

Alabama Uniform Provider Application

Practitioner Information

Social Security Number:

First Name*

Middle Name

Last Name*

Suffix

Preferred Name

Gender

If your professional license has ever been issued under a name other than the name listed above (e.g. maiden name, alias, nicknames) please indicate below:

First Name

Middle Name

Last Name

Suffix

Birth Date (mm/dd/yyyy)*

UPIN Status*

Exempt Existing Pending

UPIN*

Did you complete your medical school or medical training in a foreign country?* Yes No

If Yes, please provide your ECFMG Certificate Number

Practitioner E-Mail Address

Degree Type*

- | | | | | | |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> AA | <input type="checkbox"/> Clinic | <input type="checkbox"/> CNM | <input type="checkbox"/> CNS | <input type="checkbox"/> CRNA | <input type="checkbox"/> CSA |
| <input type="checkbox"/> CST | <input type="checkbox"/> CSW | <input type="checkbox"/> DC | <input type="checkbox"/> DDS | <input type="checkbox"/> DDS MD | <input type="checkbox"/> DMD |
| <input type="checkbox"/> DMD MD | <input type="checkbox"/> DMIN | <input type="checkbox"/> DO | <input type="checkbox"/> DPM | <input type="checkbox"/> EDD | <input type="checkbox"/> LCSW |
| <input type="checkbox"/> LD | <input type="checkbox"/> LMFT | <input type="checkbox"/> LP | <input type="checkbox"/> LPC | <input type="checkbox"/> LPN | <input type="checkbox"/> MA |
| <input type="checkbox"/> MD | <input type="checkbox"/> MD DDS | <input type="checkbox"/> MD DMD | <input type="checkbox"/> MD PHD | <input type="checkbox"/> MS | <input type="checkbox"/> NP |
| <input type="checkbox"/> OD | <input type="checkbox"/> OTR | <input type="checkbox"/> PA | <input type="checkbox"/> PHD | <input type="checkbox"/> PHD MD | <input type="checkbox"/> PSY D |
| <input type="checkbox"/> RD | <input type="checkbox"/> RN | <input type="checkbox"/> RPT | <input type="checkbox"/> Other: _____ | | |

Are you fluent in any languages other than English?

- Spanish French German Italian
 Arabic Chinese Japanese
Other language not listed: _____

US Citizen* Yes No - If No, Alien Registration Number

Country of Birth*

Legal Right to Work in U.S.* Yes No

County of Birth*

State of Birth

Do you have physician coverage for your patients 24 hours per day, seven days per week?* Yes No

Do you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital surgicenter, ambulatory surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies? * Yes No

* Indicates Required Field

Alabama Uniform Provider Application

Practice Information

Legal Practice Name*

Tax ID*

DBA

Office Effective Date*

Street Address*

Suite/Building

City*

State*

ZIP*

County*

Do you accept Medicare patients?

 Yes No

AL Medicare #

AL Medicaid #

Office Telephone Number*

Appointment Telephone Number*

Office Fax Number

Is a Telephone Device for the Deaf (TDD) Available?* No Yes – TDD Telephone Number (____) _____

Office E-Mail Address

Office Manager

Title

First Name

Last Name

Suffix

Primary Practicing Specialty*

Secondary Practicing Specialty

Languages spoken by staff in addition to English:

Spanish

French

German

Italian

Arabic

Chinese

Japanese

Other: _____

Handicap Access? *

Yes No

Are you accepting new patients? *

Yes No Not Applicable

Office Practice Type*

Individual Group

Is this location an Urgicenter, After Hours or Urgicare Clinic?*

Yes No

Physician Type

Primary Care Physician

Specialist

Are there age limitations on your patients?*

No Yes – Please specify from _____ years to _____ years

CLIA Certificate Number

CLIA Expiration Date

(mm/dd/yyyy)

CLIA Waiver

Yes No

• Indicates Required Field

Alabama Uniform Provider Application

Practice Information

Do you perform surgery in your office?* Yes No

Is your location a residence?* Yes No

If residence, please provide

Business License Number Zoning Permit Number

Office Hours*

	Monday From <input type="text"/> To <input type="text"/>	Tuesday From <input type="text"/> To <input type="text"/>	Wednesday From <input type="text"/> To <input type="text"/>
Thursday From <input type="text"/> To <input type="text"/>	Friday From <input type="text"/> To <input type="text"/>	Saturday From <input type="text"/> To <input type="text"/>	Sunday From <input type="text"/> To <input type="text"/>

Holidays your office closes*

New Year's Day Good Friday Memorial Day Independence Day Labor Day
 Thanksgiving Christmas Day Other, please specify: _____

Correspondence Address Is this address the same as the office practice address?

Street Address Suite/Building

City State ZIP

Telephone Number () Fax Number ()

Billing Address Is this address the same as the office practice address?

Is this a billing agency? * No Yes – If yes, Name:

Street Address Suite/Building

City State ZIP*

Office Telephone Number* () Office Fax Number ()

Office E-Mail Address:

• Indicates Required Field

Alabama Uniform Provider Application

Covering Physicians

Your covering physicians should agree to the same fees and follow the same administrative procedures.

First Name*	Middle Name	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

UPIN Status*	UPIN*	Telephone Number*
<input type="checkbox"/> Exempt <input type="checkbox"/> Existing <input type="checkbox"/> Pending	<input type="text"/>	()

Specialty*

First Name*	Middle Name	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

UPIN Status*	UPIN*	Telephone Number*
<input type="checkbox"/> Exempt <input type="checkbox"/> Existing <input type="checkbox"/> Pending	<input type="text"/>	()

Specialty*

First Name*	Middle Name	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

UPIN Status*	UPIN*	Telephone Number*
<input type="checkbox"/> Exempt <input type="checkbox"/> Existing <input type="checkbox"/> Pending	<input type="text"/>	()

Specialty*

First Name*	Middle Name	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

UPIN Status*	UPIN*	Telephone Number*
<input type="checkbox"/> Exempt <input type="checkbox"/> Existing <input type="checkbox"/> Pending	<input type="text"/>	()

Specialty*

Make additional copies of this page as necessary

*Indicates Required Field

Alabama Uniform Provider Application

Physician Extenders

Please enter your Physician Extenders

First Name*	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>

Specialty*	UPIN
<input type="checkbox"/> CRNA <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Other: _____	<input type="text"/>

First Name*	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>

Specialty*	UPIN
<input type="checkbox"/> CRNA <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Other: _____	<input type="text"/>

First Name*	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>

Specialty*	UPIN
<input type="checkbox"/> CRNA <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Other: _____	<input type="text"/>

First Name*	Last Name*	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>

Specialty*	UPIN
<input type="checkbox"/> CRNA <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Surgical Assistant <input type="checkbox"/> Other: _____	<input type="text"/>

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Alabama Uniform Provider Application

Conflict of Interest

If you or any member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital surgicenter, ambulatory surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies, you must list it here.

Name of Business*

Business Type*

- Ambulatory Surgical Center Clinical Laboratory Diagnostic/Testing Center
 Hospital Surgicenter Other: _____

Nature of Business*

- Investor Owner Partner
 Sole Proprietor Other: _____

Street Address*

Suite/Building

City*

State*

ZIP*

Telephone Number*

()

Tax ID Number*

*Indicates Required Field

Alabama Uniform Provider Application

State Medical License

State Medical License

In the State of *

I am in the process of applying for a Medical License

I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* Yes No

Board Description*

(Additional) State Medical License

In the State of *

I am in the process of applying for a Medical License

I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* Yes No

Board Description*

(Additional) State Medical License

In the State of *

I am in the process of applying for a Medical License

I hold a valid Medical License

License/Certificate #*

Issue Date (mm/dd/yyyy)*

Expiration Date (mm/dd/yyyy)*

Does this license/certification level require supervision?* Yes No

Board Description*

• Indicates Required Field

Alabama Uniform Provider Application

State Drug License

State Drug License

In the State of *

I am in the process of applying for a State Drug Certificate

I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* 2 2N 3 3N 4 5

Is this certification Limited or restricted?* No Yes If yes, please explain:

(Additional) State Drug License

In the State of *

I am in the process of applying for a State Drug Certificate

I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* 2 2N 3 3N 4 5

Is this certification Limited or restricted?* No Yes If yes, please explain:

(Additional) State Drug License

In the State of *

I am in the process of applying for a State Drug Certificate

I hold a State Drug Certificate

Certification #*

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* 2 2N 3 3N 4 5

Is this certification Limited or restricted?* No Yes If yes, please explain:

• Indicates Required Field

Alabama Uniform Provider Application

Federal DEA License

Federal DEA License

- I am in the process of applying for a Federal DEA Certificate
 My specialty does not require a Federal DEA Certificate
 I hold a Federal DEA Certificate OR I use my hospital's Federal DEA Certificate

Certification #*

Original Issue Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* 2 2N 3 3N 4 5

Is this certification Limited or Restricted?* No Yes If yes, please explain:

* Indicates Required Field

Federal DEA License

- I am in the process of applying for a Federal DEA Certificate
 My specialty does not require a Federal DEA Certificate
 I hold a Federal DEA Certificate OR I use my hospital's Federal DEA Certificate

Certification #*

Original Issue Date (mm/dd/yyyy)

Expiration Date (mm/dd/yyyy)*

Please indicate all schedules currently held* 2 2N 3 3N 4 5

Is this certification Limited or Restricted?* No Yes If yes, please explain:

* Indicates Required Field

Alabama Uniform Provider Application

Professional Liability

Please list your Insurance Carrier, beginning with the most current. If you have less than 10 years with your current Insurance Carrier, please list your previous Insurance Carriers.

Indicate if this carrier is your* Current Carrier Previous Carrier State Insurance Fund

Name of Carrier*		
Street Address	Suite/Building	
City	State	ZIP
Telephone Number* ()	Policy Number	
Effective Date* (mm/dd/yyyy)	Expiration Date* (mm/dd/yyyy)	Time with Carrier*
		Years Months
Amount of Coverage* \$ /Occurrence	<input type="checkbox"/> Unlimited Coverage	
Amount of Coverage* \$ Aggregate	<input type="checkbox"/> Unlimited Coverage	

Indicate if this carrier is your* Current Carrier Previous Carrier State Insurance Fund

Name of Carrier*		
Street Address	Suite/Building	
City	State	ZIP
Telephone Number* ()	Policy Number	
Effective Date* (mm/dd/yyyy)	Expiration Date* (mm/dd/yyyy)	Years With Carrier*
		Years Months
Amount of Coverage* \$ /Occurrence	<input type="checkbox"/> Unlimited Coverage	
Amount of Coverage* \$ Aggregate	<input type="checkbox"/> Unlimited Coverage	

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Education

Please enter your undergraduate, graduate and medical school education information. Any additional post-graduate training may also be entered. Please use the official school name.

School Name*		Program*	
<input type="text"/>		<input type="checkbox"/> Graduate School <input type="checkbox"/> Medical School <input type="checkbox"/> Undergraduate School	
Effective Date*	Ending Date* or <input type="checkbox"/> Check if currently in process		
Month <input type="text"/>	Year <input type="text"/>	Month <input type="text"/>	Year <input type="text"/>
Completed?* <input type="checkbox"/> Yes <input type="checkbox"/> No		Degree Received* <input type="text"/>	
Is the address within the USA?*			
<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below	
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

School Name*		Program*	
<input type="text"/>		<input type="checkbox"/> Graduate School <input type="checkbox"/> Medical School <input type="checkbox"/> Undergraduate School	
Effective Date*	Ending Date* or <input type="checkbox"/> Check if currently in process		
Month <input type="text"/>	Year <input type="text"/>	Month <input type="text"/>	Year <input type="text"/>
Completed?* <input type="checkbox"/> Yes <input type="checkbox"/> No		Degree Received* <input type="text"/>	
Is the address within the USA?*			
<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below	
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

School Name*		Program*	
<input type="text"/>		<input type="checkbox"/> Graduate School <input type="checkbox"/> Medical School <input type="checkbox"/> Undergraduate School	
Effective Date*	Ending Date* or <input type="checkbox"/> Check if currently in process		
Month <input type="text"/>	Year <input type="text"/>	Month <input type="text"/>	Year <input type="text"/>
Completed?* <input type="checkbox"/> Yes <input type="checkbox"/> No		Degree Received* <input type="text"/>	
Is the address within the USA?*			
<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below	
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Alabama Uniform Provider Application

Training

Please enter information about your Internship, Residency and Fellowship.

Facility Name*	<input type="text"/>		
Training Type*	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other Post-Graduate training		
Effective Date*	Month <input type="text"/>	Year <input type="text"/>	Ending Date* or <input type="checkbox"/> Check if currently in progress
			Month <input type="text"/> Year <input type="text"/>
Completed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program Description*	<input type="text"/>
Is the address within the USA?*	<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	City* Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>
Program Director Title	First Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Facility Name*	<input type="text"/>		
Training Type*	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other Post-Graduate training		
Effective Date*	Month <input type="text"/>	Year <input type="text"/>	Ending Date* or <input type="checkbox"/> Check if currently in progress
			Month <input type="text"/> Year <input type="text"/>
Completed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program Description*	<input type="text"/>
Is the address within the USA?*	<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	City* Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>
Program Director Title	First Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

* Indicates Required Field

Alabama Uniform Provider Application

Training

Facility Name*	<input type="text"/>		
Training Type*	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other Post-Graduate training		
Effective Date*	Month <input type="text"/>	Year <input type="text"/>	Ending Date* or <input type="checkbox"/> Check if currently in progress
			Month <input type="text"/> Year <input type="text"/>
Completed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program Description* <input type="text"/>	
Is the address within the USA?*	<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	City* Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>
Program Director	First Name		Last Name Suffix
Title <input type="text"/>	<input type="text"/>		<input type="text"/> <input type="text"/>

Facility Name*	<input type="text"/>		
Training Type*	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Other Post-Graduate training		
Effective Date*	Month <input type="text"/>	Year <input type="text"/>	Ending Date* or <input type="checkbox"/> Check if currently in progress
			Month <input type="text"/> Year <input type="text"/>
Completed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Program Description* <input type="text"/>	
Is the address within the USA?*	<input type="checkbox"/> Yes – Enter Address Directly Below		<input type="checkbox"/> No – Enter Address Directly Below
Street Address	Suite/Building	Street Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City*	State*	ZIP	City* Country*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/>
Program Director	First Name		Last Name Suffix
Title <input type="text"/>	<input type="text"/>		<input type="text"/> <input type="text"/>

* Indicates Required Field

Alabama Uniform Provider Application

Board Certification

Please add an entry for each Specialty Board and Certificate

Specialty Board*

Certificate*

Please select one:

I am Board Certified

Certificate Number*

Original Certification Date*

(mm/dd/yyyy)

Last Certification Date

(mm/dd/yyyy)

Current Expiration Date (if any)

(mm/dd/yyyy)

I am in process of taking specialty boards and my exam date is:

(mm/dd/yyyy)

Have you ever taken the Board Certifications and failed? Yes No

I am not planning to take specialty boards. Please provide a brief explanation

Have you ever taken the Board Certifications and failed? Yes No

I am not eligible to take specialty boards. Please provide a brief explanation

Have you ever taken the Board Certifications and failed? Yes No

Please make copies of this page if you have additional specialties

* Indicates required field

Alabama Uniform Provider Application

Professional Practice History

Please account for your professional practice history (other than hospital affiliations), from graduate school to present, including any military experience, if applicable.

Office Practice/Institution Name*

From (mm/dd/yyyy)*

To (mm/dd/yyyy)*

Check if this is a current affiliation

Telephone Number*

Position/Rank

Is the address within the USA?*

Yes – Enter Address Directly Below

No – Enter Address Directly Below

Street Address

Suite/Building

Street Address

City*

State*

ZIP

City*

Country*

Office Practice/Institution Name*

From (mm/dd/yyyy)*

To (mm/dd/yyyy)*

Check if this is a current affiliation

Telephone Number*

Position/Rank

Is the address within the USA?*

Yes – Enter Address Directly Below

No – Enter Address Directly Below

Street Address

Suite/Building

Street Address

City*

State*

ZIP

City*

Country*

Office Practice/Institution Name*

From (mm/dd/yyyy)*

To (mm/dd/yyyy)*

Check if this is a current affiliation

Telephone Number*

Position/Rank

Is the address within the USA?*

Yes – Enter Address Directly Below

No – Enter Address Directly Below

Street Address

Suite/Building

Street Address

City*

State*

ZIP

City*

Country*

Make additional copies of this page as necessary

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Alabama Uniform Provider Application

Current Hospital Affiliations

Hospital Affiliations - Please list your current hospital affiliations

Hospital Name*

Street Address Suite/Building

City State ZIP

Telephone Number* Fax Number Medical Staff Department*

What is your Staff Category?*

Active Affiliate Applied/Pending Associate Consulting
 Courtesy None Provisional Temporary

If Staff Category is *Applied/Pending*, list Application Date (mm/dd/yyyy)

Effective Date* Re-appointment Date*

Month Year Month Year

Do you admit patients?*

- Yes - % of patients you admit to this hospital
 My specialty does not admit patients
 No - Please provide a detailed explanation

If No, please provide the name of the practitioner who will admit on your behalf:

First Name Middle Last Name Suffix

Telephone Number Specialty

Make additional copies of this page as necessary

* Indicates Required Field

Alabama Uniform Provider Application

Past Hospital Affiliations

Hospital Affiliations - Please list your past hospital affiliations

Hospital Name*						<input type="text"/>					
Street Address			<input type="text"/>			Suite/Building			<input type="text"/>		
City			<input type="text"/>			State			ZIP		
<input type="text"/>			<input type="text"/>			<input type="text"/>			<input type="text"/>		
Telephone Number*		Fax Number		Medical Staff Department*							
<input type="text"/>		<input type="text"/>		<input type="text"/>							
Effective Date*		Year		Ending Date*		Year					
Month <input type="text"/>		<input type="text"/>		Month <input type="text"/>		<input type="text"/>					
What was your Staff Category?*											
<input type="checkbox"/> Active		<input type="checkbox"/> Affiliate		<input type="checkbox"/> Applied/Pending		<input type="checkbox"/> Associate		<input type="checkbox"/> Consulting			
<input type="checkbox"/> Courtesy		<input type="checkbox"/> None		<input type="checkbox"/> Provisional		<input type="checkbox"/> Temporary					
<input type="checkbox"/> Other _____											
What was your standing at this hospital when you left?*											
<input type="checkbox"/> Good Standing		<input type="checkbox"/> Probation		<input type="checkbox"/> Restricted		<input type="checkbox"/> Suspended		<input type="checkbox"/> Terminated			
<input type="checkbox"/> Other _____											

Hospital Name*						<input type="text"/>					
Street Address			<input type="text"/>			Suite/Building			<input type="text"/>		
City			<input type="text"/>			State			ZIP		
<input type="text"/>			<input type="text"/>			<input type="text"/>			<input type="text"/>		
Telephone Number*		Fax Number		Medical Staff Department*							
<input type="text"/>		<input type="text"/>		<input type="text"/>							
Effective Date*		Year		Ending Date*		Year					
Month <input type="text"/>		<input type="text"/>		Month <input type="text"/>		<input type="text"/>					
What was your Staff Category?*											
<input type="checkbox"/> Active		<input type="checkbox"/> Affiliate		<input type="checkbox"/> Applied/Pending		<input type="checkbox"/> Associate		<input type="checkbox"/> Consulting			
<input type="checkbox"/> Courtesy		<input type="checkbox"/> None		<input type="checkbox"/> Provisional		<input type="checkbox"/> Temporary					
<input type="checkbox"/> Other _____											
What was your standing at this hospital when you left?*											
<input type="checkbox"/> Good Standing		<input type="checkbox"/> Probation		<input type="checkbox"/> Restricted		<input type="checkbox"/> Suspended		<input type="checkbox"/> Terminated			
<input type="checkbox"/> Other _____											

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Alabama Uniform Provider Application

Questionnaire

IMPORTANT: If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered.

Education and Training

1. During your education, internship, residency, fellowship, preceptorship or additional training, as applicable were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign? Yes No

License Information

2. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state of federal agency that disciplines physicians or allied health professionals? Yes No

3. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state? Yes No

4. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health plan program (for example, Medicare, Medicaid, CLIA, professional society or managed care organization) or is any such action pending? Yes No

5. Have you ever been the subject of any investigation by any private, federal, or state health program – or is any such action pending? Yes No

6. Have your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending? Yes No

Insurance Information

7. Has your professional liability insurance coverage ever been terminated or modified by action of any insurance company? Yes No

8. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty? Yes No

9. Have any professional liability suits, actions, or claims alleging malpractice ever been filed against you? Yes No

10. Are any professional liability suits, actions or claims currently pending against you? Yes No

11. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements? Yes No

12. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No

13. Are you currently uninsured for professional liability staff (malpractice insurance) coverage? Yes No

Hospitals and Other Affiliations

14. Has your medical membership or clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? Yes No

15. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board? Yes No

16. Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership or clinical privilege(s), as the result of any investigation or disciplinary action? Yes No

17. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or any military agency? Yes No

Board Certification

18. Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted? Yes No

Practice History

19. Are there any gaps in your professional practice history? Yes No

Alabama Uniform Provider Application

Questionnaire

Page 2

IMPORTANT: If any of the following questions are answered "Yes," please provide an explanation for each answer. If any questions do not apply to you, please answer "No". Failure to check an answer or provide explanations for "Yes" responses may result in delay of application processing. All questions must be answered.

Health Status

20. Do you have you had a chemical dependency and/or substance abuse problem, treated or untreated? Yes No

21. During the last three years have you ever been under the influence of alcohol during working hours, or have you had a chemical dependency and/or substance abuse problem, treated or untreated? Yes No

22. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients? Yes No

Criminal History

23. Have you ever been arrested for, or charged with, a crime involving children? If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment of perjury. Yes No

24. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony? Yes No

Alabama Uniform Provider Application

Provider Authorization

I hereby give permission to the selected entities and/or its designee to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had medical staff membership and/or clinical privileges, professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I release and agree to hold harmless the selected entities and its affiliates to whom this information is given and their representatives, employees and agents from any and all liability for any damages, costs, and expenses which may result from the gathering or use of such information, as long as such release or use of information is done in good faith and without malice.

I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, state regulatory and licensing departments, professional liability carriers, other professional monitoring entities and present and past employers to submit information requested by the selected entities including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. I hereby further release and agree to hold harmless all such entities, their representatives, employees and agents from any and all liability for any damages which may result from providing this information, as long as such release or use of this information is done in good faith and without malice. I further agree the burden shall be upon me to prove such release was done in bad faith and with malice by a preponderance of evidence.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I represent that the information provided in or attached to this Application and the most current information provided to the selected entities is accurate and complete. I understand that a condition of this Application is that any misrepresentation, misstatement or omission from this Application, whether intentional or not, is cause for automatic and immediate rejection of this Application by the selected entities and may result in denial of my application or termination of my participation in the selected entities. I further understand that any misrepresentation, misstatement or omission from this Application, if discovered after participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform the selected entities in writing within 30 days if there is any change in the information provided or the answers to questions on the Application as a result to developments subsequent to my signing this Application.

I warrant that I have the authority to sign this Application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance of this application or me by the entity as a participating provider. I further agree that this application may only qualify as a "pre-application" under the rules of the entity.

I understand that if my application is rejected for reasons relating to my professional conduct or clinical competence, the selected entities may be required to report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review and decision takes place more than 180 days after the signature below, provider must re-sign and date this application page attesting that all application page attesting that all application information remains current, complete and correct.

- I have reviewed and **AGREE** to this attestation statement
- I have reviewed and **DO NOT AGREE** to this attestation statement

I UNDERSTAND THAT THIS APPLICATION DOES NOT ENTITLE ME TO PARTICIPATION IN ANY HOSPITAL, HEALTH CARE ENTITY, OR HEALTH PLAN.

The undersigned, being hereby warned that intentional or unintentional false statements and the like so made may jeopardize the validity of the application, declares that he/she is properly authorized to execute this application; and that all statements made of his/her own knowledge are true; and that all statements made on information and belief are believed to be true.

Signature

Signatory's Name

Date: