RECREDENTIALING CHECKLIST
ADVANCED PRACTICE PROVIDER

In order to process a request for recredentialing, all forms listed below must be completed and submitted to Medical Staff and Regulatory Affairs/Credentialing.

☐ **ADVANCED PRACTICE PROVIDER RECREDENTIALING APPLICATION:** The Recredentialing application needs to be signed by the provider and the Chair/Chief/AMD.

☐ **CONTINUING EDUCATION (CEU):** Please provide copy of current (within the past two years) Continuing Education Units related to specialty.

- **Psychologist – 36 CEUs**
- **Physician Assistant – 50 CEUs**
- **Nurse Practitioner – 30 CEUs**
- **Certified Registered Nurse Anesthetist – 30 CEUs**

☐ **JOB DESCRIPTION**

For Physician Assistants

☐ **Practice Agreement**

To be completed by the Department, PA and Supervising Provider and signed accordingly. Department, PA and Supervising Provider to keep copies prior to forwarding to Medical and Regulatory Affairs.

☐ **Standardized Procedures/Protocol Application for Advanced Practice Providers**

**Important: Check all procedures you are requesting to be approved for the upcoming recredentialing period. Competency logs with the required annual number of cases must be submitted with your request. Once approved, this will reflect the privileges you are allowed to perform for the new recredentialing cycle.

For Nurse Practitioners

☐ **Standardized Procedures/Protocol Application for Advanced Practice Providers**

**Important: Check all procedures you are requesting to be approved for the upcoming recredentialing period. Competency logs with the required annual number of cases must be submitted with your request. Once approved, this will reflect the privileges you are allowed to perform for the new recredentialing cycle.

☐ **NP Core Standardized Procedures**

☐ **CLINICAL COMPETENCE SUMMARY:** Department Chair or Designee must complete the form.

Please email the completed documentation to:

Apple Balmaceda – Medical Staff and Regulatory Affairs/Credentialing fbbalmaceda@ucdavis.edu

ADVANCE PRACTICE PROVIDER
REQUEST FOR RECREDENTIALING

First: _____ Middle: _____ Last: _____

NPI number: _____

Department: _____ Division: _____

Office Address: _____ City: _____ State: ___ Zip: _____

Office Phone Number: _____ Office Fax Number: _____ Pager Number: _____

Home Address (not PO Box): _____ City: _____ State: __ Zip: _____

Phone: _____ Cell: _____ Personal Email: _____

Supervising Provider: First Name _____ Last Name _____

LICENSES:

California professional license number 1: _____ Expires: _____

California professional license number 2: _____ Expires: _____

California professional license number 3: _____ Expires: _____

X-Ray Type: _____ X-Ray number: _____ Expiration date: _____

DEA number #1: _____ DEA expiration date: _____

DEA number #2: _____ DEA expiration date: _____

BOARD CERTIFICATION/RECERTIFICATION:

American Board of _____ Year Certified _____ Expires _____

American Board of _____ Year Certified _____ Expires _____

American Board of _____ Year Certified _____ Expires _____

OTHER CERTIFICATION/RECERTIFICATION: (ex: ACLS, ATLS, BLS, CPR, PALS)

Certification name: _____ Expiration date: _____

Certification name: _____ Expiration date: _____

Certification name: _____ Expiration date: _____

OUT-OF-STATE LICENSES: (List all licenses held outside of California during the last two years)

State: _____ License #: _____ Expiration: _____

State: _____ License #: _____ Expiration: _____

State: _____ License #: _____ Expiration: _____

State: _____ License #: _____ Expiration: _____

CLINICAL WORK HISTORY, INCLUDING TERMINATIONS IN PAST TWO YEARS:

Clinic Name: _____ Start Date: _____ End Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Clinic Name: _____ Start Date: _____ End Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Name: _____ **NPI #:** _____

If you answer yes to any questions below, please explain in section below.

Question	Yes	No
Has your professional license in any jurisdiction or your DEA registration ever been voluntarily or involuntarily revoked, suspended or limited in any manner or is any such action pending?	☐	☐
Has there ever been an involuntary termination of employment or involuntary limitation, reduction, denial or loss of clinical activities at another health care organization or is any such action pending?	☐	☐
Have you ever resigned from a health care organization to avoid disciplinary action or is any such action pending?	☐	☐
Have you ever been subject to disciplinary action in any health care organization or is any such action pending?	☐	☐
Have you ever been convicted or pleaded guilty or nolo contendere related to the practice of health care, including fraud or abuse relating to any government health program or third party reimbursement or is any such action pending?	☐	☐
Have you ever been convicted or pleaded guilty or nolo contendere to any crime (other than a minor traffic violation)?	☐	☐
Are you currently excluded from participation in any federal or state healthcare program, have you ever been excluded or is any such action pending?	☐	☐
Do you currently use drugs illegally?	☐	☐

Use this box for explanation of any yes answers to questions above:

Medical Malpractice History: In the past five years have you been involved in any legal claims relating to alleged medical malpractice (e.g., notice of intent to sue, named or served defendant, final judgments or settlements, etc.)

☐ Yes* ☐ No

***If Yes** to malpractice question above you **MUST** complete the "Professional Malpractice History Summary Form" for **each** malpractice occurrence. (One form per occurrence)

Health Question: Have you any current impairment, disability, or transmittable disease that could affect your clinical performance or your ability to provide safe and quality patient care, with or without reasonable accommodation, according to accepted standards? ☐ Yes ☐ No

***If Yes** to health question above please explain in section below:

Name: _____ **NPI #:** _____

Certification and Agreement: I understand and agree as follows:

I certify that the health statement question has been answered to the best of my ability. I agree to report any changes in my physical or mental health that could affect my ability to provide safe and quality patient care.

I agree to notify Medical Staff Administration within 14 days of any disciplinary action, including those reported by other health care organizations to the my state licensing board and/or National Practitioner Data Bank; I agree to notify Medical Staff Administration immediately upon being informed of exclusion from any state or federal health care program.

I certify that the information provided by me in this application is correct and complete to the best of my knowledge and belief. Any significant misstatements or omissions from this application constitutes' cause for denial or termination of employment. I am given the right to review information obtained from outside sources, such as state licensing boards, and the National Practitioner Data Bank, but do not have the right to review references, recommendations or other information that is peer review protected. I have the right to correct erroneous information and to be informed of the status of my application upon request.

I present this application, and arrange for the submission of other information as part of this credentialing process, in the expectation that the confidentiality and privacy of this information will be preserved, and that this information and these materials will only be released or disclosed as part of the current and future credentialing, peer review and performance improvement processes described in the UCDMC Bylaws and Rules and Regulations of the Medical Staff.

Confidentiality is vital to the free and candid communication necessary for effective performance improvement activities, peer review, and consideration of the qualifications of clinical staff to perform specific procedures. I agree to respect and maintain the confidentiality of all discussion, deliberations, records and any other information generated in connection with these activities by the Medical Staff, departments, divisions or their committees. I shall only disseminate the foregoing where expressly required by law, pursuant to officially adopted policies of UCDMC and the Medical Staff, or where no officially adopted policy exists, only with the express approval of the Medical Staff Executive Committee or its designee. I shall make no voluntary disclosures or such discussions, deliberations, records and information except to persons authorized to receive it in the conduct of UCDMC and Medical Staff affairs. In the event of a breach or threatened breach of this confidentiality agreement, the University may, as applicable and as it deems appropriate, pursue University procedures and/or take any other action available to the University to address such noncompliance. UCDMC policies and procedures and the Medical Staff Bylaws include confidentiality provisions.

I acknowledge that I have read and agree to comply with the Bylaws and Rules and Regulations of the Medical Staff of the University of California, Davis Medical Center and agree to comply with applicable hospital policies of the University of California, Davis Medical Center and the University's Health Sciences Clinical Enterprise Code of Conduct. I further agree not to participate in the division of fees, and to maintain an ethical practice and provide continuous care for my patients. I agree to participate in the teaching program of the University of California, Davis Medical Center.

Pursuant to the Federal Privacy Act of 1974, I am hereby notified that disclosure of my Social Security number is voluntary. The Social Security number is used to verify identity, and shall not be disclosed except as permitted by law. This record keeping system was established pursuant to the authority of the Regents of the University of California, under Article IX, Section 9, of the California Constitution.

Provider Signature: _____ Date: _____

Department Chair's Recommendation: The following signature indicates that the information provided on this request for credentials has been reviewed for accuracy of content and that the request has Departmental sponsorship.

Membership category: ___CRNA ___NP ___PA ___ PSYCHOLOGIST

Employment type: ____SOM ___ Hospital

Department Chair or Designee Signature: _____ Date: _____

Interdisciplinary Practice Committee Recommendation: The following signature indicates that the Interdisciplinary Practice Committee has reviewed this application and recommends this individual.

Interdisciplinary Practice Committee Chair: _____ Date: _____

Name: _____ **NPI #:** _____

RELEASE AND CERTIFICATION STATEMENT

My signature below authorizes the Regents of the University of California or their representatives to contact individuals, agencies, and health care facilities that I have listed on my application for Advanced Practice Professionals credentialing or recredentialing. I agree to release the University of California from civil liability regarding the processing of my application. Further, I hereby release from liability any and all individuals and organizations that provide information to the University of California, Davis Medical Center or its Medical Staff in good faith without malice concerning my professional competence ethics, character, and other qualifications for staff membership and clinical privileges and I hereby consent to the release of such information. I certify that the information provided in my request for credentialing or recredentialing at the University of California, Davis Medical Center is true and correct to the best of my knowledge and belief.

Signature: _____ **Date:**_____

MALPRACTICE STATEMENT OF RELEASE AND CARRIER INFORMATION

Please provide the names and addresses of all professional liability insurance carriers you have had for the past five years. Sign and date this Release and print or type your name below your signature.

TO: PROFESSIONAL LIABILITY INSURANCE CARRIER(S):

Name of Carrier	Dates of Coverage
Fax #; Phone #; and Complete Mailing Address, Including Zip Code	Policy Number
Name of Carrier	Dates of Coverage
Fax #; Phone #; and Complete Mailing Address, Including Zip Code	Policy Number
Name of Carrier	Dates of Coverage
Fax #; Phone #; and Complete Mailing Address, Including Zip Code	Policy Number
Name of Carrier	Dates of Coverage
Fax #; Phone #; and Complete Mailing Address, Including Zip Code	Policy Number
Name of Carrier	Dates of Coverage
Fax #; Phone #; and Complete Mailing Address, Including Zip Code	Policy Number

I authorize all malpractice carriers to release coverage and/or claims history information:

Credentials Unit - North Addition
Medical Staff Administration
UC Davis Medical Center
2315 Stockton Boulevard
Sacramento, CA 95817

Additionally, if my policy is cancelled for any reason, or if changes are made in my coverage amounts, I request that no such cancellation or change be made without thirty (30) days prior notice to UC Davis Medical Center at the address above. I understand that this information will be used during the evaluation process for appointment/reappointment to the Medical Staff at UC Davis Medical Center. I further understand that this information will only be disclosed to those authorized to receive it by the Bylaws of the Medical Staff.

Date:_____ _____
Signature

_____
Print or Type Full Name

PROFESSIONAL MALPRACTICE HISTORY SUMMARY

Provider Name: _____ **Occurrence #:** _____ **of** _____

Patient's age: ____ Patient's gender: ____ Occurrence date: _____

Place of Occurrence: _____

Provide details of malpractice case, including patient's diagnosis, procedure performed (if any), allegation of wrongdoing, provider's level of involvement (e.g., attending, resident, etc.), and any explanation relevant to provider's role. May email additional information if needed:

Current status of Case:

☐ Open ☐ Settled ☐ Closed without payment ☐ Judgment in favor of defendant

☐ Judgment in favor of plaintiff ☐ Provider dropped from case due to non-involvement

☐ Arbitration ☐ Other: _____

I have filled out the above items or have reviewed for accuracy.

Signature: _____ **Date:** _____

CONFIDENTIAL REFERRAL AND FINANCIAL INTEREST QUESTIONNAIRE

Instructions: Federal and state law prohibit physicians from making referrals to entities for certain services if the provider or an immediate family member has a financial relationship with the entity, unless a particular exception applies. In addition, federal and state law also prohibits anyone from receiving payment for either referring a patient or buying goods or services (a "kickback"). There are exceptions to each of these rules. Contact UCDMC Legal Affairs if you have concerns.

	YES	NO
1. Have you referred any patient to a non-University of California individual or entity that you, your department or an immediate family member has any financial relationship (ownership/investment interest or compensation arrangement)?	☐	☐
2. Have you, your department, or an immediate family member received a gift, compensation, or other remuneration from any individual or entity to which you referred a patient?	☐	☐
3. Have you, your department, or an immediate family member received a gift, compensation or other remuneration for any individual or entity in exchange for using their health related product or service?	☐	☐

If the answer is to any of the questions above was "YES", describe the nature of services and the economic interest or remuneration involved.

_____

_____

_____

_____

_____

I have filled out the above items or have reviewed for accuracy.

Signature:_____ Date: _____

Printed Name:_____

UCDMC MEDICAL STAFF CLINICAL COMPETENCE SUMMARY

Provider Name: _____ **Department**: _____ **Eval. MM/YY** (2 yr period): _____

DEPARTMENT RECOMMENDATION: The peers in the department have assessed the professional performance, judgment, and skills of this practitioner, agree that this practitioner is qualified to perform the clinical privileges requested and recommend reappointment to the UCDMC Medical Staff. ☐ **Yes** ☐ **No**

Instructions: Provide an evaluation of the practitioner in each of the areas below and check boxes in the left hand column to indicate which information sources were used to make the assessment. (signed copy will be forwarded to Medical Staff Administration)

	Improvement Needed*	Meets Expectations
I. Patient Care: Compassionate, appropriate and effective	☐	☐
☐ Direct Observation of Care ☐ Assist with Care ☐ Transfer of Service or Care ☐ Call coverage ☐ Use of consultations ☐ Student/Resident Evaluations ☐ Satisfaction Data ☐ Morbidity/Mortality/CQI Reviews	**Comments:**	
II. Medical / Clinical Knowledge: **Demonstrates knowledge of established and evolving sciences and applies it to patient care and education of others**	☐	☐
☐ Malpractice History ☐ Blood Utilization ☐ Infection Control ☐ Invasive Procedures Review ☐ Clinical Activity Report ☐ Utilization Management ☐ Complications ☐ Teaching Conferences ☐ Board Recertification ☐ Drug Utilization ☐ Grand Rounds/CME Presentations Given ☐ Prospective/Concurrent Case Management Discussions	**Comments:**	
III. Practice-Based Learning and Improvement: Uses scientific evidence and methods to investigate, evaluate, improve care	☐	☐
☐ Teaching conferences ☐ Participation in performance improvement activities ☐ CME Attended	**Comments:**	
IV. Interpersonal and Communication Skills: Establishes and maintains professional relationships with patients, families and peers	☐	☐
☐ Patient complaints ☐ Direct Observation of Care ☐ Satisfaction Data ☐ Transfer of Service or Care	**Comments:**	
V. Systems-Based Practice: Understands the contexts and systems in which care is provided and applies this knowledge	☐	☐
☐ Attendance at Dept and Medical Staff Committee Meetings ☐ CME Attended ☐ Medical Record Documentation (___ Suspensions)	**Comments:**	
VI. Professionalism: **Demonstrates a commitment to professional development, ethical practice, diversity and responsibility to patients, profession and society**	☐	☐
☐ Incident Reports ☐ Academic Honors ☐ Clinical Publications ☐ Academic Advancement Letter	**Comments:**	

*** Action Plan for Improvements Needed**:

_____

_____

_____

UCDMC OUTPATIENT AND INPATIENT CASE INVOLVEMENT

Have UCDMC privileges currently held been used in the past two years? ☐ **Yes** ☐ **No**

If yes, estimate number of cases for past two years ☐ **1-5** ☐ **6-25** ☐ **51-100** ☐ **more than 100**

If no, please modify Medical Staff membership category and privileges (if necessary) to reflect current practice at UCDMC

_____

Chair - Print **Signature** **Date**