American Association of Nurse Anesthetists
222 South Prospect Avenue
Park Ridge, IL 60068
www.aana.com

# Application for Network Provider Participation

**Sample**

## Healthcare Network

Please include copies of the following documents with this application:

1. Current license
2. Certificate of insurance (professional liability)
3. DEA certificate (if applicable)
4. Current recertification
5. Advanced nurse practitioner registration (if applicable)

## Personal Identification Data

Name _____
(Last) (First) (Middle)

Specialty _____

Address _____ Phone # _____

City _____ State _____ Zip _____ Fax # _____

Billing Address _____ Phone # _____
*(If different from above)*

Social Security # _____ – _____ – _____ Date of Birth _____/_____/_____ Tax ID #_____

## Licensure Information

| | State #1 | State #2 | State #3 |
|---|---|---|---|
| State of Issue: | | | |
| Number: | | | |
| Date First Issued: | | | |
| Restrictions and/or Suspensions: | | | |
| Expiration Date: | | | |

*(If currently licensed in more than three states, please supply the same information on a separate sheet.)*

Federal DEA Certificate # _____ Date of Expiration _____
*(Please enclose copy of certificate.)*

**Educational Data**

**Nursing School/University/College**

Name _____ Dates: From _____ To _____

Address _____

City _____ State _____ Zip _____

Degree _____

**Anesthesia Educational Program/University/College**

Name _____ Dates: From _____ To _____

Address _____

City _____ State _____ Zip _____

Degree _____

**Educational Program/University/College**

Name _____ Dates: From _____ To _____

Address _____

City _____ State _____ Zip _____

Degree _____

**Other Professional Training/Military**

Name _____ Dates: From _____ To _____

Address _____

City _____ State _____ Zip _____

Degree _____

*Please attach additional pages if more space is needed.*

**Work History**

List in chronological order since completion of graduate education. Complete addresses must be included. Please attach additional sheets if more space is needed. Explain activity during any unlisted time interval on a separate sheet.

**Institution/Work**

Name _____ Department_____ Dates: From _____To_____

Address _____

City _____State _____ Zip _____

Name of Department Chief _____

Name _____ Department _____ Dates: From _____To_____

Address _____

City _____State _____ Zip _____

Name of Department Chief _____

Name _____ Department_____ Dates: From _____To_____

Address _____

City _____State _____ Zip _____

Name of Department Chief _____

Name _____ Department_____ Dates: From _____To_____

Address _____

City _____State _____ Zip _____

Name of Department Chief _____

**Professional Liability Data** *(Please enclose copy of policy face sheet.)*

Name of Carrier_____

Address _____

City _____State _____ Zip _____

Policy # _____ Amt. of Coverage $ _____ Effective Date _____ Expiration Date _____

Policy Type *(Please check one)* □ Claims Made □ Occurrence

Please list any other professional liability carriers you have used in the last five years (include name, address, date of coverage, and policy numbers):

_____

1. Has your professional liability insurance coverage ever been terminated by action of the insurance company? □ Yes □ No
2. Have you ever been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? □ Yes □ No
3. Has your present professional liability insurance carrier excluded any specific procedures for your coverage? □ Yes □ No
4. Have any professional liability suits or claims been filed against you within the last five years? □ Yes □ No

5. Have any professional liability suits or claims been filed against you that are presently pending? □ Yes □ No
6. Have any judgments or settlements been made against you in any professional liability suit or claim within the last five years? □ Yes □ No

*If the answer is yes to any of the above questions, provide a full explanation on a separate sheet. Provide name of carrier, date of occurrence, and any allegations involved. The explanation must include the court in which any action was ruled, the caption and docket number of the case, and the name and address of the attorney defending you.*

**Practice Information**

Please answer the following questions in full. If the answer to any question is yes, please provide a full explanation of the details on a separate sheet.

1. Are there any actions that have been initiated or are pending against you by any state licensing board? __Pending _____ Settled _____ Resolved □ Yes □ No
2. Has your license to practice in any state ever been denied, limited, restricted, suspended, revoked, voluntarily or involuntarily relinquished, or not renewed? □ Yes □ No
3. Have you ever been suspended, sanctioned or otherwise restricted from participating in Medicare, Medicaid, or private, federal, or state health insurance programs? □ Yes □ No
4. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance or managed care program? □ Yes □ No
5. Have you ever been denied participation in, terminated from, or restricted in your participation in any managed care program or insurance program? □ Yes □ No
6. Have you been named as a defendant or convicted of a felony or misdemeanor within the last 10 years? □ Yes □ No
7. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily relinquished during an investigation or, as a result thereof, suspended, diminished, revoked, limited, or not renewed at any healthcare facility? □ Yes □ No
8. Have you ever been the subject of any disciplinary proceedings (including medical record suspension) at any hospital or healthcare facility? □ Yes □ No
9. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? □ Yes □ No
10. Do you have any medical, emotional, mental, and/or physical problems that could affect your clinical judgment or ability to practice? □ Yes □ No

*If you answered yes to any of the above questions, please provide details on a separate sheet.*

**National Practitioner Data Bank (NPDB)**

*A healthcare entity must query the NPDB to obtain information regarding the standing physician, dentist, or other healthcare practitioner when the individual applies for a position on the medical staff or for clinical privileges. Information must also be requested every two years for reappointment of those practitioners.*

NPDB report requested? □ Yes □ No

If so, please attach report.

**References**

Name three medical or healthcare professionals who have personal knowledge of your current clinical abilities and ethical character, and who will provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you or be a partner in your practice.

Name _____ Telephone_____

Address _____

City _____State _____ Zip _____

Name _____ Telephone_____

Address _____

City _____State _____ Zip _____

Name _____ Telephone_____

Address _____

City _____State _____ Zip _____

**Conditions of Application**

**By applying for participation in _____, I thereby:**

- Agree to cooperate with and participate in all administrative policies and procedures that may be established by _____;
- Consent to the inspection by _____, its representatives, and staff of all documents that may be material to an evaluation of my qualifications and competence;
- Consent to release of such information;
- Release from liability _____, its authorized representatives, and any third parties for any actions, recommendations, reports, communications, and disclosures involving me made in good faith without malice concerning my professional competence, ethics, character, and other qualifications for participation;
- Release from liability any and all individuals and organizations who provide information to _____ in good faith without malice concerning my professional competence, ethics, character, and other qualifications for participation;
- Agree to keep _____ informed of any change made or proposed change in the status of, or restriction placed upon, my professional license to practice in this or any other state; DEA or other controlled substance registration; or any new malpractice claims or suits or judgments or settlements;
- I understand that I must provide for suitable and comparable 24-hour coverage of my patients with licensed professionals who have staff privileges at _____ (hospital) in my absence, and will provide the name(s) of such coverage if required;
- Acknowledge that any significant misstatements in/or omissions from this application constitute cause for denial or termination of participation;
- All information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____

Date Signature