

# CCPD VERIFICATION OF HEALTH CARE PROVIDER'S CREDENTIALING CHECKLIST

(MC, DC, MSC, AND NURSES TO INCLUDE BOTH ADVANCED PRACTICE AND STAFF REGISTERED NURSES)

## HINTS TO EXPEDITE THE PROCESSING OF YOUR CREDENTIALING APPLICATION

To avoid delays in processing your Credentialing application, we have included these "quick tips" to help the Centralized Credentialing and Privileging Department (CCPD) process your application in a timely manner.

1. All copies of current licenses, certificates, and resuscitation cards (i.e., ANCC, BLS, ACLS, etc.) must be provided. Please copy both sides of the cards; include your signature (if signature is applicable to the card).
2. Include a valid daytime phone number and an e-mail address. Ensure you provide a valid email, phone/fax numbers for your points of contact (i.e. peer references, civilian employment, etc...), as we must contact them during the processing of your package.
3. Peer references: A Peer **MUST** be of the same clinical specialty. For example:
  - a. Critical Care = Critical Care (Not Staff)
  - b. FNP = FNP (Not Staff/Registered Nurse)
  - c. Dentist = Dentist (Not Flight Surgeon)
  - d. Psychologists = Psychologists (Not Anesthesiologist)
  - d. Orthodontist = Orthodontist (Not General Dentist)

**Please note that the Peer Reference Forms are provided to help you expedite your credentialing process. Although it is not required that you forward the forms on to your Peers, your assistance in helping CCPD by doing so is greatly appreciated. If you are a sole practitioner working with no other Peers or work at a facility where you are the only person working in that specialty, please include a memo stating that fact. If you are in Private Practice please provide a copy of your business licensure.**

4. Please provide all places of employment since conferring your qualifying degree, or the past 10 years of clinical work history; whichever is the lesser.

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## INSTRUCTIONS

### PERFERRED METHOD FOR THE FORM IS TYPED

USE ONLY BLACK INK IF HAND WRITTEN (Must be legible)

These guidelines should assist you with the completion of the package:

### PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS):

#### 1. DEMOGRAPHICS:

Complete all information requested. Complete month/day/year time frames in the "from-to" fields. If the information is not applicable, write "N/A" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding professional liability carrier and participation in continuing education.

A current curriculum vitae/resume is to accompany the application. Ensure that applicant's full name is legibly printed, signed and dated on each page in the lower right corner.

#### 2. PROFESSIONAL EDUCATION AND TRAINING:

Provide copies of diploma for completed education/training (include Educational Commission for Foreign Medical Graduate (ECFMG) certificate as appropriate). Copies of Diplomas; Appended official results of graduate/professional school entrance examinations (required for scholarship applicants (AFHPSP, FAP) and applicants currently in graduate/professional school or postgraduate training only); Appended official letter of acceptance for applicants who are accepted to training programs; Appended letters certifying accreditation status of internship/residency programs as appropriate, for applicants who are entering or currently enrolled in training programs.

#### 3. & 4 .BOARD CERTIFICATIONS/LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY:

Please provide copies of all National Board certifications(ANCC), and state Licensure. Should you allow any licenses or certifications to lapse/expire, please note this on the application with a brief explanation.

DRUG ENFORCEMENT AGENCY CERTIFICATES (DEA)/CONTROLLED DANGEROUS SUBSTANCE CERTIFICATES (CDS).

**Please submit a current copy of the DEA and/or CDS certificate (as applicable).**

#### 5. MEDICAL READINESS TRAINING:

Other contingency training documents may be submitted (BLS, ACLS, NRP, ATLS, etc).

#### 6. HEALTH STATUS/ABILITY TO PERFORM:

Please respond to the questions that address this area. If you answer "yes" (**except 6a**) to any of the questions, provide a brief, factual response in the spaces below the questions.

**Do not send a copy of a physical examination.**

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**7. MALPRACTICE, LICENSURE, PRIVILEGING ACTION, AND LEGAL HISTORY:**

Please respond to the questions that address this area. If you answer "yes" to any of the questions, provide a brief, factual response in the spaces below the questions. In addition you will need to provide the malpractice carrier name, address and phone number, policy number, dates of coverage and coverage amount.

**8. PROFESSIONAL LIABILITY:** Self explanatory.

**9. OTHER INFORMATION:** Self explanatory.

**10. CONTINUING EDUCATION HOURS:** Self-explanatory.

**11. & 12. SUPERVISOR/DEPARTMENT HEAD/ CHIEF OF SERVICE REFERENCE & PEER REFERENCE:** Please provide contact information. Ensure all addresses and phone numbers are complete and accurate. PEER - is a person who has equivalent education and training, and has worked with you in same specialty.

**13. PROFESSIONAL ASSIGNMENTS:** Please complete the civilian employment/civilian facilities where privileges were held since completing the respective qualifying degree program (Nursing School, Medical School, Dental, Family Nurse Practitioner, etc.). Provide the names, complete address and phone numbers of **two** peers who can attest to current competence for each specialty you qualify.

**CONSENT and RELEASE/PRIVACY ACT and DISCLOSURE STATEMENT**

Please read the form, then sign and date in the appropriate space.

**OTHER PROFESSIONAL DOCUMENTS:**

You may submit copies of any other associated training relevant to your profession.

**TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL TO THE RIGHT OF THE LINE. DO NOT USE CORRECTION FLUID/TAPE ON THE APPLICATION PACKAGE UNDER ANY CIRCUMSTANCE.**