FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date: 06/30/2013
Estimated response time below.

INDIAN HEALTH SERVICE

Application for Medical Staff Appointment and/or Privileges

INSTRUCTIONS

This application form must be typed or clearly printed using black ink only. Provide all requested information. If more space is needed, attach additional sheets.

Do not submit curriculum vitae or resume in lieu of completing this application form. “Refer to CV” will not be accepted, and the application form will be returned to you for completion.

So that it is understood that you did not intentionally omit an item, type or print N/A (Not Applicable) beside those items that do not apply to you, unless instructions indicate otherwise.

Failure to complete this form in its entirety will delay the credentialing process and your appointment to the Medical Staff.

Misrepresentations, inaccuracies, or falsification of information can be grounds for termination of Medical Staff appointment and associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank.

Please attach to Page 1 of this application form a copy of government-issued photo identification (for example, a driver’s license, passport, or military ID).

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 60 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.

Indian Health Service

Application for Medical Staff Appointment and/or Privileges

IMPORTANT: All parts of this application must be completed. No part of this application may be completed by writing "See CV."

Area applying to:			**Hospital/Clinic:**		
DEMOGRAPHIC INFORMATION					
Name (Last, First, Middle):			Other Names Used:		
Degree:	Specialty:		Email Address:		
Office Address:			Home Address:		
City:	State:	Zip:	City:	State:	Zip:
Office Phone:			Home Phone:		
Date of Birth:	Place of Birth:		Social Security Number:		
Languages Spoken:			Country of Citizenship:		

PROFESSIONAL EDUCATION Please include a copy of diploma. If more than TWO schools, identify and explain on separate sheet			
1. Name of Institution:		Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:
Degree Obtained:	Honors:		
Did you successfully complete this program? ☐ Yes ☐ No (if no, attach an explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)			

IMPORTANT: All parts of this application must be completed. No part of this application may be completed by writing "See CV."

PROFESSIONAL EDUCATION (Continued)			
2. Name of Institution:		Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:
Degree Obtained:	Honors:		
Did you successfully complete this program? ☐ Yes ☐ No (if no, attach an explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)			

ECFMG (Foreign medical graduates) **Include copy of certificate**		
Certificate Number:	Date Issued (mm/yyyy):	Serial Number for ECFMG:

INTERNSHIP If more than *one* program, use separate sheet			
Name of Institution:	Dates Attended (mm/yyyy):		
Address:	City:	State:	Zip:
Type of Internship: ☐ Rotating ☐ Straight (If straight, list discipline:)			
Did you successfully complete this program? ☐ Yes ☐ No (if no, attach an explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)			

RESIDENCY Please include copy of certificate(s). If more than *two* programs, use separate sheet			
1. Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:
Did you successfully complete this program? ☐ Yes ☐ No (if no, attach an explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)			

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RESIDENCY (Continued)

2. Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:

Did you successfully complete this program?
☐ Yes ☐ No (if no, attach an explanation)

Were you the subject of any disciplinary action during your attendance at this institution?
☐ No ☐ Yes (if yes, attach an explanation)

FELLOWSHIP Please include copy of certificate. If more than *one* program, use separate sheet.

Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:

Did you successfully complete this program?
☐ Yes ☐ No (if no, attach an explanation)

Were you the subject of any disciplinary action during your attendance at this institution?
☐ No ☐ Yes (if yes, attach an explanation)

TEACHING EXPERIENCE/FACULTY APPOINTMENT List current and previous appointments.
If more than *two* programs, use separate sheet

1. Name of Institution:	Position/Rank:	Dates of Affiliation (mm/yyyy):	
Address:	City:	State:	Zip:
Phone:	Fax:	Program Director:	

Were you the subject of any disciplinary action during your attendance at this institution?
☐ No ☐ Yes (if yes, attach an explanation)

2. Name of Institution:	Position/Rank:	Dates of Affiliation (mm/yyyy):	
Address:	City:	State:	Zip:
Phone:	Fax:	Program Director:	

Were you the subject of any disciplinary action during your attendance at this institution?
☐ No ☐ Yes (if yes, attach an explanation)

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BOARD CERTIFICATION		
1. Name of Board:	Certification Dates (mm/yyyy):	Primary ☐ Secondary ☐
2. Name of Board:	Certification Dates (mm/yyyy):	Primary ☐ Secondary ☐
3. Name of Board:	Certification Dates (mm/yyyy):	Primary ☐ Secondary ☐
If not certified, have you applied for certification examination? ☐ Yes ☐ No (if no, attach an explanation) If no, do you intend to apply for certification? ☐ Yes Date: ☐ No		

PROFESSIONAL LICENSURE If more space is needed, please list on separate sheet.
***If limits or restrictions, please explain on separate sheet**.

1. State:	License Number:	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes***
2. State:	License Number:	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes***
3. State:	License Number:	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes***
State CDS Number:	Expiration Date (mm/yyyy):		Limits/Restrictions: ☐ No ☐ **Yes***	

NATIONAL PROVIDER IDENTIFICATION (NPI) Number:

NARCOTICS REGISTRATION CERTIFICATES ***If limits or restrictions, please explain on separate sheet.**

DEA Number:	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes***

PROFESSIONAL REFERENCES Please list names of two (2) individuals who have personal knowledge (within the last 12 months) of your current clinical abilities, ethical character, and interpersonal skills. Receipt of this information is required before action can be taken on your application. For those in training, one reference must be from the Director of the training program. For all other applicants, one letter must be from the Chief of Staff or Departmental Chairperson from each hospital, where the applicant is on the active clinical staff

Name:		Title:	
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		

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PROFESSIONAL REFERENCES (Continued)			
Name:		Title:	
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		

AFFILIATIONS/WORK HISTORY List in chronological order, beginning with most current, all practice history (past and present) that has occurred since completion of medical or professional school. List hospitals, ambulatory centers, and medical offices where you have ever had an affiliation or where you have an application in process. Include all work engagements (including employment, self-employment, and service as an independent contractor). Indicate staff status (Active, Courtesy, Provisional, Temporary, etc.) Do not duplicate fellowship or internship/residency information previously reported. Enter additional affiliations on a separate sheet of paper and attach to application. If there is any gap greater than 30 days in chronology, explain in next section.

1. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

2. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

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AFFILIATIONS/WORK HISTORY (Continued).

3. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

4. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

5. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

6. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:	
Street Address:	City:		State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes (if yes, attach an explanation)				

IMPORTANT: All parts of this application must be completed. No part of this application may be completed by writing "See CV."

AFFILIATIONS/WORK HISTORY (Continued).

7. Organization Name:	Title/Professional Occupation:	Dates of Affiliation (mm/yyyy):	Reason for Leaving:
Street Address:	City:	State:	Zip:
Phone:	Fax:	Staff Status:	Supervisor:

Were you the subject of any disciplinary action during your attendance at this institution?
☐ No ☐ Yes (if yes, attach an explanation)

EXPLANATION OF WORK HISTORY GAPS Any time period or gaps greater than 30 days since graduation from professional school, which are not explained in the application, must be addressed here. If the application is found to have any unexplained time periods or gaps, the application will not be processed and will be returned to the applicant as incomplete.

Dates (mm/dd/yyyy)	Explanation of work history gap	Person who can verify (phone/email)

Continuing Professional Education

Describe topics, sources, and dates of all continuing education you have completed in the **past two years on a separate sheet**.

EMERGENCY PROCEDURE CERTFICATION
Current training and certification in the following is highly desirable for all professionals involved in direct patient care. Please check the appropriate box for any certification you hold.

	Title	Expiration Date
☐	Basic Life Support	
☐	Advanced Cardiac Life Support	
☐	Advanced Trauma Life Support	
☐	Advanced Life Support for Obstetrics	
☐	Pediatric Advanced Life Support	
☐	Neonatal Resuscitation Program	

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MALPRACTICE COVERAGE List current and past insurance carriers during the past 10 years. **If additional space is needed, use separate sheet.**				
Present Carrier:			Agent Name:	
Address:			Policy Number:	
City:	State:	Zip:	Amount of Coverage:	Coverage Dates (mm/yyyy):
Past Carrier:			Agent Name:	
Address:			Policy Number:	
City:	State:	Zip:	Amount of Coverage:	Coverage Dates (mm/yyyy):

PROFESSIONAL PRACTICE QUESTIONS For each question, check Yes or No. If you check Yes for any question, provide full details on a separate sheet.	Yes	No
1. Has your license to practice in any jurisdiction ever been or ever attempted to have been denied, restricted, limited, suspended, revoked, or canceled?	☐	☐
2. Has your license ever been subjected to probation either voluntarily or involuntarily?	☐	☐
3. Has your license ever been withdrawn either voluntarily or involuntarily?	☐	☐
4. Has any disciplinary actions or investigations been initiated against you by any state licensure board?	☐	☐
5. Have you been reprimanded and/or fined, by any local, state, or federal agency that licenses providers?	☐	☐
6. Have you ever been the subject of an informal or formal hearing process at any healthcare organization?	☐	☐
7. Have you been the subject of a complaint or have you been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal agency that licenses providers?	☐	☐
8. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization (e.g., hospital, HMO, PPO, IPA), professional group or society, licensing board, certification board, PSRO or PRO?	☐	☐
9. Have you been cautioned, reprimanded, or disciplined by any institution, any local, state, or national professional society or regulatory agency?	☐	☐
10. Has your employment and or clinical privileges at any hospital, clinic, or other health care setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?	☐	☐

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PROFESSIONAL PRACTICE QUESTIONS (Continued)	Yes	No
11. Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges before a hospital or health facility's governing board made a decision?	☐	☐
12. Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating in or voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, Tri-Care, and/or any other governmental health related programs?	☐	☐
13. Have Medicare, Medicaid, Tri-Care, PRO authorities, and/or any other third party payers brought charges against you for alleged inappropriate fees, and/or quality of care issues?	☐	☐
14. Has any information pertaining to you, including malpractice judgments and/or disciplinary action ever been reported to the National Practitioner Data Bank or any other practitioner data bank?	☐	☐
15. Has your federal DEA number and/or state controlled substance license been suspended, revoked, restricted, limited, or relinquished either voluntarily or involuntarily?	☐	☐
16. Have you been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	☐	☐
17. Have you had a claim for professional negligence asserted against you in the past 10 years? (If yes, you are required to note the final judgment and settlements involving yourself as a practitioner. Include date, amount of settlement.)	☐	☐
18. Have liability claims, judgments or settlements been made against a hospital, corporation, or the United States Government in professional liability suits based on a case with which you were professionally associated? (If yes, you are required to note the final judgment and settlements involving yourself as a practitioner.)	☐	☐
19. Have you ever withdrawn from or been suspended, dismissed, or expelled from a professional school or postgraduate training program, or has any third party ever attempted to have you withdrawn, suspended, dismissed, or expelled from a professional school or postgraduate training program?	☐	☐
20. Have you ever been placed on probation or taken a leave of absence from a medical, dental, or other graduate school or postgraduate training program?	☐	☐
21. Have you been charged with or convicted of a crime (other than a minor traffic offense) in any state or country?	☐	☐
22. Have you been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse?	☐	☐
23. Do you have, or has it been suggested to you that you have, a history including the present, of any physical, mental, or emotional impairment that either you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership and which could require an accommodation for you to exercise your clinical privileges and clinical staff duties completely and safely? (If yes, please describe the accommodation needed.)	☐	☐
24. Do you have, or has it been suggested to you that you have, a diagnosed or undiagnosed chemical dependency (i.e., alcohol, illegal drugs, prescriptive drugs, etc)?	☐	☐

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PROFESSIONAL PRACTICE QUESTIONS (Continued)	Yes	No
25. Are you currently engaged in illegal use of any legal or illegal substances?	☐	☐
26. Are you currently participating in a supervised rehabilitation program and/or professional assistance program, which monitor you for alcohol and/or substance abuse?	☐	☐

CERTIFICATION

By signing this application, I certify that all the information submitted by me in this application is true and complete to the best of my knowledge. I agree to immediately disclose to the governing body if any answer to a question above becomes “Yes” while staff membership and/or privileges are pending or have been granted.

I agree to abide by all lawful standards, policies, rules, regulations, and bylaws of the facility, the Area, the Indian Health Service, the U.S. Public Health Service, and the Department of Health and Human Services, as they apply to my responsibilities and practice as a member of the clinical staff.

I further agree to answer any questions concerning the contents of this application either during the application process or subsequent to having been granted privileges. I agree that inquiries may be made to any federal or private sector facility with which I have been affiliated.

I pledge to maintain an ethical practice and to provide for the continuous care of all my patients.

Applicant’s Signature _____ Date _____

Indian Health Service

Health Screens/Immunizations

1. Rubella and Measles Immunity

Applicants requesting hospital/clinic privileges are required to submit evidence of rubella and measles immunity **prior** to being granted privileges. Individuals born before 1957 do not need to submit proof of immunity to measles. If the titer is negative, the applicant must receive the rubella and measles vaccine. Please submit documentation that your rubella and measles immunity was positive or that that you have received the vaccine.

2. TB Skin Test

Applicants requesting hospital/clinic privileges are required to submit documentation of a current (within the past 12 months) TB skin test or chest x-ray if the skin test was previously positive.

3. Hepatitis B Immunity

Health care professionals are at risk of acquiring Hepatitis B virus (HBV) infection due to occupational exposure to blood and other potentially infectious materials. The Indian Health Service strongly encourages applicant to obtain the Hepatitis B vaccination series. However, this is not required as a condition of employment.

☐ I have received the Hepatitis B vaccine.

☐ My Hepatitis B antibody test results indicate prior exposure.

☐ I decline the Hepatitis B vaccine at this time.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself; however, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B virus (HBV) infection, a serious disease, due to my occupational exposure to blood or other potentially infectious materials. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at the service unit where I am employed or contracted at no charge to me.

Applicant's Signature _____ Date _____

Indian Health Service

Statement of Understanding and Release

I authorize the Indian Health Service (IHS) and its representatives to inquire of any individual or entity with whom or which I have been associated (including medical malpractice carriers) who or which it deems relevant in its assessment of my professional competence, character and ethical qualifications. This includes any information otherwise protected from disclosure by the Privacy Act, 5 United States Code (U.S.C.) 552a, et seq. and/or the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. This authorization includes copying and inspecting any documentation (including but not limited to any general medical records, behavioral health records and substance abuse treatment records), which the IHS and its representatives deem relevant.

I consent to the disclosure by the IHS and its representatives of any information regarding my professional services at any IHS facility to any individual or entity to whom or which I subsequently apply for clinical privileges, membership, or licensure. Additionally, I release the IHS from any liability for providing such information in response to any inquiry made by any IHS employee to another IHS employee.

I release from any sort of liability the United States, the IHS, any of their representatives, and any third parties from whom or which is obtained either information or documentation for the above purposes.

I understand that I have the right to review information received about me from any outside primary source except references or recommendations that are peer review protected. In the event that the information obtained from outside primary sources varies substantially from the information I have provided, I am aware that I have the right to review and correct, if necessary, the information obtained.

Upon request, I agree to appear for purposes of responding to questions relating to any record, document or information obtained pursuant to the foregoing paragraph. I understand that my refusal to so appear may constitute cause for future denial of clinical privileges and/or appointment to any medical staff or other healthcare position for the IHS.

All information submitted by me in this application is true and correct to the best of my knowledge. I understand that any intentional misstatement in or omission from this application may constitute cause for denial of appointment or summary dismissal from the clinical staff, at the sole discretion of the deciding entity. I agree that in either of these events, I waive all rights of recourse and damages against the United States, the IHS, and its representatives.

Applicant's Signature _____ Date _____

Indian Health Service

Statement of Health

By my signature hereto, I represent that presently, and for five years prior to the date of my signature, I do not have, have not had, and have not been diagnosed and/or treated as having any illness, condition or symptom relating to any physical or behavioral health condition that would impact in any manner upon my ability to either practice medicine in general, or perform any of the functions in particular that are set out in the position description of the position for which I am presently applying.

OR

I have an impairment that

☐ affects my ability to perform the clinical privileges requested and for which I require special accommodation (describe the accommodation needed).

☐ **does not** affect my ability to perform the clinical privileges requested. No special accommodations are needed.

Applicant's Signature _____ Date _____

This statement must be confirmed by either the director of your training program, chief of staff, or personal primary physician, as required by accrediting bodies.

I hereby confirm that the provider identified above ☐ does ☐ does not currently have any health problems (including disability, emotional stability, drug, or alcohol dependency) that might impair his/her ability to care for patients.

Reasonable accommodation needed: _____

Name (printed or typed) _____ Signature _____

Title _____ Date _____

Address _____ Daytime Phone No. _____

Indian Health Service

Certification of Professional Licenses and Certificates

I certify that my professional licenses and certifications (nurse, medical, dental, or other health profession) have not been terminated, suspended, or revoked in any state, the District of Columbia, or Puerto Rico.

I currently hold **active** licenses and certifications in the following states and organizations:

State/Organization	License/Certificate Number	Expiration Date

I have **inactive** licenses and certifications in the following states and organizations:

State/Organization	License/Certificate Number	Expiration Date

I also certify, as required by the false statements provisions of the Program Fraud Civil Remedies Act of 1986, 45 Code of Federal Regulations (CFR) 79, that to the best of my knowledge, each of the above statements are true, accurate, and do not omit any material or facts which would render the statement false, fictitious, or fraudulent as a result of omission.

_____ _____
Applicant's Signature Date

Name (printed or typed): _____

Address: _____

City, State, Zip Code: _____

Phone: _____

Indian Health Service

Confidential Malpractice Claims Information Report

APPLICANT: Complete this form if you answered "Yes" to either professional liability question (Question 17 or 18) on Page 10.

Note: If you have more than one incident to report, complete a separate Supplemental Confidential Malpractice Claims Information Report for each incident. Print and sign each additional report and mail with your completed application.

Please furnish the following information regarding any lawsuits or complaints against you. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc) of your response if requested. You may choose to have your attorney complete this form.

1. Date of Claim: _____ Date of Incident: _____

2. Where incident occurred: _____

3. Claimant/patient name: _____

4. Nature of incident (type of case, procedure, major allegation, other pertinent information:

5. Current status: ☐ Pending/Open or ☐ Closed (date)

If closed, indicate:

☐ Dropped ☐ Dismissed ☐ Judgment for defendant (you)

☐ Appeal: _____ ☐ Settled: $ _____

☐ Judgment for plaintiff: $ _____

Represented by Legal Counsel for this claim/malpractice lawsuit? Yes ☐ No ☐

If yes, give name and address of counsel:

6. Name of insurance company that provides/provided coverage for this claim:

Name of Insurance Company:	Policy Number:		
Address:	City:	State:	Zip:
Phone:	Fax:		

7. Additional comments:

Signature: _____ Date: _____

Printed Name: _____

Report number: _____ of _____ report(s)

Indian Health Service

Privacy Act Notice for Credentials and Privileges Review

Process for the Medical Staff

The Privacy Act of 1974, 5 United States Code (U.S.C.) 552a, requires that a Federal agency provide a notice to each individual from whom it collects information.

1. The authority for collecting the information requested is found in Indian Self Determination and Education Assistance Act (25 U.S.C. 450); Snyder Act (25 U.S.C. 13); Indian Health Care Improvement Act (25 U.S.C. 1601 et. seq.); and the Transfer Act (42 U.S.C. 2001-2004).

2. The principal purpose for collecting the information requested is to systematically review the credentials of all current members of Indian Health Service (IHS) medical staff and those of persons applying for positions on IHS medical staff, either as employees or contractors, regarding membership and the granting of clinical privileges.

This information is being requested to ensure that members of the IHS medical staff are qualified, competent, and capable of delivering quality health services consistent with those of the medical community at large and that they are granted privileges commensurate with their training and competence and with the ability of the facility to provide adequate support equipment, services, and staff. This responsibility includes the initial review and verification of a provider's credentials for the purpose of determining eligibility for medical staff membership. The applicant's training, prior experience, and current competence, the needs of the IHS medical staff relative to patient load and diagnostic caseload mix, and the ability of the facility to provide adequate support facilities, services and staff must be considered prior to granting medical staff membership an delineating specific medical staff privileges. This responsibility requires a mechanism whereby the credentials and clinical privileges will be evaluated, re-evaluated, and recertified on a recurring and standardized basis.

3. Information contained in the records created for these purposes will be maintained by IHS staff in a confidential manner. Releases of this information will only be made on a "need to know" basis to employees of the Department of Health and Human Services (HHS) in the performance for the following routine uses: Records in part or total, may be disclosed to:

a) Authorized organization to conduct program evaluations studies sponsored by IHS (e.g., Joint Commission).

b) State or local government health profession licensing boards, to the National Practitioner Date Bank (NPDB) established under title IV of Public Law (P.L.) 99-660, to the Federation of State Medical Boards and/or to similar entities to inform them of current or former IHS medical staff members whose professional health care activity so significantly failed to conform to generally accepted standards of professional medical practice as to raise reasonable concern for the health and safety of members of the general public. This will be done within the guidelines for notice, hearing and appellate review as delineated in the medical staff bylaws for the IHS facility and/or within other HHS or IHS regulations or policies.

c) References listed on the IHS medical staff application for the purpose of evaluating your professional qualifications, experience, and suitability.

d) State or local health professional licensing boards, health professional organizations, the NPDB established under Title IV of P.L. 99-660, the Federation of State Medical Boards or similar entities for the purpose of verifying that all claimed background and employment data are valid and all claimed credentials are current and in good standing.

e) Other agencies of the Federal Government, State, and local governments and organizations in the private sector you have or will apply to for clinical privileges, membership, or licensure for the purpose of documenting your qualifications and competency to provide health services in your health profession based on your professional performance while employed by the IHS.

f) Department of Justice in case of litigation.

g) Federal, State or local agency charged with enforcing or implementing a statute, rule, regulation or order when information contained in the record indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature.

h) Indian Health Service Staff will maintain a log of such disclosures. You may review a copy of this log of disclosures. You may review a copy of this log of disclosures or review copies of materials contained in your medical staff credentials and privileges file. To do so, contact the Clinical Director of your facility or the Area Director, if the official file is maintained at the Area Office.

i) Information collected through the use of IHS Credentials and Privileges forms are contained in System of Records: 09-17-0003 IHS Medical Staff Credentials and Privileges Records, HHS/IHS/OHS.

j) Applicants are advised that failure to provide the information requested, including Social Security Number, will result in a denial to receive, or to continue, funding as an IHS medical staff member (direct or contract).