     | Υ   | Υ |    |                  |             |     |     |        |        |      |     |      |
| IMPORTANT  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| In the box provided,<br>indicate to which<br>practice location this<br>page belongs. | PHYSICIAN GROUP                              | / PRACTICE NA | AME TO APP  | EAR IN D  | IRECTOR                          | Y (DO NO | OT ABE | BREVIA | ATE)* |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| For example, if you<br>practice at three<br>locations, the primary                   | GROUP / CORPORAT                             | TE NAME AS IT | T APPEARS ( | ON W-9, I | F DIFFER                         | ENT FRO  | М АВС  | OVE (D | ο ΝΟΊ | Г АВВ | REVIA | TE) |   |    |                  |             |     |     |        |        |      |     |      |
| location is reported in the main application   | NUMBER*                                      |               | STREET*     |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     | SUITI  | BUIL   | DING |     |      |
| and remaining<br>locations would be  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| reported on  | CITY*  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  | STAT        | E*  |     | ZIP C  | ODE*   |      |     |      |
| Supplemental Forms<br>as Location 2 and<br>Location 3.                               | SEND GENERAL<br>CORRESPON-<br>DENCE HERE?*   | YES           | NO          | TELEPH    |                                  | -        |        |        |       |       |       |     |   | AX |                  | -           |     |     | -      |        |      |     |      |
|  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| TIP Your Individual Tax  | OFFICE E-MAIL ADD                            | PESS          |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| ID is assumed to be<br>your Primary Tax ID   | OFFICE E-MAIL ADD                            | RESS          |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     | INDIVI | DUAL   |      |     | GRO  |
| unless you specify otherwise to the right.   | INDIVIDUAL TAX ID                            |               |             |           |                                  | OUP TAX  |        |        |       |       |       |     |   |    | TAX ID<br>(ONE ( | ,<br>ONLY)* |     | ТАХ | ID     |        |      | ТАХ | ID   |
| Office Manager   |  |               |             |           | GRU                              |          |        | _      |       | _     |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| or Business  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| Office Contact   | LAST NAME*                                   |               |             |           |                                  |          |        | _      |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| List each contact  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| separately. You may<br>use the check boxes   | FIRST NAME*                                  |               |             |           |                                  |          |        |        | _     |       |       |     |   |    |                  | _           |     |     |        |        |      |     | M.I. |
| below for convenience.<br>Do not write   | -  |               |             |           |                                  |          |        | _      |       |       |       | -   |   |    |                  |             |     |     |        |        |      |     |      |
| instructions like "see<br>above". These  | TELEPHONE*                                   |               |             |           |                                  | FAX      |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      | _   |      |
| responses will be<br>rejected and will   |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| require follow-up.   | E-MAIL ADDRESS                               |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| Billing Contact  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
|  | LAST NAME*                                   |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| CHECK HERE TO<br>USE OFFICE<br>MANAGER AND   |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| OFFICE ADDRESS<br>AS BILLING   | FIRST NAME*                                  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     | M.I. |
|  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
|  | NUMBER*                                      |               | STREET*     |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     | SUITE  | /BUILI | DING |     |      |
|  |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| NOTE:  | CITY*  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  | STA         | ΓE* |     | ZIP C  | ODE*   |      |     |      |
| Even if you checked the boxes above,   | TELEPHONE*                                   |               | -           |           |                                  | FAX      |        |        |       |       |       | -   |   |    |                  |             |     |     |        |        |      |     |      |
| please provide the<br>e-mail address of the<br>Billing Contact, if                   |  |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
| available.   | E-MAIL ADDRESS                               |               |             |           |                                  |          |        |        |       |       |       |     |   |    |                  |             |     |     |        |        |      |     |      |
|  |  |               |             |           |                                  | 3        | 31(    | 00     |       |       |       |     |   |    |                  |             |     |     |        |        | -    |     | I    |

| -  | * REQUIRED RE                                  | SPONSE (IF THI  | IS PAGE IS   | S USED). NC    | RESPON              | NSE MAY                          | CAUSE F      | ROCES  | SING DE          | LAYS A  | ND RI | EQUIR  | E FOLL  | OW-UP        |        |       |        |       | -            |            |
|--|--|-----------------|--------------|----------------|---------------------|----------------------------------|--------------|--------|------------------|---------|-------|--------|---------|--------------|--------|-------|--------|-------|--------------|------------|
| Section 4  | Practice                                       | Location        | Inforn       | nation -       | Page                | 2 of :                           | 5            |        |                  |         |       |        |         |              |        |       |        |       |              |            |
| Add'l Practice<br>Location (Cont.)   | LOCA   |                 |              | ]              |                     |                                  |              |        |                  |         |       |        |         |              |        |       |        |       |              |            |
| Payment and<br>Remittance  | ELECTRONIC<br>BILLING<br>CAPABILITIES?*        | YES             | NO           | BILLIN         |                     | TMENT (IF                        | HOSPITA      | L-BASE |                  |         |       |        |         |              |        |       |        |       |              |            |
| YOUR "CHECK PAYABLE TO"<br>INFORMATION SHOULD BE<br>CONSISTENT WITH YOUR<br>W-9.                     | CHECK PAYABL                                   | E TO*           |              |                |                     |                                  |              |        |                  |         |       |        |         |              |        |       |        |       |              |            |
| CHECK HERE TO<br>USE OFFICE<br>MANAGER AND<br>OFFICE ADDRESS<br>AS BILLING<br>INFORMATION            | LAST NAME*                                     |                 |              |                |                     |                                  |              |        |                  |         |       |        |         |              |        |       |        |       |              | M.I.       |
| NOTE:  | NUMBER*  |                 | STREE        | :T*            |                     |                                  |              |        |                  |         |       |        |         |              |        | SUIT  | E/BUIL | .DING |              |            |
| Even if you checked<br>the boxes above,<br>please provide the<br>E-mail Address,<br>Department Name, | CITY*  |                 |              |                |                     | FAX                              |              | -      |                  | -       |       |        |         | STATE*       |        | ZIP   | CODE*  |       |              |            |
| Electronic Billing and<br>Check Payable To, if<br>applicable.  | E-MAIL ADDRES                                  | s               |              |                |                     |                                  |              |        |                  |         |       |        |         |              |        |       |        |       |              |            |
| Office Hours   | (USE HHMM                                      | FORMAT AND      | ROUND        | TO THE N       | IEARES <sup>-</sup> | T HALF-I                         | HOUR)        |        |                  |         |       |        |         |              |        |       |        |       |              | _          |
|  |  | START           |              | A=AM<br>P=PM   | END                 | )                                | A=AM<br>P=PM |        |                  |         | STA   | RT     |         | A=AM<br>P=PM |        | EN    | ID     |       | A=AM<br>P=PM |            |
|  | MONDAY   |                 |              |                |                     |                                  |              |        | FRIDAY<br>'URDAY |         |       |        |         |              |        |       |        |       |              | <br> <br>1 |
| NOTE:<br>After hours back office<br>telephone will be used   | WEDNESDAY<br>THURSDAY                          |                 |              |                |                     |                                  |              | s      | UNDAY            |         |       |        |         |              |        |       |        |       |              |            |
| only by the health plan<br>and will not be   | 24/7 PHONE COV                                 | /ERAGE?* IF     | YES          |                |                     |                                  |              |        |                  |         |       | AFTER  | HOURS   | BACK         | OFFICE | TELEP | HONE   |       |              | -          |
| published under any circumstances.   | YES  | NO              | ANSV<br>SERV | VERING<br>/ICE | INSTR               | MAIL WIT<br>UCTIONS<br>ERING SEI | TO CALL      | ۷      | OICE MA          | IER     |       |        |         | -            |        |       | -      |       |              |            |
| Open Practice<br>Status  | ACCEPT NEW P                                   | ATIENTS INTO TH | HIS PRACT    | ICE?*          |                     | YES                              | NO           |        | ACCEP            | T ALL N | IEW P | ATIENT | S?*     |              |        |       |        | YES   |              | NO         |
|  | ACCEPT EXISTI                                  | NG PATIENTS WI  | ITH CHANG    | E OF PAYOR     | ?*                  | YES                              | NO           |        | ACCEP            | TNEW    | MEDIC | ARE P  | ATIENTS | 5?*          |        |       |        | YES   |              | NO         |
|  |  | ATIENTS WITH P  | HYSICIAN     | REFERRAL?*     |                     | YES                              | NO           |        | ACCEP            | TNEWI   | MEDIC | AID PA | TIENTS  | ?*           |        |       |        | YES   |              | NO         |
|  | IF ANY OF THE<br>ABOVE VARIES<br>PLAN, EXPLAIN |                 |              |                |                     |                                  |              |        |                  |         |       |        |         |              |        |       |        |       |              |            |
|  | ARE THERE AN<br>PRACTICE LIMI                  |                 | F YES        | MA             |                     |                                  |              |        | INIMUM           | LIST    | OTHE  |        | TATIONS | ;            |        |       |        |       |              |            |
|  | YES  | NO              |              | FE             |                     |                                  |              | M      | GE<br>AXIMUM     |         |       |        |         |              |        |       |        |       |              |            |
| I  |  |                 |              |                | ILY                 | <b>.</b>                         | 101          |        | GE               |         |       |        |         |              |        |       |        |       |              |            |
|  | -  |                 |              |                |                     | 5.                               | гот          |        |                  |         |       |        |         |              |        |       |        | -     |              |            |

| -  | * REQUIF           | RED RES              | PONS             | E (IF THIS              | PAGE              | IS USE           | D). NO           | RESPO              | ONSE M | AY CAU | SE PRO | OCESSI | NG DEL  | AYS A  | ND RE | QUIRE FO | LLOW- | UP. |      |         |        |                  | •     |
|--|--------------------|----------------------|------------------|-------------------------|-------------------|------------------|------------------|--------------------|--------|--------|--------|--------|---------|--------|-------|----------|-------|-----|------|---------|--------|------------------|-------|
| Section 4  | Prac               | tice L               | Loca             | ation I                 | nfor              | mati             | on -             | Pag                | e 3 c  | of 5   |        |        |         |        |       |          |       |     |      |         |        |                  |       |
| Additional<br>Practice                                 |                    | САТ                  | ION              | ı∗ <b>#</b>             |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
| Location<br>(Continued)                                | DO MID-<br>ASSIST/ | -LEVEL P<br>ANTS, ET | RACTI<br>C.) CAI | TIONERS (I<br>RE FOR PA | NURSE I<br>TIENTS | PRACTI<br>IN YOU | TIONEF<br>R PRAC | RS, PHY<br>CTICE?* | SICIAN |        | YES    | NO     | 1       |        |       |          |       |     |      |         |        |                  |       |
| IMPORTANT<br>In the box provided,<br>indicate to which | (IF YES,           | PLEASE               | PROVI            | DE THE IN               | FORMA             | TION BE          | LOW)             |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
| practice location this<br>page belongs.                | PRACTI             | TIONER L             | AST N            | AME                     |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER F             | IRST N           |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          | M.I.  |     | PRAC | TITIONE | ER TYF | PE (E.G.         | , PA, |
| Mid-Level<br>Practitioners                             |                    |                      |                  | E / CERTIF              |                   |                  | ,<br>,           |                    |        |        |        | PR     | ACTITIC | NER ST | ATE   |          |       |     |      |         |        | CNP,             | NP)   |
|  |                    |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER L             | AST N            | AME                     |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER F             | IRST N           | IAME                    |                   |                  |                  |                    |        |        |        |        |         |        |       |          | M.I.  |     | PRAC | TITIONE | R TYP  | PE (E.G.<br>CNP, |       |
|  | PRACTI             | TIONER L             | ICENS            | E / CERTIF              |                   | UMBEF            | 2                |                    |        |        |        | PR     | ACTITIC | NER ST | ATE   |          |       |     |      |         |        |                  |       |
|  |                    |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER L             | AST N            | AME                     |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  | _     |
|  | PRACTI             | TIONER F             | IRST N           | IAME                    |                   |                  |                  |                    |        |        |        |        |         |        |       |          | M.I.  |     | PRAC | TITIONE | ER TYF | PE (E.G.<br>CNP, |       |
|  |                    |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER L             | ICENS            | E / CERTIF              | ICATE N           | NUMBER           | 2                |                    |        |        |        | PR     | ACTITIC | NER ST | AIE   |          |       |     |      |         |        |                  |       |
|  |                    |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER L             | AST N            | AME                     |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER F             | IRST N           | IAME                    |                   |                  |                  |                    |        |        |        |        |         |        |       |          | M.I.  |     | PRAC | TITIONE | ER TYF | PE (E.G.<br>CNP, |       |
|  | PRACTI             | TIONER L             | ICENS            | E / CERTIF              |                   | UMBER            | 2                |                    |        |        |        | PR     | ACTITIC | NER ST | ATE   |          |       |     |      |         |        | chir,            | NI )  |
|  |                    |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER L             | AST N            | AME                     |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  |       |
|  | PRACTI             | TIONER F             | IRST N           | IAME                    |                   |                  |                  |                    |        |        |        |        |         |        |       |          | M.I.  |     | PRAC | TITIONE | ER TYF | PE (E.G.         | , PA, |
|  | PRACTI             | TIONER L             | ICENS            | E / CERTIF              |                   | UMBER            | 2                |                    |        |        |        | PR     | ACTITIC | NER ST | ATE   |          |       |     |      |         |        | CNP,             | NP)   |
| I  | I                  |                      |                  |                         |                   |                  |                  |                    |        |        |        |        |         |        |       |          |       |     |      |         |        |                  | I     |
|  | _                  |                      |                  |                         |                   |                  |                  |                    |        | 31(    | 12     |        |         |        |       |          |       |     |      |         |        | _                |       |

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| Section 4                                 | Practice Lo                                      | cation l     | nform      | ation - Page                                  | 4 of 5         |          |        |                |      |        |           |                    |               |     |     |    |
|---|--|--------------|------------|---|----------------|----------|--------|----------------|------|--------|-----------|--------------------|---------------|-----|-----|----|
| Additional                                |  | NI* #        |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
| Practice                                  | FLOCATIO   |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
| Location<br>Continued)                    | LANGUAGES  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | NON-ENGLISH LANG<br>SPOKEN BY OFFICE             |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
| MPORTANT                                  | 0.0.2.02.0000                                    |              | LAN        | IGUAGE CODE                                   | ANGUAGE CO     | DE L     | ANGUA  | GE COD         | E I  | ANGUAG | E CODE    | LANGU              | AGE COD       | E   |     |    |
| In the box provided,<br>indicate to which | INTERPRETERS                                     | YES          | NO         | LANGUAGES                                     |                |          |        |                | 1 [  |        |           |                    |               | 1   |     |    |
| practice location this page belongs.      | AVAILABLE?*                                      |              |            | INTERPRETED                                   | LANGUAGE CO    | DE       | LANGUA | GE COL         | F    | ANGUAG | E CODE    |                    | AGE COD       | _   |     |    |
| Accessibilities                           |  |              |            |   |                |          | LANCOA |                |      |        |           | LANCO              |               | -   |     |    |
| Accessibilities                           | DOES THIS OFFICE M                               | IEET ADA ACO | ESSIBILI   | TY REQUIREMENTS?*                             | YES            | NO       |        |                |      |        |           |                    |               |     |     |    |
|   | DOES THIS SITE OFF<br>ACCESS FOR THE FO          |              | PPED       |   | S SITE OFFER   |          |        | YES            | NO   |        |           | .E BY<br>ANSPORTAT | ION2*         | YES | 5   | NC |
|   |  |              | 7          | OLIVIOLO                                      |                | DEED.    |        |                |      |        |           |                    |               |     |     | 1  |
|   | BUILDING?*                                       | YES          | NO         | TEXT  | TELEPHONY (T   | TY)*     |        | YES            | NO   |        | BU        | IS*                |               | YES | 6   | NC |
|   | PARKING?*  | YES          | NO         | AMER  | ICAN SIGN LA   | NGUAGE*  |        | YES            | NO   |        | su        | IBWAY*             | E F           | YES |     | NC |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     | 1  |
|   | RESTROOM?*                                       | YES          | NO         |   | AL/PHYSICAL II | MPAIRMEN | ит     | YES            | NO   |        | RE        | GIONAL TR          | AIN*          | YES | 5   | NC |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     | í. |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | OTHER HANDICAPP                                  | ED ACCESS    |            | OTHER   | DISABILITY SE  | RVICES   |        |                |      |        | OTHER TR  | ANSPORTAT          | ION ACCE      | :55 |     |    |
| Services                                  | Does this location                               | provide an   | / of the f | following services?                           |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | LABORATORY                                       | VEO          |            | IF YES, PROVIDE A<br>CERTIFYING PROG          |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | SERVICES?  | YES          | NO         | (E.G., CLIA, COLA,                            |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | RADIOLOGY  |              | ٦          | IF YES, PROVIDE X                             | -RAY           |          |        |                |      |        |           |                    |               |     |     |    |
|   | SERVICES?  | YES          | NO         | CERTIFICATION TY                              |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      | _      |           | ROUTI              | NE OFFIC      | F   |     | _  |
|   | EKGS?  | YES          | NO         | ALLERGY<br>INJECTIONS?                        | YES            | NO       | TEST   | RGY SK<br>ING? | N    | YES    | NO        | GYNEO              | C/PAP)?       |     | YES |    |
|   | DRAWING  | YES          | NO         | AGE<br>APPROPRIATE                            | YES            | NO       | FLEX   |                |      | YES    | NO        |                    |               |     | YES |    |
|   | BLOOD?   |              |            | IMMUNIZATIONS?                                |                | NO       | SIGM   | OIDOSC         | OPY? | 123    |           |                    | NING?         |     |     |    |
|   | ASTHMA<br>TREATMENT?                             | YES          | NO         | OSTEOPATHIC<br>MANIPULATION?                  | YES            | NO       |        | DRATIO         |      | YES    | NO        | CARDI<br>STRES     | AC<br>S TEST? |     | YES |    |
|   | PULMONARY  |              |            | PHYSICAL                                      |                |          |        | E OF MIN       |      |        |           |                    |               |     |     |    |
|   | FUNCTION<br>TESTING?                             | YES          | NO         | THERAPY?                                      | YES            | NO       |        | RATION         |      | YES    | NO        |                    |               |     |     |    |
|   |  |              | _          |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | IS ANESTHESIA<br>ADMINISTERED IN<br>YOUR OFFICE? | YES          | NO         | IF YES, WHAT<br>CLASS/CATEGORY<br>DO YOU USE? |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            | D0 100 0321                                   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | IF YES, WHO<br>ADMINISTERS IT?                   |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | l  | AST NAME     |            |   |                |          |        |                |      | FIRST  | IAME      |                    |               |     |     |    |
|   | TYPE OF PRACTICE<br>(SELECT ONE ONLY)            |              | SOLO P     | RACTICE                                       | SINGLE         | SPECIAL  | TY GRO | UP             |      | MULTI- | SPECIALTY | GROUP              |               |     |     |    |
|   | (SELECT ONE ONET)                                |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   | ADDITIONAL OFFICE                                | PROCEDURE    | S PROVI    | DED (INCLUDING SUR                            | GICAL PROCED   | URES)    |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |
| I   | I  |              |            |   |                | -        |        |                |      |        |           |                    |               |     |     |    |
|   | -  |              |            |   | 310            | 3        |        |                |      |        |           |                    |               | _   |     |    |
|   |  |              |            |   |                |          |        |                |      |        |           |                    |               |     |     |    |

## **Practice Location Information**

| Section 4  | * REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW<br>Practice Location Information - Page 5 of 5 |      |                                    |
|--|---|------|------------------------------------|
| Additional   |   |      |                                    |
| Practice   | ► LOCATION* #   |      |                                    |
| Location   |   |      |                                    |
| (Continued)  | LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE   |      |                                    |
| IMPORTANT  |   |      |                                    |
| In the box provided,                               | LAST NAME   |      | SPECIALTY CODE COVERING            |
| ndicate to which<br>practice location this         |   |      | COLLEAG<br>(Y/N)?                  |
| page belongs.                                      | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
| f you have additional                              |   |      |                                    |
| If you have additional partners/associates at      |   |      |                                    |
| THIS location, use the<br>Partner/Associate        | LAST NAME   |      | SPECIALTY CODE COVERING<br>COLLEAG |
| Supplemental Form on page 23. Photocopy as         |   |      | (Y/N)?                             |
| necessary. Be certain                              | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
| to indicate the Practice<br>Location Number at the |   | _    |                                    |
| top of the page.                                   |   |      |                                    |
| Code lists are found on                            | LAST NAME   |      | SPECIALTY CODE COVERING            |
| pages 36-43. Enter the associated 3-digit code     |   |      | COLLEAGU<br>(Y/N)?                 |
| in the space provided.                             | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
|  |   |      |                                    |
|  |   |      |                                    |
|  | LAST NAME   |      | SPECIALTY CODE COVERING            |
|  |   |      | COLLEAGU<br>(Y/N)?                 |
|  |   | M.I. | PROVIDER TYPE (CODE PG 36)         |
| <u> </u>   |   |      |                                    |
| Covering<br>Colleagues                             | LIST ALL COVERING COLLEAGUES THAT ARE <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE   |      |                                    |
| Colleagues   |   |      |                                    |
| Code lists are found on                            | LAST NAME   |      | SPECIALTY CODE                     |
| pages 36-43. Enter the associated 3-digit code     |   |      |                                    |
| in the space provided.                             | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
| If you have additional covering colleagues         |   |      |                                    |
| that are not partners at                           |   |      |                                    |
| THIS location, use the Covering Colleagues         |   |      | SPECIALTY CODE                     |
| Supplemental Form on page 24. Photocopy as         |   |      |                                    |
| necessary. Be certain                              | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
| to indicate the Practice Location Number at the    |   |      |                                    |
| top of the page.                                   | LAST NAME   |      | SPECIALTY CODE                     |
|  |   |      |                                    |
|  | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
|  |   |      |                                    |
|  |   |      |                                    |
|  | LAST NAME   |      | SPECIALTY CODE                     |
|  |   |      |                                    |
|  | FIRST NAME  | M.I. | PROVIDER TYPE (CODE PG 36)         |
|  |   |      |                                    |

## Hospital Privileges (Current) Supplemental Form

| Hopitial<br>Drokense<br>instruction<br>operation where<br>operation where<br>o | Section 5                                     | Но    | spit   | al /  | Affil | iatio | ons     |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|--|---|-------|--------|-------|-------|-------|---------|--------|---------|---------|-------|--------|-------|--------|-------|----------|--------|-----|------|------|-----|-------|--------|--------|-----|------|-------|--------|------|---|------|
| Privileges   Use this form form form form form form form form  | Hospital                                      | отн   | ER H   | OSPI  | ITAL  |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| ordinational space of or operative data consistent of the operativ   |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| contructing of reports of reports defined on the protecting of repo   | Use this form to                              | HOSE  | ITAL I | NAME  | :     |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| underseit in verproteine in verproteine en enverteine en enverteine en enverteine en enverteine en enverteine  | continue listing                              |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| privage.<br>Hy our need to report<br>hototoop this page on<br>hototoop thi   | currently have                                | NUMI  | BER    |       |       |       |         | STRE   | ET      |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      | SUITE | /BUILI | DING |   |      |
| additional speeds of hot pays as instructed.   |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        | Г      |     |      |       |        |      |   |      |
| Heghal Privilege, heeded and sucht as manufacture to the state of the  | If you need to report<br>additional space for |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| needed aukumi as<br>instructed.<br>THE BE oction you<br>diffusion percentage<br>add up to 100% for<br>unrent hopfusion<br>wrote:<br>DEPARTMENT DIRECTOR'S INST NAME<br>DEPARTMENT DIR   | Hospital Privileges,                          | CITY  |        |       | 1     |       |         |        |         |         |       |        | 1     | _      |       |          |        |     |      | _    |     |       |        | SI     | AIE |      | ZIP C | ODE    |      |   |      |
| TIP Be certain you<br>difficulty processing<br>origination processing<br>originations of the second se  | needed and submit as                          |       |        |       | -     |       |         | -      |         |         |       |        |       |        |       |          | -      |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| admission performages<br>adv up to 10% for https://www.ill.<br>here to controct this<br>error.   | instructed.                                   | TELE  | PHONE  | E     |       |       |         |        |         |         |       |        |       | FAX    |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| admission performages<br>adv up to 10% for https://www.ill.<br>here to controct this<br>error.   |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| add up to 100% for<br>Chremsen, you will<br>have to correct this<br>error.  DEPARTMENT DIRECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  DEPARTMENT DIRECTOR'S LAST NAME  AFFILIATION TO RECTOR'S LAST NAME  AFFILIATION  THIS SPACE HAS BEEN PURPOSELY LEFT BLANK  |   | DEPA  | RTME   | NT N  | AME   |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| Otherwise, you will have to cortect this share to intercort or s FIRST NAME         DEPARTMENT DIRECTOR'S FIRST NAME         DEPARTMENT DIRECTOR'S FIRST NAME         AFFLIATION START DATE         PIEASE EXPLAIN         TERMINATED AFFLICATION         THIS SPACE HAS BEEN PURPOSELY LEFT BLANK   | admission percentages<br>add up to 100% for   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| have is corrised this<br>error.<br>DEPARTMENT DIRECTOR'S FIRST HAME<br>MANY Y Y PULL UNRESTRICTED YES NO ARE PRIVACEORS YS<br>AFFILIATION START DATE<br>AFFILIATION END DATE<br>OF YOUN TOTAL HANNAL<br>ADMISSIONS, WAAT PRALADOR<br>ADMISSIONS, WAAT PRALADOR  |   | DEPA  | RTME   | NT DI | RECTO | R'S L | AST N   | AME    |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| DEPARTMENT URRECTOR'S FIRST HAME         MM       MM </td <td>have to correct this</td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>  | have to correct this                          |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     | 1     |        |        |     |      |       |        |      |   |      |
| MMMYYYY       MMMYYYYY       FULL UNRESTRICTED       YES       NO       ARE PRIVILEGES       YES         AFFILATION START DATE       AFFILATION END DATE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE         PLEASE EXPLAIN<br>TERMINATED AFFILATION       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE         PLEASE EXPLAIN<br>TERMINATED AFFILATION       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE         THIS SPACE HAS BEEN PURPOSELY LEFT BLANK       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE       OF YOUR TOTAL ANNUAL<br>ADMISSION, WAT PERCENTAGE  | enor.   | DEDA  | DTME   |       | DECTO |       | Det     |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   | M.I. |
| AFFLIATION START DATE       AFFLIATION END DATE       OF YOUR TOTAL ANNUAL<br>ON YOUR TOTAL ANNUAL<br>ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)         PLEASE EXPLAIN         TERMINATED AFFLIATION   |   | DEPA  |        |       | REGIC |       | KSIN    |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      | _ | 1    |
| OF YOUR TOTAL ANNUAL     OF YOUR TOTAL ANNUAL     ADMITTINO PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)  PLEASE EXPLAIN TERMINATED AFFILIATION  THIS SPACE HAS BEEN PURPOSELY LEFT BLANK   |   | Μ     | М      | Υ     | Y     | Y     | Υ       |        | Μ       | M       | Y     | Y      | Y     |        | Y     | FU<br>PR | LL, UN | RES | TRIC | TED  |     | YES   |        | NO     |     |      |       |        | YES  |   | NO   |
| ADMISSIONS, WHAT PERCENTAGE  |   | AFFIL | IATION | N STA | RT DA | ТЕ    |         |        | AFF     | ILIATIO | ON EN | D DAT  | E     |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
| ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)  PLEASE EXPLAIN  TERMINATED AFFILIATION  THIS SPACE HAS BEEN PURPOSELY LEFT BLANK  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     | ADM   | ISSIO  | NS, W  | HAT | PERC | AGE   |        |      |   | %    |
| TERMINATED AFFILIATION   |   | ADMI  | TTING  | PRIV  | ILEGE | STATI | JS (E.0 | G. NOP | NE, FUI | L UN    | RESTR | RICTED | , PRC | ovisio | DNAL, | TEMF     | PORAR  | Y)  |      |      |     | 10 10 | 5 1110 | , 1001 |     |      |       |        |      |   |      |
| THIS SPACE HAS BEEN PURPOSELY LEFT BLANK   |   | PLE/  | SE EX  |       | N     |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   | IEN   |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         | TH    | S SP/  | ACE   | HAS    | BEE   | N PL     | JRPO   | SEL | LY L | EFT. | BLA | NK    |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  | -   | I     |        |       |       |       |         |        |         |         |       |        |       |        |       |          |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |
|  |   |       |        |       |       |       |         |        |         |         |       |        |       | 3      | 10    | )5       |        |     |      |      |     |       |        |        |     |      |       |        |      |   |      |

## Professional Liability Insurance Carrier Supplemental Form

|   | * REQUIRED R                    | ESPONS   | E. NO RES | SPONSE | E MAY | CAUS  | SE PR | OCES | SING     | DELA | YS AN | D RE | QUIRE  | FOLL        | OW-U  | P.   |   |    |               |             |         |        |            |       |     |      |
|---|---------------------------------|----------|-----------|--------|-------|-------|-------|------|----------|------|-------|------|--------|-------------|-------|------|---|----|---------------|-------------|---------|--------|------------|-------|-----|------|
| Section 6   | Professi                        | onal     | Liabili   | ity In | sur   | anc   | e Ca  | arri | er       |      |       |      |        |             |       |      |   |    |               |             |         |        |            |       |     |      |
| Other<br>Professional<br>Liability<br>Insurance   | CARRIER OR S                    | ELF-INS  | URED NAM  | IE     |       |       |       |      |          |      |       |      |        |             |       |      |   |    |               | ]:          | SELF-IN | ISUREI | )?         | YE    | s   | NO   |
| Carrier   | NUMBER*                         |          |           | STREE  | ET*   |       |       |      |          |      |       |      |        |             |       |      |   |    |               |             |         | SUITE  | BUILD      | DING  |     |      |
| List secondary /<br>second layer / future or<br>previous carrier(s).                        | CITY*                           |          |           |        |       |       |       |      |          |      |       |      |        |             |       |      |   | T  | STA<br>YPE C  |             | ]       | 1      | ODE*       |       |     |      |
| For second layer<br>coverage list name of   |                                 |          |           |        | M     | CTIVE |       | ľ    | Ŷ        | Ŷ    |       | M    |        | Y<br>N DATE | ľ     | Y    | Ŷ |    |               | AGE?        | *       | INDIA  | /IDUAL     | •     | БПА | RED  |
| hospital/organization<br>providing coverage   |                                 |          |           |        |       |       |       |      | <b>•</b> |      |       |      |        |             |       | 1    |   |    |               |             |         |        |            |       |     |      |
|   | DO YOU HAVE U<br>WITH THIS INSU |          |           |        |       | YES   |       | NO   | \$       |      |       | ,    |        |             | ,     |      |   | \$ |               |             | ,       |        |            | ,     |     |      |
|   | POLICY INCLU                    | DES TAIL | COVERAG   | E?     |       | YES   |       | NO   |          | AMOU | NT OF | COVI | ERAGE  | E PER (     | OCCUR | RENC | E | Α  | MOU           | NT OF       | COVE    | RAGE   | AGGRE      | :GATE |     |      |
|   | POLICY NUMBI                    | ER*      |           |        |       |       |       |      |          |      |       |      |        |             |       |      |   |    |               |             |         |        |            |       |     |      |
| Other<br>Professional<br>Liability<br>Insurance<br>Carrier                                  | CARRIER OR S                    | SELF-INS | URED NAM  | 1E     |       |       |       |      |          |      |       |      |        |             |       |      |   |    |               | ] ;         | SELF-II | ISURE  | <b>)</b> ? | YE    | S   | NO   |
| Carrier   | NUMBER*                         |          |           | STRE   | ET*   |       |       |      |          |      |       |      |        |             |       |      |   |    | _             |             | -       | SUITE  | E/BUILD    | DING  |     | _    |
| List secondary /<br>second layer / future or<br>previous carrier(s).                        | CITY*                           |          |           |        |       |       |       |      |          |      |       |      |        |             |       |      |   |    | STA           | ATE*        |         | ZIP (  | CODE*      |       |     |      |
| For second layer coverage list name of  | MM                              | Y        | YY        | /      | Μ     | Μ     | Υ     | Υ    | Υ        | Y    |       | Μ    | Μ      | Υ           | Υ     | Υ    | Y |    | YPE (<br>OVER | DF<br>RAGE? | *       | INDI   | VIDUAL     | -     | SHA | ARED |
| hospital/organization<br>providing coverage   | ORIGINAL EFF                    | UNLIMIT  | ED COVER  |        | EFFE  | YES   | DATE  | NO   | \$       |      |       | EXP  | IRATIC | ON DAT      | E     |      |   | \$ |               |             |         |        |            |       |     |      |
| If you need additional<br>space for Insurance<br>Coverage, photocopy<br>this page as needed | WITH THIS INSI                  |          |           |        |       | YES   |       | NO   |          | AMOU | NT OF | COV  | ERAGI  | E PER       | OCCUF | RENC | E |    | AMOU          | INT OI      | FCOVE   | RAGE   | AGGRI      | EGATE |     |      |
| and submit as instructed.   |                                 |          |           |        |       |       |       |      |          |      |       |      |        |             |       |      |   |    |               |             |         |        |            |       |     |      |
|   | POLICY NUMB                     | EK-      |           |        |       |       |       |      |          |      |       |      |        |             |       |      |   |    |               |             |         |        |            |       |     |      |

## Work History Supplemental Form

| <b>REQUIRED RESPONSE (IF 1</b> | THIS PAGE IS USED). NO | O RESPONSE MAY CAUSE | PROCESSING DELAYS AND REQU | RE FOLLOW-UP. |
|--------------------------------|------------------------|----------------------|----------------------------|---------------|
|                                |                        |                      |                            |               |

| Section 7   | Work History  |
|---|---|
| Work History  | WORK HISTORY  |
| Use this form to continue listing work history.               | PRACTICE / EMPLOYER NAME  |
| If you need additional space for Work History,                | NUMBER     STREET     SUITE/BUILDING                                  |
| photocopy this page as<br>needed and submit as<br>instructed. |   |
| instructed.   | CITY STATE ZIP/POSTAL CODE  |
|   |   |
|   | TELEPHONE FAX   |
|   |   |
|   | COUNTRY CODE START DATE END DATE REASON FOR DEPARTURE (IF APPLICABLE) |
|   |   |
|   |   |
|   |   |
|   | WORK HISTORY  |
|   |   |
|   |   |
|   |   |
|   | NUMBER STREET SUITE/BUILDING  |
|   | CITY STATE ZIP/POSTAL CODE  |
|   |   |
|   | TELEPHONE FAX   |
|   |   |
|   | COUNTRY CODE START DATE END DATE                                      |
|   | REASON FOR DEPARTURE (IF APPLICABLE)                                  |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
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|   |   |

## Professional Training / Work History Gaps Supplemental Form

| Section 7   | Professio     | onal Tra | ining / Wo | ork Hist | ory Gaps     |   |    |    |   |      |      |
|---|---------------|----------|------------|----------|--------------|---|----|----|---|------|------|
| Professional<br>Training /  | GAP START DAT |          | I Y Y      | ΥY       | GAP END DATE | M | ΙY | YY | Υ |      |      |
| Work History<br>Gaps  |               |          |            |          |              |   |    |    |   |      |      |
| Please explain any time periods or gaps in  |               |          |            |          |              |   |    |    |   |      |      |
| training or work history<br>that have occurred<br>since graduation from   |               |          |            |          |              |   |    |    |   |      |      |
| professional school<br>and are longer than<br>three month in duration<br>or of a shorter duration<br>if required by the | GAP START DAT |          | I Y Y      | YY       | GAP END DATE | M | IY | YY | Y | <br> | <br> |
| organization for which<br>you are being<br>credentialed.  |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   | GAP START DAT | MN       | YY         | ΥY       | GAP END DATE | M | Y  | YY | Υ |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   | GAP START DAT |          | I Y Y      | ΥY       | GAP END DATE | M | ΙY | YY | Υ |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   | GAP START DAT | me M N   | YY         | ΥY       | GAP END DATE | M | ΙY | YY | Y |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |
|   |               |          |            |          |              |   |    |    |   |      |      |

## Disclosure Questions Supplemental Form

| Section 8  | Disclosur              | e Questions |   |  |  |  |
|--|------------------------|-------------|---|--|--|--|
| Disclosure   | QUESTION # EXPLANATION |             |   |  |  |  |
| Questions  |                        |             |   |  |  |  |
| Use this form to report<br>any "Yes" response to<br>one or more of the |                        |             |   |  |  |  |
| Disclosure Questions<br>in Section 8. Your<br>response should not      |                        |             |   |  |  |  |
| exceed the spaces<br>provided.   |                        |             |   |  |  |  |
| Record the question<br>number in the first                             |                        |             |   |  |  |  |
| column, then your<br>explanation in the<br>second column.              |                        |             |   |  |  |  |
| If you need additional space to explain a Yes                          |                        |             |   |  |  |  |
| response, photocopy<br>this page as needed<br>and submit as            |                        |             |   |  |  |  |
| instructed.  | QUESTION #             | EXPLANATION |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  | QUESTION #             | EXPLANATION | - |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
|  |                        |             |   |  |  |  |
| _  |                        |             | _ |  |  |  |
|  |                        | 3109        |   |  |  |  |

## Malpractice Claims Explanation Supplemental Form

\* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 8 **Malpractice Claims Explanation** Malpractice DATE OF OCCURRENCE\* DATE CLAIM Claims WAS FILED\* Explanation STATUS OF CLAIM\* (NOTE: IF CASE IS PENDING, SELECT OPEN) Use this form to report IF SETTLED, ENTER DATE OPEN CLOSED any "Yes" response to CLAIM WAS SETTLED **Disclosure Question** #19 If you need additional space to explain a Yes response, photocopy this page as needed and submit as PROFESSIONAL LIABILITY CARRIER INVOLVED\* (USE BOTH LINES IF NECESSARY) instructed. NUMBER\* STREET SUITE/BUILDING CITY\* STATE\* ZIP CODE\* TELEPHONE POLICY NUMBER METHOD OF DISMISSED SETTLED MEDIATION ARBITRATION **RESOLUTION?\*** AMOUNT OF AWARD OR SETTLEMENT JUDGMENT FOR DEFENDANT(S) JUDGMENT FOR PLAINTIFF(S) DESCRIPTION OF ALLEGATIONS\* (USE ALL FOUR LINES BELOW, IF NECESSARY) WERE YOU THE PRIMARY PRIMARY NUMBER OF OTHER CO-DEFENDANT DEFENDANT OR CO-DEFENDANT?\* DEFENDANT CO-DEFENDANTS (IF ANY) YOUR INVOLVEMENT IN CASE\* (ATTENDING, CONSULTING, ETC) DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY) DID THE ALLEGED INJURY TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED NO YES NO YES **RESULT IN DEATH?** IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? 3110

### **Provider Type Codes**

- Medical Doctor (MD) 001
- 002 Doctor of Dental Surgery (DDS)
- 003 Doctor of Dental Medicine (DMD)
- Doctor of Podiatric Medicine (DPM) 004
- Doctor of Chiropractic (DC) 005
- 007 Osteopathic Doctor (DO)

| 020 | Acupuncturist                  | 030 | L |
|-----|--------------------------------|-----|---|
| 021 | Alcohol/Drug Counselor         | 031 | Ν |
| 022 | Audiologist                    | 032 | N |
| 023 | Biofeedback Technician         | 033 | Ν |
| 024 | Certified Registered Nurse     | 034 | Ν |
|     | Anesthetist                    | 035 | Ν |
| 025 | Christian Science Practitioner | 036 | Ν |
| 026 | Clinical Nurse Specialist      | 037 | Ν |
| 027 | Clinical Psychologist          | 038 | Ν |
| 028 | Clinical Social Worker         | 039 | С |

029 Dietician

#### License Status Codes

| 001 | Active   |
|-----|----------|
| 002 | Canceled |
| 003 | Denied   |
| 004 | Expired  |
| 005 | Inactive |
| 006 | Lapsed   |
| 007 | Limited  |

### **Country Codes**

| 004 | Afghanistan                    |
|-----|--------------------------------|
| 800 | Albania                        |
| 012 | Algeria                        |
| 016 | American Samoa                 |
| 020 | Andorra                        |
| 024 | Angola                         |
|     | Anguilla                       |
| 010 | Antarctica                     |
| 028 | Antigua and Barbuda            |
| 032 | Argentina                      |
| 051 | Armenia                        |
| 533 | Aruba                          |
| 036 | Australia                      |
| 040 | Austria                        |
| 031 | Azerbaijan                     |
| 044 | Bahamas                        |
| 048 | Bahrain                        |
| 050 | Bangladesh                     |
| 052 | Barbados                       |
| 112 | Belarus                        |
| 056 | Belgium                        |
| 084 |                                |
| 204 | Benin                          |
| 060 | Bermuda                        |
| 064 | Bhutan                         |
| 068 | Bolivia                        |
|     | Bosnia and Herzegovina         |
| 072 | Botswana                       |
| 074 |                                |
| 076 | Brazil                         |
| 086 | British Indian Ocean Territory |
| 096 | Brunei Darussalam              |
| 100 | Bulgaria                       |
| 854 | Burkina Faso                   |
| 108 | Burundi                        |
| 116 | Cambodia                       |
| 120 | Cameroon                       |
| 124 | Canada                         |
| 132 | Cape Verde                     |
| 136 | Cayman Islands                 |
| 140 | Central African Republic       |
| 148 | Chad                           |
| 152 | Chile                          |
| 156 | China<br>Christman Island      |
| 162 |                                |
| 166 | Cocos (Keeling) Islands        |
| 170 | Colombia                       |

| 030 | Licensed Practical Nurse  |
|-----|---------------------------|
| 031 | Marriage/Family Therapist |
| 032 | Massage Therapist         |
| 033 | Naturopath                |
| 034 | Neuropsychologist         |
| 035 | Midwife                   |
| 036 | Nurse Midwife             |
| 037 | Nurse Practitioner        |
| 038 | Nutritionist              |
|     |                           |

- Occupational Therapist
- 040 Optician

008 Pending

Probation

Provisional

Restricted

Revoked

Comoros

Cook Islands

Costa Rica

Cote d'Ivoire

Czech Republic

214 Dominican Republic

El Salvador

226 Equatorial Guinea

Faroe Islands

249 France, Metropolitan

French Guiana

French Polvnesia

260 French Southern Territories

East Timor (provisional)

Falkland Islands (Malvinas)

Croatia

Cyprus

Diibouti

Cuba

208 Denmark

212 Dominica

218 Ecuador

818 Egypt 222

232 Eritrea

233 Estonia

246 Finland

Ethiopia

France

Gabon

Gambia

Georgia

288 Ghana

300 Greece

308 Grenada

312 Guadaloupe

Guam

320 Guatemala

Guinea

Guyana

Guinea-Bissau

Germany

Gibraltar

Greenland

Congo, Democratic Republic of the

Conao

013 Suspended 014 Surrendered

009

010 011

012

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238

234

242 Fiji

250

254

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624 328

332 Haiti

- 044 Physician Assistant 045 Professional Counselor

042

- 046 Registered Nurse Registered Nurse First Assistant 047
- 048 Respiratory Therapist
- 049 Speech Pathologist

041 Optometrist

. Pharmacist 043 Physical Therapist

- 015 Temporary Terminated 016 017 Time Limited
  - 018 Unrestricted
  - 019 Other
- Heard Island and McDonald 334 Islands 340 Honduras 344 Hong Kong 348 Hungary 352 Iceland 356 India 360 Indonesia 364 Iran 368 Iraq 372 Ireland 376 Israel 380 Italy 388 Jamaica 392 Japan 400 Jordan 398 Kazakhstan 404 Kenya 296 Kiribati 408 Korea, North 410 Korea, South 414 Kuwait 417 Kyrgyzstan 418 Laos 428 Latvia Lebanon 422 426 Lesotho 430 Liberia 434 Libya Liechtenstein 438 440 Lithuania 442 Luxembourg 446 Macau 807 Macedonia 450 Madagascar 454 Malawi 458 Malaysia 462 Maldives 466 Mali 470 Malta 584 Marshall Islands 474 Martinique Mauritania 478 480 Mauritius 175 Mavotte 484 Mexico 583 Micronesia
- 498 Moldova 492 Monaco 496 Mongolia 500 Montserrat Morocco 504 508 Mozambique 104 Myanmar 516 Namibia 520 Nauru 524 Nepal 528 Netherlands 530 Netherlands Antilles 540 New Caledonia 554 New Zealand 558 Nicaragua 562 Niger Nigeria 566 570 Niue Norfolk Island 574 580 Northern Mariana Islands 578 Norway Oman 512 586 Pakistan 585 Palau 591 Panama Papua New Guinea 598 600 Paraguay Peru 604 Philippines 608 Pitcairn 612 616 Poland Portugal 620 630 Puerto Rico Qatar 634 638 Réunion 642 Romania 643 Russian Federation 646 Rwanda Saint Helena 654 659 Saint Kitts and Nevis 662 Saint Lucia Saint Pierre and Miguelon 666 Saint Vincent and the 670 Grenadines

### **Country Codes (continued)**

| 882 | Samoa                       |     | Sandwich Islands       |
|-----|-----------------------------|-----|------------------------|
| 674 | San Marino                  | 724 | Spain                  |
| 678 | São Tomé and Príncipe       | 144 | Sri Lanka              |
| 682 | Saudi Arabia                | 736 | Sudan                  |
| 683 | Scotland                    | 740 | Suriname               |
| 686 | Senegal                     | 744 | Svalbard and Jan Mayen |
| 690 | Seychelles                  | 748 | Swaziland              |
| 694 | Sierra Leone                | 752 | Sweden                 |
| 702 | Singapore                   | 756 | Switzerland            |
| 703 | Slovakia                    | 760 | Syria                  |
| 705 | Slovenia                    | 158 | Taiwan                 |
| 090 | Solomon Islands             | 762 | Tajikistan             |
| 706 | Somalia                     | 834 | Tanzania               |
| 710 | South Africa                | 764 | Thailand               |
| 239 | South Georgia and the South | 768 | Togo                   |

### Language Codes

| 001 | Abkhazian      |
|-----|----------------|
|     |                |
| 002 | Afan (Oromo)   |
| 003 | Afar           |
| 004 | Afrikaans      |
|     |                |
| 005 | Albanian       |
| 006 | Amharic        |
| 007 | Arabic         |
| 008 | Armenian       |
|     |                |
| 009 | Assamese       |
| 010 | Zerbaijani     |
| 011 | Bashkir        |
| 012 | Basque         |
|     |                |
| 013 | Bengali;Bangla |
| 014 | Bhutani        |
| 015 | Bihari         |
| 016 | Bislama        |
|     | Breton         |
| 017 |                |
| 018 | Bulgarian      |
| 019 | Burmese        |
| 020 | Byelorussian   |
| 021 | Cambodian      |
|     |                |
| 022 | Catalan        |
| 023 | Chinese        |
| 024 | Corsican       |
| 025 | Croatian       |
|     |                |
| 026 | Czech          |
| 027 | Danish         |
| 028 | Dutch          |
| 140 | English        |
|     | -              |
| 030 | Esperonto      |
| 031 | Estonian       |
| 032 | Faroese        |
| 033 | Fiji           |
|     | ,              |
| 034 | Finnish        |
| 035 | French         |
| 036 | Frisian        |
| 037 | Galican        |
| 038 | Georgian       |
|     |                |
| 039 | German         |
| 040 | Greek          |
| 041 | Greenlandic    |
| 042 | Guarani        |
|     |                |
| 043 | Gujarati       |
| 044 | Hausa          |
| 045 | Hebrew         |
| 046 | Hindi          |
|     |                |
| 047 | Hungarian      |
| 048 | Icelandic      |
| 049 | Indonesian     |
| 050 | Interlingua    |
| 051 | Interlingue    |
|     |                |
| 052 | Inuktitut      |
| 053 | Inupiak        |
| 054 | Irish          |
| 055 | Italian        |
|     |                |
| 056 | Japanese       |
| 057 | Javanese       |
| 058 | Kannada        |
| 059 | Kashmiri       |
| 060 | Kazakh         |
|     |                |

061 Kinyarwanda 062 Kirghiz 063 Kurundi 064 Korean 065 Kurdish 066 Laothian 067 Latin 068 Latvian;Lettish 069 Lingala 070 Lithuanian 071 Macedonian 072 Malagasy 073 Malay Malayalam 074 075 Maltese 076 Maori 077 Marathi 078 Moldavian 079 Mongolian 080 Nauru 081 Nepali 082 Norwegian 083 Occitan 084 Oriya 085 Pashto;Pushto Persian (Farsi) 086 087 Polish 088 Portuguese 089 Punjabi 090 Quechua Rhaeto-Romance 091 092 Romanian 093 Russian 094 Samoan 095 Sangho Sanskrit 096 097 Scot Gaelic 098 Serbian Serbo-Croatian 099 100 Sesotho Setswana 101 102 Shona 103 Sindhi 104 Singhalese 105 Siswati 106 Slovak 107 Slovenian 108 Somali 109 Spanish 110 Sundanese 111 Swahili 112 Swedish 113 Tagalog 114 Tajik 115 Tamil 116 Tatar Telugu 117 118 Thai 119 Tibetan 120 Tigrinya

- 772 Tokelau
- 776 Tonga 780 Trinidad and Tobago
- 788 Tunisia
- Turkey795 Turkmenistan 792
- Turks and Caicos Islands 796
- 798 Tuvalu
- 800 Uganda
- 804 Ukraine
- 784 United Arab Emirates
- 826 United Kingdom
- 840 United States
- 581 U.S. Minor Outlying Islands
- 858 Uruguay

121 Tonga

122 Tsonga

123 Turkish

Turkmen

124

Uzbekistan 860

548 Vanuatu

- 336 Vatican City State (Holy See)
- 862 Venezuela
- 704 Viet Nam
- Virgin Islands, British 092
- Virgin Islands, U.S. 850
- 876 Wallis and Fortuna Islands
- 732 Western Sahara (provisional)
- 887 Yemen
- Yugoslavia 891
- 894 Zambia
- 716 Zimbabwe

125 Twi 126 Uigur 127 Ukrainian 128 Urdu 129 Uzbek 130 Vietnamese 131 Volapuk 132 Welsh 133 Wolof 134 Xhosa 135 Yiddish 136 Yoruba 10 Zerbaijani 137 Zhuang 138 Zulu

### **U.S. / Canadian Professional School Codes**

#### Alabama

- 300 University of Alabama School of Dentistry
- 001 University of Alabama School of Medicine
- 002 University of South Alabama College of Medicine

#### Arkansas

003 University of Arkansas College of Medicine

#### Arizona

- Arizona College of Osteopathic Medicine 500
- 004 University of Arizona College of Medicine

#### California

- California College of Podiatric Medicine 801 Cleveland Chiropractic College of Los Angele
- 400 005
- Keck School of Medicine Life Chiropractic College West 401
- 301
- Loma Linda University School of Dentistry 006 Loma Linda University School of Medicine
- 402 Los Angeles College of Chiropractic
- 403 Palmer College of Chiropractic West
- 404 Quantum University/SCCC
- 007 Stanford University School of Medicine
- 501 Touro University College of Osteopathic Medicine
- 800 UCLA School of Medicine
- University of California 009
- 010 University of California, Irvine, College of Medicine
- 302 University of California, Los Angeles School of Dentistry
- University of California, San Diego, School of Medicine 011
- 303 University of California, San Francisco, School of Dentistry
- University of California, San Francisco, School of Medicine 012
- University of Southern California School of Dentistry 304
- University of the Pacific School of Dentistry 305
- Western University of Health Sciences, College of Osteopathic Medicine 502 of the Pacific

#### Colorado

- 306 University of Colorado School of Dentistry
- 013 University of Colorado School of Medicine

#### Connecticut

- 405 University of Bridgeport College of Chiropractic
- 307 University of Connecticut School of Dental Medicine
- University of Connecticut School of Medicine 014
- 015 Yale University School of Medicine

#### District of Columbia

- 016 George Washington University
- 017 Georgetown University School of Medicine
- Howard University College of Dentistry 308
- 018 Howard University College of Medicine

#### Florida

- 800 Barry University School of Graduate Medical Sciences
- Nova Southeastern University College of Dentistry 309
- Nova Southeastern University College of Osteopathic Medicine 503
- University of Florida College of Dentistry 310
- University of Florida College of Medicine 019
- 020 University of Miami School of Medicine
- 021 University of South Florida College of Medicine

#### Georgia

- 022 Emory University School of Medicine
- Life Chiropractic College 406
- Medical College of Georgia School of Dentistry 311
- 023 Medical College of Georgia School of Medicine
- 024 Mercer University School of Medicine
- 025 Morehouse School of Medicine

### Hawaii

026 John A. Burns School of Medicine

### lowa

- 802 College of Podiatric Medicine and Surgery Des Moines University
- Des Moines University, Osteopathic Medical Center, College of 504 Osteopathic Medicine and Surgery
- 407 Palmer College of Chiropractic
- 312 University of Iowa College of Dentistry
- 027 University of Iowa College of Medicine

#### Illinois

- 028 Chicago Medical School, Finch University of Health Sciences
- 029 Loyola University Chicago, Stritch School of Medicine
- 505 Midwestern University, Chicago College of Osteopathic Medicine
- 408 National College of Chiropractic
- 313 Northwestern University Dental School
- 030 Northwestern University Medical School
- 031 Rush Medical College of Rush University
- 804 Scholl College of Podiatric Medicine at Finch University 314 Southern Illinois University School of Dental Medicine
- 032 Southern Illinois University School of Medicine
- 033 University of Chicago, The Pritzker School of Medicine
- 315 University of Illinois at Chicago College of Dentistry
- 034 University of Illinois College of Medicine

#### Indiana

- 316 Indiana University School of Dentistry
- 035 Indiana University School of Medicine

#### Kansas

036 University of Kansas School of Medicine

#### Kentucky

- 506 Pikeville College, School of Osteopathic Medicine
- 317 University of Kentucky College of Dentistry
- 037 University of Kentucky College of Medicine
- 318 University of Louisville School of Dentistry
- 038 University of Louisville School of Medicine

#### Louisiana

- 319 Louisiana State University School of Dentistry
- 039 Louisiana State University School of Medicine in New Orleans
- 040 Louisiana State University School of Medicine in Shreveport
- 041 Tulane University School of Medicine

#### Massachusetts

Marvland

Maine

Michigan

Minnesota

Missouri

052 Mayo Medical School

411 Logan Chiropractic College

042 Boston University School of Medicine

321 Harvard School of Dental Medicine 322 Tufts University School of Dental Medicine

044 Tufts University School of Medicine

045 University of Massachusetts Medical School

046 Johns Hopkins University School of Medicine

048 University of Maryland School of Medicine

047 Uniformed Services University of the Health Sciences

323 University of Maryland, Baltimore, College of Dental Surgery

507 University of New England, College of Osteopathic Medicine

508 Michigan State University, College of Osteopathic Medicine

049 Michigan State University College of Human Medicine

324 University of Detroit Mercy School of Dentistry

053 University of Minnesota, Duluth School of Medicine

054 University of Minnesota Medical School, Twin Cities

056 University of Missouri, Columbia School of Medicine

327 University of Missouri Kansas City School of Dentistry

057 University of Missouri Kansas City School of Medicine

058 Washington University in St. Louis School of Medicine

510 University of Health Sciences, College of Osteopathic Medicine

Page 38

050 University of Michigan Medical School

409 Northwestern College of Chiropractic

325 University of Michigan School of Dentistry

051 Wayne State University School of Medicine

326 University of Minnesota School of Dentistry

410 Cleveland Chiropractic College of Kansas City

509 Kirksville College of Osteopathic Medicine

055 Saint Louis University School of Medicine

043 Harvard Medical School

320 Boston University, Goldman School of Dental Medicine

### U.S. / Canadian Professional School Codes (continued)

#### Mississippi

328 University of Mississippi School of Dentistry 059 University of Mississippi School of Medicine

#### North Carolina

- 060 Duke University School of Medicine
- 061 The Brody School of Medicine at East Carolina University
- University of North Carolina at Chapel Hill School of Dentistry 329
- University of North Carolina at Chapel Hill School of Medicine 062
- 063 Wake Forest University School of Medicine

### North Dakota

064 University of North Dakota School of Medicine and Health Sciences

#### Nebraska

- Creighton University School of Dentistry 330
- Creighton University School of Medicine 065
- University of Nebraska College of Medicine 066
- 331 University of Nebraska Medical Center, College of Dentistry

#### **New Hampshire**

067 Dartmouth Medical School

#### New Jersev

- 068 Robert Wood Johnson Medical School
- 069 University of Medicine and Dentistry of New Jersey (UMDNJ)
- 332 UMDNJ, New Jersey Dental School
- UMDNJ, School of Osteopathic Medicine 511

#### New Mexico

070 University of New Mexico School of Medicine

#### Nevada

- 071 University of Nevada School of Medicine

#### New York

- 072 Albany Medical College
- Albert Einstein College of Medicine 073
- Columbia University College of Physicians and Surgeons 074
- 333 Columbia University School of Dental and Oral Surgery
- 075 Joan & Sanford I. Weill Medical College of Cornell University
- 076 Mount Sinai School of Medicine of New York University
- 412 New York Chiropractic College
- 512 NY College of Osteopathic Medicine of the NY Institute of Technology
- 077 New York Medical College
- 334 New York University Kriser Dental Center
- 078 New York University School of Medicine
- 335 State University of New York at Buffalo School of Dental Medicine
- 082 State University of New York at Buffalo School of Medicine
- State University of New York at Stony Brook School of Dental Medicine 336
- State University of New York at Stony Brook School of Medicine 081
- State University of New York College of Medicine 079
- 080 State University of New York Upstate Medical University
- 083 University of Rochester School of Medicine and Dentistry

#### Ohio

- Case Western Reserve University School of Dentistry 337
- 084 Case Western Reserve University School of Medicine
- Medical College of Ohio 085
- 086 Northeastern Ohio Universities College of Medicine
- 803 Ohio College of Podiatric Medicine
- 338 Ohio State University College of Dentistry
- Ohio State University College of Medicine and Public Health 087
- 513 Ohio University College of Osteopathic Medicine
- 088 University of Cincinnati College of Medicine
- 089 Wright State University School of Medicine

#### Oklahoma

- 514 Oklahoma State University, College of Osteopathic Medicine
- 339 University of Oklahoma College of Dentistry
- University of Oklahoma College of Medicine 090

### Oregon

- Oregon Health & Science University School of Medicine 091
- 340 Oregon Health Sciences University School of Dentistry
- 413 Western States Chiropractic College

### Pennsvlvania

092 Jefferson Medical College of Thomas Jefferson University

- 515 Lake Erie College of Osteopathic Medicine
- 093 MCP Hahnemann University School of Medicine
- Pennsylvania State University College of Medicine 094
- 516 Philadelphia College of Osteopathic Medicine
- 341 Temple University School of Dentistry
- Temple University School of Medicine 095 805 Temple University School of Podiatric Medicine
- University of Pennsylvania School of Dental Medicine 342
- University of Pennsylvania School of Medicine 096
- University of Pittsburgh School of Dental Medicine 343
- University of Pittsburgh School of Medicine 097

#### Puerto Rico

- 098 Ponce School of Medicine
- 099 Universidad Central del Caribe School of Medicine
- 100 University of Puerto Rico School of Medicine
- 344 University of Puerto Rico School of Dentistry

#### Rhode Island

101 Brown Medical School

#### South Carolina

345 Medical University of South Carolina College of Dental Medicine

Texas Tech University Health Sciences Center School of Medicine

UNT Health Sciences Center, Texas College of Osteopathic Medicine

University of Texas Health Science Center at Houston Dental School

115 UT Southwestern Medical Center at Dallas Southwestern Medical School

117 Eastern VA Medical School of the Medical College of Hampton Roads

University of Texas Health Science Center at San Antonio Dental School

The Texas A & M University System College of Medicine

University of Texas Medical Branch at Galveston

118 University of Virginia School of Medicine Health System

351 Virginia Commonwealth University School of Dentistry

119 Virginia Commonwealth University School of Medicine

124 Joan C. Edwards School of Medicine at Marshall University

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University of Texas Medical School at Houston

114 University of Texas Medical School at San Antonio

116 University of Utah School of Medicine

120 University of Vermont College of Medicine

352 University of Washington School of Dentistry 121 University of Washington School of Medicine

518 West Virginia School of Osteopathic Medicine 354 West Virginia University School of Dentistry

125 West Virginia University School of Medicine

353 Marquette University School of Dentistry

122 Medical College of Wisconsin 123 University of Wisconsin Medical School

- 102 Medical University of South Carolina College of Medicine
- 414 Sherman College of Chiropractic
- 103 University of South Carolina School of Medicine

#### South Dakota

104 University of South Dakota School of Medicine

#### Tennessee

Texas

415

416

110

111

517

349

350

112

113

Utah

Virginia

Vermont

Washington

Wisconsin

West Virginia

105 East Tennessee State University

348 Baylor College of Dentistry

109 Baylor College of Medicine Parker College of Chiropractic

Texas Chiropractic College

- 346 Meharry Medical College School of Dentistry
- 106 Meharry Medical College School of Medicine
- University of Tennessee College of Dentistry 347
- 107 University of Tennessee College of Medicine
- 108 Vanderbilt University School of Medicine

### U.S. / Canadian Professional School Codes (continued)

#### Canada

247

- 355 Dalhousie University Faculty of Dentistry
- 126 Dalhousie University Faculty of Medicine
- Laval University Faculty of Dentistry 357
- 127 Laval University Faculty of Medicine
- McGill University Faculty of Dentistry 356
- McGill University Faculty of Medicine 128 McMaster University School of Medicine 129
- Memorial University of Newfoundland Faculty of Medicine 130 131
- Queen's University Faculty of Health Sciences 132 The University of Western Ontario Faculty of Medicine & Dentistry
- 133 Universite de Montreal Faculty of Medicine
- Universite de Sherbrooke Faculty of Medicine 134
- University of Alberta Faculty of Dentistry 358
- University of Alberta Faculty of Medicine 135
- 359 University of British Columbia Faculty of Dentistry
- University of British Columbia Faculty of Medicine 136
- 137 University of Calgary Faculty of Medicine
- University of Manitoba Faculty of Dentistry 360
- 138 University of Manitoba Faculty of Medicine
- 361 University of Montreal Faculty of Dentistry
- 139 University of Ottawa Faculty of Medicine
- 362 University of Saskatchewan College of Dentistry
- 140 University of Saskatchewan College of Medicine
- 363 University of Toronto Faculty of Dentistry
- 141 University of Toronto Faculty of Medicine
- University of Western Ontario Faculty of Dentistry 364

#### Specialty Codes - MD / DO Only

Allergy & Immunology

| NOTE: THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST. | PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) |
|---|---|
|   |   |

- 246 Allergy & Immunology, Allergy 288 Internal Medicine, Hematology & Oncology 291 Allergy & Immunology, Clinical & 450 Internal Medicine, Hepatology Laboratory Immunology Internal Medicine, Infectious Disease 299 249 Anesthesiology 451 Anesthesiology, Addiction Medicine 235 453 Anesthesiology, Critical Care Medicine (MRI) 258 126 Anesthesiology, Pain Medicine 325 Internal Medicine, Medical Oncology 363 **Clinical Pharmacology** 309 Internal Medicine, Nephrology 367 Colon & Rectal Surgery 378 Internal Medicine, Pulmonary Disease Internal Medicine, Rheumatology 263 Dermatology 390 Dermatology, Clinical & Laboratory 292 397 Internal Medicine, Sports Medicine Dermatological Immunology 433 Laboratories, Clinical Medical Laboratory 444 Dermatology, Dermatological Surgery 481 Legal Medicine Dermatology, Dermatopathology 266 278 264 Dermatology, MOHS-Micrographic Surgery 261 Medical Genetics, Clinical Cytogenetic Medical Genetics, Clinical Genetics (M.D.) 443 Dermatology, Pediatric Dermatology 277 **Emergency Medicine** Medical Genetics, Clinical Molecular Genetics 268 280 Emergency Medicine, Emergency Medical 445 455 Services 454 427 Emergency Medicine, Medical Toxicology 306 Neonatal-Perinatal Medicine 348 Emergency Medicine, Pediatric Emergency 308 Neopathology Neurological Surgery Medicine 409 Neuromusculoskeletal Medicine & OMM 395 Emergency Medicine, Sports Medicine 330 Emergency Medicine, Undersea and Hyperbaric 446 440 Medicine 317 Nuclear Medicine 391 Facial Plastic Surgery 318 Family Practice 272 Medicine Family Practice, Addiction Medicine 315 Nuclear Medicine, Nuclear Cardiology 447 237 Family Practice, Adolescent Medicine 316 Nuclear Medicine, Nuclear Imaging & Therapy **Obstetrics & Gynecology** 448 Family Practice, Adult Medicine 321 Family Practice, Geriatric Medicine Obstetrics & Gynecology, Critical Care Medicine 282 260 396 Family Practice, Sports Medicine Obstetrics & Gynecology, Gynecologic Oncology 326 **General Practice** 225 286 Obstetrics & Gynecology, Gynecology 479 Hospitalist 303 301 Internal Medicine Medicine Internal Medicine, Addiction Medicine 320 Obstetrics & Gynecology, Obstetrics 449 236 Internal Medicine, Adolescent Medicine 271 Obstetrics & Gynecology, Reproductive Internal Medicine, Allergy & Immunology 248 Endocrinology Internal Medicine, Cardiovascular Disease Ophthalmology 255 328 294 Internal Medicine, Clinical & Laboratory 441 Oral & Maxillofacial Surgery Immunology 411 Orthopaedic Surgery 253 Internal Medicine, Clinical Cardiac 412 Orthopaedic Surgery Electrophysiology Internal Medicine, Critical Care Medicine 257
  - Internal Medicine, Endocrinology, Diabetes &
  - Metabolism Internal Medicine, Gastroenterology
- 275 285 Internal Medicine, Geriatric Medicine

267

Internal Medicine, Interventional Cardiology

Internal Medicine, Hematology

287

- Internal Medicine, Magnetic Resonance Imaging

- Medical Genetics, Clinical Biochemical Genetics

- Medical Genetics, Molecular Genetic Pathology
- Medical Genetics, Ph.D. Medical Genetics

- Neuromusculoskeletal Medicine, Sports Medicine
- Nuclear Medicine, In Vivo & In Vitro Nuclear

- Obstetrics & Gynecology, Maternal & Fetal

- Orthopaedic Surgery, Adult Reconstructive
- Orthopaedic Surgery, Foot and Ankle 456 Orthopaedics
- 406 Orthopaedic Surgery, Hand Surgery
- Orthopaedic Surgery, Orthopaedic Surgery of the 415 Spine

- 416 Orthopaedic Surgery, Orthopaedic Trauma
- 457 Orthopaedic Surgery, Sports Medicine
- 119 Orthopedic
- 331 Otolaryngology
- 458 Otolaryngology, Otolaryngic Allergy
- Otolaryngology, Otolaryngology/ Facial Plastic 459 Surgery
- Otolaryngology, Otology & Neurotology 332
- 357 Otolaryngology, Pediatric Otolaryngology
- 417 Otolaryngology, Plastic Surgery within the Head & Neck
- 480 Pain Medicine, Interventional Pain Medicine
- 337 Pain Medicine
- 338 Pathology, Anatomic Pathology
- 340 Pathology, Anatomic Pathology & Clinical Pathology
- 250 Pathology, Blood Banking & Transfusion Medicine
- Pathology, Chemical Pathology 344
- 302 Pathology, Clinical
- Pathology/Laboratory Medicine
- 262 Pathology, Cytopathology
- Pathology, Dermatopathology 265
- 273 Pathology, Forensic Pathology
- 290 Pathology, Hematology
- 298 Pathology, Immunopathology
- 305 Pathology, Medical Microbiology
- 461 Pathology, Molecular Genetic
- Pathology 312
- Pathology, Neuropathology 358 Pathology, Pediatric Pathology

**Behavioral Pediatrics** 

Pediatrics. Adolescent Medicine

Pediatrics, Clinical & Laboratory

Pediatrics, Developmental -

Pediatrics, Medical Toxicology

Pediatrics, Pediatric Allergy &

Pediatrics, Pediatric Cardiology

Pediatrics. Pediatric Critical Care

Pediatrics, Pediatric Emergency

Pediatrics, Pediatric Endocrinology

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Pediatrics, Neurodevelopmental

Pediatrics

Immunology

Disabilities

Immunology

Medicine

Medicine

244

239

295

462

354

356

345

346

347

463

### Specialty Codes - MD/DO Only

- 350 Pediatrics, Pediatric Gastroenterology
- 351 Pediatrics, Pediatric Hematology-Oncology
- 352 Pediatrics, Pediatric Infectious Diseases
- 355 Pediatrics, Pediatric Nephrology
- Pediatrics, Pediatric Pulmonology 359 361
- Pediatrics, Pediatric Rheumatology 398
- Pediatrics, Sports Medicine Physical Medicine & Rehabilitation 365
- Physical Medicine & Rehabilitation, 468 Pain Medicine
- Physical Medicine & Rehabilitation, 389 Pediatric Rehabilitation Medicine
- Physical Medicine & Rehabilitation, 466
- Spinal Cord Injury Medicine Physical Medicine & Rehabilitation. 469
- Sports Medicine 419 Plastic Surgery
- Plastic Surgery, Plastic Surgery 470 Within the Head and Neck
- 407 Plastic Surgery, Surgery of the Hand
- Preventive Medicine, Aerospace 242 Medicine
- 429 Preventive Medicine, Medical Toxicology
- 112 Preventive Medicine, Occupational Medicine

### Specialty Codes - DDS / DMD / DPM / DC

471 Preventive Medicine, Sports

- Medicine 431 Preventive Medicine, Undersea
- and Hyperbaric Medicine 114 Preventive Medicine/Occupational **Environmental Medicine**
- 370 Psychiatry & Neurology, Addiction Medicine
- 473 Psychiatry & Neurology, Addiction Psychiatry
- Psychiatry & Neurology, Child & 371 Adolescent Psychiatry
- Psychiatry & Neurology, Clinical 313 Neurophysiology
- 274 Psychiatry & Neurology, Forensic Psychiatry
- 373 Psychiatry & Neurology, Geriatric Psychiatry
- 472 Psychiatry & Neurology,
- Neurodevelopmental Disabilities 100 Psychiatry & Neurology, Neurology
- 311 Psychiatry & Neurology, Neurology
- with Special Qualifications in Child Neurology
- Psychiatry & Neurology, Pain 474 Medicine
- 368 Psychiatry & Neurology, Psychiatry 475 Psychiatry & Neurology, Sports
- Medicine
- 476 Psychiatry & Neurology, Vascular

DPM

3

- Neurology
- Public Health & General Preventive 366 Medicine 252 Radiology, Body Imaging 173 Radiology, Diagnostic Radiology 430 Radiology, Diagnostic Ultrasound Radiology, Neuroradiology 314 Radiology, Nuclear Radiology 319 360 Radiology, Pediatric Radiology 380 Radiology, Radiation Oncology Radiology, Radiological Physics 477 Radiology, Therapeutic Radiology 381 Radiology, Vascular & 384
- Interventional Radiology 434 Supplier
- 399 Surgery
- 418
- Surgery, Pediatric Surgery Surgery, Plastic and Reconstructive 420
- Surgery
- 405 Surgery, Surgery of the Hand
- 425 Surgery, Surgical Critical Care
- 413 Surgery, Surgical Oncology
- 423 Surgery, Trauma Surgery
- 400 Surgery, Vascular Surgery
- 421 Thoracic Surgery (Cardiothoracic Vascular Surgery) Transplant Surgery
- 442 424 Urology

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#### DDS / DMD 2

- Dentist Dentist, Dental Public Health 13
- Dentist, Endodontics 14
- 438 Dentist General Practice
- 16 Dentist, Oral and Maxillofacial Pathology
- Dentist, Oral and Maxillofacial Radiology 439
- 20 Dentist, Oral and Maxillofacial Surgery
- Dentist, Orthodontics and Dentofacial Orthopedics 15
- Dentist. Pediatric Dentistry 17
- Dentist, Periodontics 18
- Dentist, Prosthodontics 19

### **Specialty Codes - Allied Providers**

| 1 Acupuncturist  | 753 | Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family  |
|--|-----|---|
| 3 Audiologist  | 754 | Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically III |
| 4 Audiologist, Assistive Technology Practitioner                           | 755 | Clinical Nurse Specialist, Psychiatric/Mental Health, Community       |
| 5 Audiologist, Assistive Technology Supplier                               | 756 | Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric |
| 1 Christian Science Practitioner   | 757 | Clinical Nurse Specialist, Rehabilitation                             |
| 7 Clinical Nurse Specialist  | 759 | Clinical Nurse Specialist, School                                     |
| 8 Clinical Nurse Specialist, Acute Care                                    | 758 |   |
| 9 Clinical Nurse Specialist, Adult Health                                  | 760 | Clinical Nurse Specialist, Women's Health                             |
| 0 Clinical Nurse Specialist, Chronic Care                                  | 513 | Counselor   |
| 1 Clinical Nurse Specialist, Community Health/Public Health                |     | Counselor, Addiction (Substance Use Disorder)                         |
| 2 Clinical Nurse Specialist, Critical Care Medicine                        |     | Counselor, Mental Health  |
| 3 Clinical Nurse Specialist, Emergency                                     | 516 | Counselor, Professional   |
| 4 Clinical Nurse Specialist, Ethics  | 533 | Dietitian, Registered   |
| 5 Clinical Nurse Specialist, Family Health                                 | 536 | Dietitian, Registered, Nutrition, Metabolic                           |
| 6 Clinical Nurse Specialist, Gerontology                                   | 534 | Dietitian, Registered, Nutrition, Pediatric                           |
| 7 Clinical Nurse Specialist, Holistic                                      | 535 | Dietitian, Registered, Nutrition, Renal                               |
| 8 Clinical Nurse Specialist, Home Health                                   | 651 | Licensed Practical Nurse  |
| 9 Clinical Nurse Specialist, Informatics                                   | 517 | Marriage & Family Therapist   |
| 0 Clinical Nurse Specialist, Long-Term Care                                | 547 | Massage Therapist   |
| 1 Clinical Nurse Specialist, Medical-Surgical                              | 549 | Midwife, Certified  |
| 2 Clinical Nurse Specialist, Neonatal                                      | 652 | Midwife, Certified Nurse  |
| 3 Clinical Nurse Specialist, Neuroscience                                  | 551 | Naturopath  |
| 4 Clinical Nurse Specialist, Occupational Health                           | 553 | Neuropsychologist   |
| 5 Clinical Nurse Specialist, Oncology                                      | 653 | Nurse Anesthetist, Certified Registered                               |
| 6 Clinical Nurse Specialist, Oncology, Pediatrics                          | 654 | Nurse Practitioner  |
| 7 Clinical Nurse Specialist, Pediatrics                                    | 655 | Nurse Practitioner, Acute Care  |
| 8 Clinical Nurse Specialist, Perinatal                                     |     | Nurse Practitioner, Adult Health                                      |
| 9 Clinical Nurse Specialist, Perioperative                                 | 658 | Nurse Practitioner, Community Health                                  |
| 0 Clinical Nurse Specialist, Psychiatric/Mental Health                     | 657 | Nurse Practitioner, Critical Care Medicine                            |
| 1 Clinical Nurse Specialist, Psychiatric/Mental Health, Adult              | 659 | Nurse Practitioner, Family  |
|  |     |   |
| 2 Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent |     |   |

231 Podiatrist, Foot & Ankle Surgery 230 Podiatrist, Foot Surgery 225 Podiatrist General Practice

Podiatrist

- 227 Podiatrist, Primary Podiatric Medicine
- Podiatrist, Public Medicine 226
- Podiatrist, Radiology 228
- 229 Podiatrist, Sports Medicine

Chiropractor Chiropractor, Internist Chiropractor, Neurology

DC

1

5

- 7 Chiropractor, Nutrition
- 8 Chiropractor, Occupational Medicine
- Chiropractor, Orthopedic 9
- 10 Chiropractor, Radiology
- Chiropractor, Sports Physician 11
- Chiropractor, Thermography 12

### **Specialty Codes - Allied Providers (continued)**

| Spe        | ecialty Codes - Allied Providers (continued)  |            |  |
|------------|---|------------|--|
| 660        | Nurse Practitioner, Gerontology   | 675        | Registered Nurse, Critical Care Medicine   |
|            | Nurse Practitioner, Neonatal  |            | Registered Nurse, Diabetes Educator  |
|            | Nurse Practitioner, Neonatal, Critical Care   |            | Registered Nurse, Dialysis, Peritoneal   |
| 670        | Nurse Practitioner, Obstetrics & Gynecology   | 684        | Registered Nurse, Emergency  |
| 671        | Nurse Practitioner, Occupational Health   | 685        | Registered Nurse, Enterostomal Therapy   |
|            | Nurse Practitioner, Pediatrics  | 686        | 5  |
|            | Nurse Practitioner, Pediatrics, Critical Care   | 688        | с  |
|            | Nurse Practitioner, Perinatal   | 687        |  |
|            | Nurse Practitioner, Primary Care<br>Nurse Practitioner, Psych/Mental Health                 | 689<br>691 | 5 · · · · · · · · · · · · · · · · · · ·  |
|            | Nurse Practitioner, School  | 690        | <b>e</b>   |
|            | Nurse Practitioner, Women's Health  |            | Registered Nurse, Hospice  |
|            | Nutritionist  |            | Registered Nurse, Infection Control  |
|            | Nutritionist, Nutrition, Education  |            | Registered Nurse, Infusion Therapy   |
|            | Occupational Therapist  |            | Registered Nurse, Lactation Consultant   |
| 556        | Occupational Therapist, Ergonomics  | 696        | Registered Nurse, Maternal Newborn   |
|            | Occupational Therapist, Hand  |            | Registered Nurse, Medical-Surgical   |
|            | Occupational Therapist, Human Factors   |            | Registered Nurse, Neonatal Intensive Care  |
|            | Occupational Therapist, Neurorehabilitation   |            | Registered Nurse, Neonatal, Low-Risk   |
|            | Occupational Therapist, Pediatrics  | 701        | 5 · · · · · · · · · · · · · · · · · · ·  |
|            | Occupational Therapist, Rehabilitation, Driver<br>Optician                                  |            | Registered Nurse, Neuroscience<br>Registered Nurse, Nurse Massage Therapict (NMT)                    |
|            | Optometrist   |            | Registered Nurse, Nurse Massage Therapist (NMT)<br>Registered Nurse, Nutrition Support               |
|            | Optometrist, Corneal and Contact Management   |            | Registered Nurse, Obstetric, High-Risk   |
|            | Optometrist, Low Vision Rehabilitation  |            | Registered Nurse, Obstetric, Inpatient   |
|            | Optometrist, Occupational Vision  | 721        |  |
|            | Optometrist, Pediatrics   |            | Registered Nurse, Oncology   |
|            | Optometrist, Sports Vision  | 725        | Registered Nurse, Ophthalmic   |
| 570        | Optometrist, Vision Therapy   | 724        | Registered Nurse, Orthopedic   |
| 573        | Pharmacist  | 726        | Registered Nurse, Ostomy Care  |
|            | Pharmacist, General Practice  |            | Registered Nurse, Otorhinolaryngology & Head-Neck  |
|            | Pharmacist, Nuclear Pharmacy  |            | Registered Nurse, Pain Management  |
|            | Pharmacist, Nutrition Support   |            | Registered Nurse, Pediatric Oncology   |
|            | Pharmacist, Pharmacotherapy   |            | Registered Nurse, Pediatrics   |
|            | Pharmacist, Psychopharmacy  |            | Registered Nurse, Perinatal  |
|            | Physical Therapist<br>Physical Therapist  |            | Registered Nurse, Plastic Surgery  |
|            | Physical Therapist, Cardiopulmonary<br>Physical Therapist, Electrophysiology, Clinical      | 708        | Registered Nurse, Psych/Mental Health<br>Registered Nurse, Psych/Mental Health, Adult                |
|            | Physical Therapist, Ergonomics  |            | Registered Nurse, Psych/Mental Health, Child & Adolescent  |
|            | Physical Therapist, Ergonomics  |            | Registered Nurse, Rehabilitation   |
|            | Physical Therapist, Hand  |            | Registered Nurse, Reproductive Endocrinology/Infertility   |
|            | Physical Therapist, Human Factors   |            | Registered Nurse, School   |
|            | Physical Therapist, Neurology   |            | Registered Nurse, Urology  |
| 590        | Physical Therapist, Orthopedic  | 718        | Registered Nurse, Women's Health Care, Ambulatory  |
| 588        | Physical Therapist, Pediatrics  | 717        | Registered Nurse, Wound Care   |
| 589        | Physical Therapist, Sports  | 617        | Respiratory Therapist, Certified   |
|            | Physician Assistant   |            | Respiratory Therapist, Certified, Critical Care  |
|            | Physician Assistant, Medical  |            | Respiratory Therapist, Certified, Educational  |
|            | Physician Assistant, Surgical   |            | Respiratory Therapist, Certified, Emergency Care   |
|            | Psychologist<br>Bsychologist Addiction (Substance Use Disorder)                             |            | Respiratory Therapist, Certified, General Care   |
|            | Psychologist, Addiction (Substance Use Disorder)<br>Psychologist, Adult Development & Aging |            | Respiratory Therapist, Certified, Geriatric Care<br>Respiratory Therapist, Certified, Home Health    |
|            | Psychologist, Behavioral  |            | Respiratory Therapist, Certified, Neonatal/Pediatrics  |
|            | Psychologist, Child, Youth & Family   | 627        |  |
|            | Psychologist, Clinical  | 629        | Respiratory Therapist, Certified, Patient Transport  |
|            | Psychologist, Counseling  | 624        | Respiratory Therapist, Certified, Pulmonary Diagnostics  |
| 603        | Psychologist, Educational   | 626        | Respiratory Therapist, Certified, Pulmonary Function Technologist                                    |
| 604        | Psychologist, Exercise & Sports   | 625        | Respiratory Therapist, Certified, Pulmonary Rehabilitation   |
|            | Psychologist, Family  | 630        | Respiratory Therapist, Certified, SNF/Subacute Care  |
|            | Psychologist, Forensic  | 631        |  |
|            | Psychologist, Health  |            | Respiratory Therapist, Registered, Critical Care   |
|            | Psychologist, Men & Masculinity   |            | Respiratory Therapist, Registered, Educational   |
|            | Psychologist, Mental Retardation & Developmental Disabilities                               |            | Respiratory Therapist, Registered, Emergency Care  |
|            | Psychologist, Psychoanalysis<br>Psychologist, Psychotherapy                                 |            | Respiratory Therapist, Registered, General Care<br>Respiratory Therapist, Registered, Geriatric Care |
|            | Psychologist, Psychotherapy, Group  | 637        |  |
|            | Psychologist, Rehabilitation  |            | Respiratory Therapist, Registered, Neonatal/Pediatrics   |
|            | Psychologist, School  | 641        |  |
|            | Psychologist, Women   | 643        |  |
|            | Registered Nurse  | 638        |  |
| 673        | Registered Nurse, Addiction (Substance Use Disorder)  | 640        | Respiratory Therapist, Registered, Pulmonary Function Technologist                                   |
|            | Registered Nurse, Administrator   | 639        | Respiratory Therapist, Registered, Pulmonary Rehabilitation  |
|            | Registered Nurse, Ambulatory Care   | 644        |  |
| 681        | 5   |            | Social Worker, Clinical  |
|            | Registered Nurse, Calego Health   | 648        |  |
| 677<br>678 |   | 506<br>649 | Speech-Language Pathologist  |
|            | Registered Nurse, Community Health<br>Registered Nurse, Continence Care                     | 502        | Technician, Other, Biomedical Engineering<br>Other, Not Listed                                       |
| 200        |   | 502        |  |

- 678 Registered Nurse, Community Health 680 Registered Nurse, Continence Care
- 679 Registered Nurse, Continuing Education/Staff Development

### **Specialty Boards - Allied Providers**

- 940 Academy of Certified Social Workers
- 1150 ACNM Certification Council
- 360 American Academy of Ambulatory Care Nursing 1550 American Academy of Anesthesiologist Assistants
- 230 American Academy of Audiology
- 370 American Academy of Experts in Traumatic Stress
- 270 American Academy of Health Providers in the Addictive Disorders
- 200 American Academy of Medical Acupuncture
- 405 American Academy of Nurse Practitioners
- 380 American Academy of Nursing
- 1330 American Academy of Optometry
- 1480 American Academy of Physician Assistants
- 1110 American Association for Marriage and Family Therapy
- 390 American Association of Critical Care Nurses
- 1590 American Association of Nurse Anesthetists 330 American Association of Pastoral Counselors
- 1010 American Association of Sex Educators, Counselors and Therapists
- 710 American Board Medical Psychotherapists
- 280 American Board of Addiction Medicine
- 950 American Board of Examiners in Clinical Social Work
- 720 American Board of Medical Psyhotherapists & Psychodiagnosticians
- 400 American Board of Nursing Specialties
- 1240 American Board of Nutrition
- 1300 American Board of Occupational Medicine
- 1360 American Board of Ophthalmology
- 1510 American Board of Physical Therapy Specialties
- 700 American Board of Professional Psychology
- 1130 American Naturopath Certification Board

### Specialty Boards - MD / DDS / DMD / DO / DPM

#### MD Boards

- 044 American Board of Allergy & Immunology
- 045 American Board of Anesthesiology
- 046 American Board of Colon & Rectal Surgery
- 047 American Board of Dermatology
- 048 American Board of Emergency Medicine
- 049 American Board of Family Medicine
- 050 American Board of Internal Medicine
- 051 American Board of Medical Genetics
- 052 American Board of Neurological Surgery
- 053 American Board of Nuclear Medicine
- 054 American Board of Obstetrics & Gynecology
- 055 American Board of Ophthalmology
- 109 American Board of Oral & Maxillofacial Surgeons
- 056 American Board of Orthopedic Surgery
- 057 American Board of Otolaryngology
- 058 American Board of Pathology
- 059 American Board of Pediatrics
- 060 American Board of Physical Medicine & Rehabilitation
- 061 American Board of Plastic Surgery
- 062 American Board of Preventive Medicine
- 063 American Board of Psychiatry & Neurology
- 064 American Board of Radiology
- 065 American Board of Surgery
- 066 American Board of Thoracic Surgery
- 067 American Board of Urology
- 142 Boards other than ABMS/AOA

#### Dental Boards

- 113 American Board of Endodontics
- 114 American Board of Oral & Maxillofacial Pathology
- 117 American Board of Oral & Maxillofacial Radiology
- 109 American Board of Oral & Maxillofacial Surgeons

- 350 American Nurses Credentialing Center 740 American Psychological Association 750 American Psychological Society 760 American Psychotherapy Association 290 American Society of Addiction Medicine 1650 American Speech-Language-Hearing Association 250 Biofeedback Certification Institute of America 1430 Board of Pharmaceutical Specialties 1250 Commission on Dietetic Registration 960 Employee Assistance Professionals Association 780 National Association for the Advancement of Psychoanalysis 1450 National Association of Boards of Pharmacy 1600 National Association of Nurse Anesthetists 770 National Association of School Psychologists 980 National Association of Social Workers 1310 National Board for Certification in Occupational Therapy 1490 National Board for Certification of Orthopaedic Physician Assistants 790 National Board for Certified Clinical Hypnotherapists 310 National Board for Certified Counselors 1630 National Board for Respiratory Care
- 1050 National Board of Addiction Eventing
- 300 National Board of Addiction Examiners 800 National Board of Cognitive Behavioral Therapists
- 1350 National Board of Examiners in Optometry
- 1090 National Certification Board for Therapeutic Massage and Bodywork
- 210 National Certification Commission for Acupuncture and Oriental Medicine
- 1440 National Institute for Standards in Pharmacist Credentialing
- 220 Other Not Listed
- 108 American Board of Orthodontics
- 112 American Board of Pediatric Dentistry
- 111 American Board of Periodontology
- 115 American Board of Prosthodontics
- 106 American Board of Public Health Dentistry
- 120 Boards other than ABMS/AOA

#### DO Boards

- 118 American Osteopathic Board of Anesthesiology
- 119 American Osteopathic Board of Dermatology
- 120 American Osteopathic Board of Emergency Medicine
- 121 American Osteopathic Board of Family Practice
- 123 American Osteopathic Board of Internal Medicine
- 124 American Osteopathic Board of Neurology and Psychiatry
- 125 American Osteopathic Board of Neuromuskuloskeletal Medicine
- 126 American Osteopathic Board of Nuclear Medicine
- 127 American Osteopathic Board of Obstetrics and Gynecology
- 128 American Osteopathic Board of Ophthalmology and Otolaryngology
- 129 American Osteopathic Board of Orthopedic Surgery
- 130 American Osteopathic Board of Pathology
- 131 American Osteopathic Board of Pediatrics
- 132 American Osteopathic Board of Preventive Medicine
- 133 American Osteopathic Board of Proctology
- 134 American Osteopathic Board of Radiology
- 135 American Osteopathic Board of Rehabilitation Medicine
- 136 American Osteopathic Board of Surgery

#### **DPM Boards**

- 140 American Board of Medical Specialists in Podiatry
- 137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
- 138 American Board of Podiatric Surgery
- 139 American Council of Certified Podiatric Surgeons and Physicians