The New Mexico Physician and Practitioner Credentials Application ©

Name(s) of Health Care Organization(s) to Which Application is Being Made

Date of Application: _____

Name: _____
Last First Middle Maiden or Other Names Used

Circle all that apply and for which you are currently licensed: MD DO DDS DC DPM OD PA CNM CNP CRNA RN PT OT ST DOrienMed Acup Clin Psych Psych Assoc LMHC LPAT LADAC LISW LMSW LPC LPCC LMFT CNS/Psych CNS/Medical Spch Path

Other:_____ Specialty: _____

Gender: ☐ F ☐ M Citizenship:_____ Place of Birth: _____

Social Security Number:_____ Date of Birth: _____

State Tax ID#: _____ ☐ Pending Federal Tax ID#: _____ ☐ Pending

Medicare #:_____ ☐ Pending Medicaid #: _____ ☐ Pending

Unique Physician Identification Number (UPIN):_____ ☐ Pending

National Provider Identifier Number (NPI): _____ ☐ Applied

Practice/Group Name: _____ Effective Date: _____

Street Address:_____

City, State and Zip Code: _____

Telephone Number:_____ Facsimile Number: _____

E-Mail Address: _____ Answering Service Number: _____

Foreign Languages (spoken fluently by practitioner): _____

Foreign Languages (spoken fluently at practice):_____

Office Manager or Contact Person:_____

Current Mailing Address (if different from above): ☐ Same As Above

Street Address:_____

City, State and Zip Code: _____

Telephone Number:_____ Facsimile Number: _____

Billing Address (if different from mailing address): ☐ Same As Mailing Address

Contact Person:_____ Tax ID #: _____

Street Address:_____

City, State and Zip Code:_____

Telephone Number:_____ Facsimile Number: _____

Other Practice Locations: (Attach a separate page for additional practice locations.)

Practice Name:_____ Tax ID #: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number:_____ Facsimile Number: _____

Home Address:

Street Address:_____

City, State and Zip Code:_____

Telephone Number:_____ Pager Number:_____

Cell Phone Number:_____ Spouse's Name (Optional):_____

Practice Associates:

_____

_____

_____

_____

Call Coverage (if different):

/

/

/

/

What are the office hours for your Practice or Group Practice? (Provide days/hours):

M - **T** - **W** - **T** - **F** -

What provisions have been made for after hours?

PROFESSIONAL REFERENCES

Please list five professional peers with the same type of license or a higher level of licensure who are familiar with your professional performance in the past three (3) years.

Name and Title:_____ Specialty: _____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile:_____

Name and Title:_____ Specialty: _____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile:_____

Name and Title: _____ Specialty: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

Name and Title: _____

Street Address: _____

City, State, Country and Zip Code: _____

Telephone Number: _____ Facsimile: _____

EDUCATION

Undergraduate Education:

College or University: _____

Street Address: _____

City, State, Country and Zip Code: _____

Dates Attended: From: ___/___ (Mo/Yr) To: ___/___ (Mo/Yr) Degree Earned: _____

Graduate Education: (List all medical, osteopathic, dental or podiatric schools attended.)

College or University: _____

Street Address: _____

City, State, Country and Zip Code: _____

Dates Attended: From: ___/___ (Mo/Yr) To: ___/___ (Mo/Yr) Degree Earned: _____

POST GRADUATE TRAINING ☐ N/A

List all hospitals where you received training and attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page, if necessary.

_____ Specialty: _____

Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From: ___/___ (Mo/Yr)

Street Address: _____ To: ___/___ (Mo/Yr)

City, State, Country and Zip Code: _____

_____ Specialty: _____

Specify Internship, Residency, or Fellowship

Institution: _____ Dates Attended: From: ___/___ (Mo/Yr)

Street Address: _____ To: ___/___ (Mo/Yr)

City, State, Country and Zip Code: _____

________________________________ Specialty: ________________________________
Specify Internship, Residency, or Fellowship

Institution:________________________________ Dates Attended: From:____/____
Mo/Yr

Street Address:________________________________ To:____/____
Mo/Yr

City, State, Country and Zip Code:________________________________

☐ Teaching Appointments ☐ N/A

Institution:________________________________

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Dates Attended: From___/____ To ___/____ Department/Position:________________

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume. ***Please provide a written explanation for any gaps in work history of six (6) months or more.***

Organization:________________________________ From:____/____ To:____/____
Mo/Yr Mo/Yr

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Telephone Number: ________________ Contact Person:________________

Organization:________________________________ From:____/____ To:____/____
Mo/Yr Mo/Yr

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Telephone Number: ________________ Contact Person:________________

Organization:________________________________ From:____/____ To:____/____
Mo/Yr Mo/Yr

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Telephone Number: ________________ Contact Person:________________

Organization:________________________________ From:____/____ To:____/____
Mo/Yr Mo/Yr

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Telephone Number: ________________ Contact Person:________________

Organization:________________________________ From:____/____ To:____/____
Mo/Yr Mo/Yr

Street Address:________________________________

City, State, Country and Zip Code:________________________________

Telephone Number: ________________ Contact Person:________________

HOSPITAL AND HEALTHCARE AFFILIATIONS

Are you a PCP? ☐ Yes ☐ No
Do you deliver babies? ☐ Yes ☐ No
Are you an MD, DO, or DPM? ☐ Yes ☐ No

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list below) **OR**
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Do you have courtesy or consulting privileges at your current primary admitting facility? ☐ Yes ☐ No

If yes, do these courtesy or consulting privileges allow you to admit patients? ☐ Yes ☐ No

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page, if necessary.

Current Primary Admitting Facility (Hospital Name):_____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile:_____

Appointment Dates: From:_____ To:_____ Type of Appointment/Status:_____

Privileges Assigned:_____

Facility Name:_____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile: _____

Appointment Dates: From:_____ To:_____ Type of Appointment/Status:_____

Privileges Assigned:_____

Facility Name:_____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile:_____

Appointment Dates: From:_____ To:_____ Type of Appointment/Status: _____

Facility Name:_____

Street Address:_____

City, State, Country and Zip Code:_____

Telephone Number:_____ Facsimile:_____

Appointment Dates: From:_____ To:_____ Type of Appointment/Status: _____

MILITARY SERVICE

Branch:_____ Dates: From: _____ To: _____

Rank:_____ Type of Discharge:

LICENSURE-REGISTRATION-CERTIFICATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page, if necessary.

State Professional License/Certification Number:_____ ☐ Pending

State:_____ Issue Date:_____ Expiration Date:_____

State Professional License/Certification Number:_____ ☐ Pending

State:_____ Issue Date:_____ Expiration Date:_____

State Professional License/Certification Number:_____ ☐ Pending

State:_____ Issue Date:_____ Expiration Date:_____

State Professional License/Certification Number:_____ ☐ Pending

State:_____ Issue Date:_____ Expiration Date:_____

ECFMG (Educational Commission for Foreign Medical Graduates) Number (if applicable):_____

Date Issued:_____ Please attach a copy of your ECFMG certificate.

Federal Drug Enforcement Administration (DEA) Registration: ☐ Pending ☐ N/A

DEA Number:_____ Expiration Date: _____

State Controlled Substance Registration (CSR): ☐ Pending ☐ N/A

CSR Number:_____ Expiration Date: _____ State:_____

Immigration Status: _____ Immigration Certification Number: _____

CLIA Number (if applicable):_____ Approval Level:_____ Expiration Date:_____

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☐ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page, if necessary.

Current Carrier:_____ Limits: _____

Street Address: _____ ☐ Current ☐ Pending

City, State, Country and Zip Code:_____

Dates Insured: From:_____ To:_____ Policy Number: _____

Carrier:_____ Limits: _____

Street Address:_____

City, State, Country and Zip Code:_____

Dates Insured: From:_____ To:_____ Policy Number: _____

Carrier:_____ Limits: _____

Street Address:_____

City, State, Country and Zip Code:_____

Dates Insured: From:_____ To:_____ Policy Number:_____

SPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? ☐ Yes ☐ No ☐ N/A
If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted by examination in your specialty, please give a brief explanation on an attached sheet. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

Certified/Recertified by the Board of: _____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Certification Number: _____

Certified/Recertified by the Board of: _____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Certification Number: _____

Accepted for Examination by the Board of: _____

Until (Expiration Date):_____ If not accepted, have you made application? ☐ Yes ☐ No

If no, provide an explanation:_____

Certified/Recertified by the Subspecialty Board of:_____

Date Certified: _____ Date Last Recertified:_____ Expiration Date:_____

Certification Number: _____

Certified/Recertified by the Subspecialty Board of: _____

Date Certified:_____ Date Last Recertified:_____ Expiration Date:_____

Certification Number: _____

Accepted for Examination by the Subspecialty Board of:_____

CERTIFICATION

ACLS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires:_____

ATLS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires: _____

PALS CERTIFICATION
Certified: ☐ Yes ☐ No
Expires: _____

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please attach documentation of all continuing education hours you have obtained in the last two years or complete the attached statement of continuing medical education.
2. If you are applying for privileges at a hospital or clinic, please complete the enclosed privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. Note that "N/A" is not an acceptable response except for question #14. **If you answer YES to any question, you must give details including name, address, and telephone number of significant parties on a separate sheet of paper. You must respond to each question.**

1. Has your professional liability coverage ever been terminated by action of the insurance company?	☐ Yes	☐ No
2. Have you ever been denied professional liability insurance coverage?	☐ Yes	☐ No
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	☐ Yes	☐ No
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☐ No
5. Have you ever had any sanctions imposed by Medicare and/or Medicaid?	☐ Yes	☐ No
6. Have you ever been arrested, convicted of, or pled no contest to a crime?	☐ Yes	☐ No
7. Have you ever been convicted of a felony or named as a defendant in any criminal proceedings?	☐ Yes	☐ No
8. Have you ever been subject to investigation by a governmental entity that could result in sanctions or licensure adverse actions?	☐ Yes	☐ No
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)?	☐ Yes	☐ No
10. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked or not renewed, except for medical records?	☐ Yes	☐ No
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges?	☐ Yes	☐ No
12. Has your license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended or revoked, or are any currently held licenses pending investigation or being challenged?	☐ Yes	☐ No
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	☐ Yes	☐ No
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or surrendered, or is it currently being challenged?	☐ Yes	☐ No ☐ N/A
15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet of paper for each case. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	☐ Yes	☐ No
16. Do you know of any reason why you cannot perform the essential duties of the clinical privileges/functions which you are requesting with or without a reasonable accommodation according to acceptable standards of professional performance and without posing a direct threat to patients?	☐ Yes	☐ No
17. Do you use illegal drugs or have you illegally used drugs in the past five years?	☐ Yes	☐ No

APPLICANT'S ATTESTATION

I, _____, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

_____ _____

Signature Date (do not type)

All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate health care organization. Practitioners may utilize any or all of the following to ensure accurate file information.

- **The right of practitioners to review information submitted to support their credentialing application.**
- **The right of practitioners to correct erroneous information.**
- **The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request.**
- **The right of practitioners to be notified of these rights.**

This application has been designed to streamline the credentials verification process for providers, and meets the standards of many accrediting organizations. The application will be processed in accordance with the customer's required standards.

Hospital Services Corporation, a subsidiary of the New Mexico Hospital Association, maintains this form. If you have any questions about this form, please contact one of our credentials analysts at (505) 343-0070 or toll-free (866) 908-0070, or by e-mail at cvs@nmhsc.com. This application has been copyrighted and is intended for the sole use of our customers and approved users.

CHECKLIST OF DOCUMENTS TO BE RETURNED BY APPLICANT

☐ Completed and signed application (and supplemental documents required by the healthcare organization, if applicable). The application attestation page must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.

☐ Completed and signed release, with all organizations to which you are applying identified in the first line of the release. Please note that if you do not provide the authority to redisclose, you will be required to sign a separate release for any additional healthcare organizations to which you have made application. The release must have been signed within sixty (60) days. Signature stamps and date stamps are not acceptable.

☐ Current curriculum vitae or resume including months and years for all places of employment during the past fifteen (15) years. Explain any gaps of six (6) months or more during the past five (5) years.

☐ Copy of latest professional state license/certificate or registration. ☐ Pending

☐ Proof of current medical malpractice coverage that includes the effective date, amount and type of coverage. If your coverage will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current state Controlled Substance Registration. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ Copy of current federal DEA registration certificate. If your registration will be expiring within the next sixty (60) days, please provide a copy of the renewal certificate. ☐ Pending

☐ For hospital appointments, please attach privileges requested. Privileges forms are available on our website at www.nmhsc.com, Credentials Verification Forms, then Applications, Privileges and Forms.

☐ For health plan membership, all MD's, DPM's, DO's, and Nurse Midwives, and any primary care provider (PCP) Nurse Practitioners, must either have admitting privileges or a letter explaining the arrangements that have been made with a physician to admit patients, along with a signed letter from this physician confirming the arrangement. A sample copy of this form letter is available on our website at www.nmhsc.com, Credentials Verification Forms, then Applications, Privileges and Forms.

☐ Copy of your driver's license, if applying for hospital privileges.

☐ Copy of ECFMG Certificate, if foreign medical graduate.

☐ Copies of continuing medical education credits obtained during the last two (2) years or since your last appointment.

☐ Any additional attachments required by the application.

Return to:

Hospital Services Corporation
Credentials Verification Services
P. O. Box 92200
Albuquerque, NM 87199-2200
Telephone: (505) 343-0070
Toll Free: (866) 908-0070
Facsimile: (505) 346-0288

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")

Authority to Release: I have applied to participate as a provider for _____

_____

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date (do not type)

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations ("MCO's"), Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICES
STATEMENT OF CONTINUING MEDICAL EDUCATION

This form is only required for those applicants applying for hospital or clinic privileges. It is not required for health plan credentialing.

Each licensing board has specific requirements governing the amount of CME credits needed each year to maintain current licensure. Please list below the courses completed, and the location, date and the number of hours of CME credits you have obtained during the past two years. If necessary, use an additional sheet, or you may send us a copy of your own listing of courses completed.

Course Taken	Location	Date	Number of CME Hours

During the past two years, _____% of my continuing medical educational activities was related to the privileges requested. I hereby certify that within the past two years I have completed at least the minimum number of hours of continuing education credits required by the board through which I am licensed, and have participated in all performance improvement activities as specified by the hospital(s) at which I have privileges. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical staff.

_____ _____

Provider Name (Printed) Medical Director's Name (Printed)

_____ _____

Signature Medical Director's Signature

_____ _____

Date (do not type) Date (do not type)

Credentials Verification Services

Please take a few moments to help us improve how we serve you.

1. Please indicate how easy this process is versus others you may have experienced. **N/A**

EASIER THAN OTHERS **AS EASY** **NOT AS EASY**

2. If not as easy, please list why and provide your suggestions as to how HSC can better meet your needs regarding the credentials process.

3. Please rate the customer service and responsiveness provided by HSC.

EXCELLENT **GOOD** **FAIR** **POOR**

4. How would you rate the overall performance of HSC's Credentials Verification Services?

EXCELLENT **GOOD** **FAIR** **POOR**

5. Please provide any other comments that will help us improve our services.

HOSPITAL SERVICES CORPORATION
2121 Osuna Rd. NE Albuquerque, NM 87113 505-343-0070 / 866-908-0070
www.nmhsc.com P.O. Box 92200 87199-2200 Facsimile 505-346-0288