TO APPLICANTS TO THE UNIVERSITY OF SOUTH FLORIDA MORSANI COLLEGE OF MEDICINE:

The process of credentialing faculty members of the USF Morsani College of Medicine who provide patient care is an extensive procedure. To expedite verification of your credentials, which is mandatory if you are offered a position with the faculty, the **enclosed Clinical Provider Application** must be completed by you.

All areas must be completed and copies of the documents, indicated on page 2 of the Application, are required in order to begin the credentialing process. After this process is completed, only then can the Morsani College of Medicine extend a **Letter of Employment Offer**.

The completed **Clinical Provider Application**, including the signed **Authorization for Release of Information**, and requested **copies of documents** should be returned to the Office of Professional Credentialing **within two weeks**. A prompt return of the **Clinical Provider Application** will expedite the credentialing process, you may either mail in your application to the address below or email it to usfopc@health.usf.edu. Please be sure to carefully read all the instructions on the application to avoid any unnecessary delays.

Please be advised that the granting of credentials by the USF Morsani College of Medicine Credentials Committee does **NOT** award privileges at any USF affiliated hospitals. Separate applications for medical staff privileges must be completed as soon as possible. Please contact your USF Morsani College of Medicine department representative for assistance regarding hospital privileges.

If you have any questions or wish to inquire about the status of your application, please do not hesitate to contact Ashley Kamensky at (813) 974-8292, usfopc@health.usf.edu in the Office of Professional Credentialing.

Sincerely,

J. K. Williams

J. Kell Williams, MD
Chairman, Morsani College of Medicine Credentials Committee

ENCLOSURES: Clinical Faculty Application
Authorization for Release of Information
All Health Plans Form

USF PHYSICIANS GROUP
Department of Manged Care • Office of Professional Credentialing
Mailing Address: 12901 Bruce B. Downs Blvd., MDC62, Tampa, FL 33612 • Physical Address: 13220 USF Laurel Drive, MDF 3rd Floor, Tampa, FL 33612
(813) 974-8390 • FAX (813) 974-0483

USF College of Medicine Credentialing Packet

Application Checklist

The following documents (most current copy) are required and must be returned with the completed and signed application. If any of the below documents are pending i.e. Florida Medical License, DEA Certificate, etc. you may still submit you application to the Office of Professional Credentialing.

- □ Medical License
- □ DEA Certificate – if applicable [***Please note that the address on the DEA Certificate must reflect the primary practice address at which the physician will practice. You can update your primary practice address online at www.deadiversion.usdoj.gov. Please provide a copy of the corrected DEA Certificate when it is received.]***
- □ Curriculum Vitae
- □ ECFMG Certificate (if applicable)
- □ Medical, Dental or Graduate education Degree – translated, if not in English
- □ Training Certificates - all (i.e. Internship, Residency)
- □ Fellowship Completion Certificate (if applicable)
- □ Board Certificate(s) (if applicable)
- □ ACLS/BLS/PALS Certification card(s)
- □ Malpractice Coverage Facesheets (current and previous) including dates of coverage
- □ Driver's License
- □ Social Security Card
- □ NPI email (when number was first issued) ***[If you do not have this email please call the National Plan & Provider Enumeration System (NPPES) at 1-800-465-3203 and they will re-issue this email]***

If you have any questions, or wish to inquire about the status of your application, please do not hesitate to contact Ashley Kamensky at (813) 974-8292 in the Office of Professional Credentialing.

USF Physicians Group
Office of Professional Credentialing
Mailing Address: 12901 Bruce B. Downs Blvd., MDC Box 62
Tampa, FL 33612
Physical Location: 13220 USF Laurel Drive, 3th Floor, Tampa, FL 33612
Fax: (813) 974-0483

University of South Florida

Morsani College of Medicine

CLINICAL PROVIDER APPLICATION

CLINICAL PROVIDER APPLICATION

Instructions for Completing

Appointment of faculty members who will provide health care services to patients of the USF Morsani College of Medicine requires an extensive review of credentials. This review is conducted by the Office of Professional Credentialing (OPC) under the direction of the Credentials Committee of the USF Physicians Group, the faculty practice plan of the USF Morsani College of Medicine.

This Application begins the Credentialing Review process, and approval by the Credentials Committee Chairman is required. The credentialing process requires complete accountability for each month of every year since completion of Medical School training. Most curriculum vitae do not provide the detail mandated for this process, and **are not acceptable** as a substitute for any part of this document. Incomplete applications will not be processed, and will be returned for completion.

General:

- Please print legibly or type all responses.
- Write clearly either *"yes" or "no"* to questions requiring one of these responses.
- Explanatory information for all *"yes"* answers must be provided and should be attached inside the rear cover of this application.
- Please indicate N/A (*"Does not apply"*) where appropriate. Do not leave any blanks.
- A *month and year* is **required** for all date entries.
- Additional space is provided, if needed, inside the rear cover of this application.

Certification:

A certification signature is required on Page 11 which attests to the validity, accuracy and completeness of the information provided. All responses are subject to verification. Any misrepresentations of fact, or omissions of substance, must be satisfactorily explained.

Authorization for Release of Information:

An authorization for release of information is required since no verification can be obtained without this authorization.

Letter of Employment Offer:

The Department of Faculty Affairs will issue a Letter of Employment Offer and the OPC will require a copy of your **signed** Letter of Employment Offer to present you to the Credentials Committee. Without the Letter of Offer, the OPC cannot confirm that you have accepted a position with the University. This only applies to Physicians, Pharmacists and Physical Therapists, who will be considered Faculty Members. All other providers will receive their Letter of Offer from Human Resources upon approval by the Credentials Committee.

If you have any questions or wish to inquire about the status of your application, please do not hesitate to contact Ashley Kamensky at (813) 974-8292, usfopc@health.usf.edu in the Office of Professional Credentialing.

CLINICAL PROVIDER APPLICATION

University of South Florida Morsani College of Medicine
USF Health Endoscopy and Surgery Center

☐ ***Check box if requesting Privileges at the USF Health Endoscopy and Surgery Center***

Please indicate N/A where applicable. Do not leave any blanks.

I. PERSONAL DATA

Anticipated Start Date: _____

Name: _____ _____ Gender: _____
First Middle Last Degree(s) (M/F)

Department: _____ Division: _____

Home Address: _____
City State Zip Code

Phone: _____ Email: _____

Have You Ever Been Known by Any Other Name? (Y/N): _____ If So, Date: _____ Other Name: _____

Reason Name Changed: _____ Spouse's Name: _____

Social Security #: _____ Date of Birth: _____

Place of Birth: _____
City State Country

Languages Spoken: _____ Citizenship: _____

Race: _____ Height: _____ Weight: _____

Hair Color: _____ Eye Color: _____

II. EDUCATION

NOTE: Each month since completion of medical/graduate school MUST be documented. PLEASE PROVIDE MONTH/YEAR AND EXPLANATION FOR ANY GAPS ON AN ATTACHED SHEET.

Undergraduate School:

College Name: _____

City: _____ State: _____ Country: _____

Major: _____ Dates Attended: From _____ (Mo/Yr) To _____ (Mo/Yr)

Degree: _____ Graduation Date: _____ (Mo/Yr)

Graduate Education:

College/University:_____

City/State/Zip Code:_____ Country: _____

Major:_____ Dates Attended: From_____ To_____
Mo/Yr Mo/Yr

Degree: _____Graduation Date:_____
Mo/Yr

Medical Education:

College/University_____

City/State/Zip Code: _____ Country:_____

Dates Attended: From/To _____/_____ Graduation Date:_____ Degree:_____
Mo/Yr Mo/Yr

Internship (PGY-1):

Institution Name:_____

City/State/Zip Code:_____ Country: _____

Program Director:_____Program Type:_____

Dates Attended: From _____ To _____ Completed:_____
Mo/Yr Mo/Yr Mo/Yr

Residency Programs (PGY-2+):

Institution Name:_____

City/State/Zip Code:_____ Country: _____
Full Name of Program Director:_____Program/Specialty Type:_____

Dates Attended: From _____ To _____ Completed:_____
Mo/Yr Mo/Yr Mo/Yr

Institution Name:_____

City/State/Zip Code:_____ Country: _____
Full Name of Program Director:_____Program/Specialty Type:_____

Dates Attended: From _____ To _____ Completed:_____
Mo/Yr Mo/Yr Mo/Yr

Fellowships:

Institution Name:_____

City/State/Zip Code:_____ Country: _____
Full Name of
Program Director_____Program/Specialty Type:_____

Dates Attended: From _____ To _____ Completed:_____
Mo/Yr Mo/Yr Mo/Yr

Institution Name:_____

City/State/Zip Code:_____ Country: _____
Full Name of
Program Director:_____Program/Specialty Type:_____

Dates Attended: From _____ To _____ Completed:_____
Mo/Yr Mo/Yr Mo/Yr

III. LICENSURE

Current Medical License:

Florida License No.:_____Issue Date:_____
(Mo/Day/Yr)

Active? (Yes/No):_____Expiration Date:_____
(Mo/Day/Yr)

DEA Number: _____ Active? Yes/No):_____

DEA Expiration:_____ State in which you are registered:_____
(Mo/Day/Yr)

ECFMG Number:_____ ECFMG Date:_____
(Mo/Day/Yr)

NPI Number: _____

Florida Medicare #: _____ *** If applicable**

Other State Medical Licenses (ALL active or inactive) to include Canada, Puerto Rico, Guam and U.S. Virgin Islands:

State:_____Number:_____ Active: Issue/Expiration Dates: _____
(Mo/Day/Yr)

State:_____Number:_____ Active: Issue/Expiration Dates: _____
(Mo/Day/Yr)

State:_____Number:_____ Active: Issue/Expiration Dates: _____
(Mo/Day/Yr)

State:_____Number:_____ Active: Issue/Expiration Dates: _____
(Mo/Day/Yr)

Board Certification/Admissibility:

1) Certifying Board:_____ Specialty: _____

Date of Initial Issue:_____ (Mo/Day/Yr) Date of Last Recertification:_____ (Mo/Day/Yr) Expiration Date: _____ (Mo/Day/Yr)

Do you practice this specialty?

If not certified, do you intend to pursue certification?

If Yes, please provide status: Date of Written Exam Taken/Scheduled _____
Date of Oral Exam Taken/ _____
Scheduled Date Certification _____
Results Expected

If not certified, have you ever taken and failed a certification exam?

2) Certifying Board:_____ Specialty: _____

Date of Initial Issue:_____ (Mo/Day/Yr) Date of Last Recertification:_____ (Mo/Day/Yr) Expiration Date: _____ (Mo/Day/Yr)

Do you practice this specialty?

If not certified, do you intend to pursue certification?

If Yes, please provide status: Date of Written Exam Taken/Scheduled _____
Date of Oral Exam Taken/ _
Scheduled Date Certification _____
Results Expected _____

If not certified, have you ever taken and failed a certification exam?

Other Advanced Certification:

TYPE	*Mo/Yr Issued*	*Mo/Yr Expires*
_____	_____	_____
_____	_____	_____

Please list all the specialties under which you prefer to be listed on the website and health plan directories: _____

_____

Research Interests (For example, NeuroOphthalmology, Cardiac Anesthesiology):

_____

_____

IV. PROFESSIONAL ACTIVITIES AND AFFILIATIONS

Practice Chronology (Employment):

List chronologically all professional activities since graduation from your Residency or Graduate program. Use attached pages if additional space is needed*. Please sign attachment. NOTE: *Each month since completion of residency/graduate program MUST be documented, including any gaps. PLEASE PROVIDE MONTH/YEAR AND EXPLANATION FOR ANY GAPS.

1) Name or Description of Practice:_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Country:_____
Solo, Partnership, or Group:_____ Specialty:_____
Dates in Practice: From:_____ (Mo/Yr) To:_____ (Mo/Yr)

2) Name or Description of Practice:_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Country:_____
Solo, Partnership, or Group:_____ Specialty:_____
Dates in Practice: From:_____ (Mo/Yr) To:_____ (Mo/Yr)

3) Name or Description of Practice:_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Country:_____
Solo, Partnership, or Group:_____ Specialty:_____
Dates in Practice: From:_____ (Mo/Yr) To:_____ (Mo/Yr)

4) Name or Description of Practice:_____
Street Address:_____
City:_____ State:_____ ZIP:_____
Country:_____
Solo, Partnership, or Group:_____ Specialty:_____
Dates in Practice: From:_____ (Mo/Yr) To:_____ (Mo/Yr)

Hospital Affiliations (EACH hospital in which staff privileges of any type were granted MUST be noted). Use attached pages as needed. Sign attached pages.

1) Hospital Name:_____

City/State/Zip Code:_____ Country:_____

Status/Staff Category: Active:☐ Provisional:☐ Courtesy:☐ Consulting:☐ Other: _____

Specialty:_____ Dates Affiliated: From _____ (Mo/Yr) To _____ (Mo/Yr)

2) Hospital Name:_____

City/State/Zip Code:_____ Country:_____

Status/Staff Category: Active:___ Provisional:___ Courtesy:___ Consulting:___ Other: _____

Specialty:_____ Dates Affiliated: From _____ To _____
Mo/Yr Mo/Yr

3) Hospital Name:_____

City/State/Zip Code:_____ Country:_____

Status/Staff Category: Active:___ Provisional:___ Courtesy:___ Consulting:___ Other: _____

Specialty:_____ Dates Affiliated: From _____ To _____
Mo/Yr Mo/Yr

4) Hospital Name:_____

City/State/Zip Code:_____ Country:_____

Status/Staff Category: Active:___ Provisional:___ Courtesy:___ Consulting:___ Other: _____

Specialty:_____ Dates Affiliated: From _____ To _____
Mo/Yr Mo/Yr

Academic Appointments:

School Name:_____
Street Address:_____
City:_____ State_____ ZIP:_____
Country:_____ Rank:_____
Appointment
Department:_____ Dates: From_____ To_____
Mo/Yr Mo/Yr

School Name:_____
Street Address:_____
City:_____ State_____ ZIP:_____
Country:_____ Rank:_____
Appointment
Department:_____ Dates: From_____ To_____
Mo/Yr Mo/Yr

Military Service:

Branch of Service:_____
Highest Rank:_____
Active Duty Dates: From_____ To_____
Mo/Yr Mo/Yr

CURRENT MILITARY STATUS:

Reserve - Active (Drilling)?
Reserve - Individual Ready Reserve (Non-Drilling Status)?
Retired?
Other?

TYPE OF DISCHARGE:

Honorable?
Other than Honorable? (If YES, attach details)
Dishonorable? (If YES, attach details)
Release from active duty? (If YES, attach details)

Other Institutional Affiliations (*example*: U. S. Public Health Service):

Name of Institution:_____
Street Address:_____
City:_____State:_____Zip:_____Country:_____
Nature of Affiliation:_____
Affiliation Dates: From_____ To_____
Mo/Yr Mo/Yr

V. PROFESSIONAL LIABILITY INSURANCE

Present Liability (Malpractice) Insurance Carrier Information:

Name:_____Agent:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone Number:_____

Policy Number:_____
Inception Date:_____ Expiration Date: _____
Mo/Day (If Available)/Yr Mo/Day (If Available)/Yr

LIMITS: Per Occurrence $_____Aggregate $_____
Present policy is written on (*Indicate either A or B*):

A. _____A Claims made basis *or* B. _____An Occurrence basis

Previous Professional Liability Insurance Carriers:

ALL PREVIOUS professional liability insurance carriers MUST be listed. Use attached sheet if necessary. Please sign attached sheet.

Company/Agent Name:_____
Street Address:_____
City:_____State:_____ Zip:_____
Phone: _____ Fax: _____

Inception Expiration
Policy Number:_____Date:_____ Date:_____
Mo/Day (If Available)/Yr Mo/Day (If Available)/Yr

Company/Agent Name:_____
Address:_____
City:_____State:_____ Zip:_____
Phone: _____ Fax: _____
Policy Number:_____ Inception Date:_____ (Mo/Day (If Available)/Yr) Expiration Date:_____ (Mo/Day (If Available)/Yr)

Company/Agent Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone: _____ Fax: _____
Policy Number:_____ Inception Date:_____ (Mo/Day (If Available)/Yr) Expiration Date:_____ (Mo/Day (If Available)/Yr)

1) Have there been, or are there currently pending, any malpractice claims, suits, settlements, verdicts, or arbitration proceedings involving your professional practice? (Y/N) ☐

Total number of incidents: _____

If YES, the following information must be provided on EACH claim, suit, settlement, verdict, arbitration proceeding: Please provide information on a separate page.

a) Date of Incident (Month/Day/Year)
b) Description of Incident
c) Professional Liability Insurance Carrier on Date of Incident
d) Disposition or Current Status of Claim

2) Has your professional liability insurance ever been or is it currently in the process of being suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, revoked, canceled, denied, or granted with stated limitations (either temporarily or permanently)? ☐

If YES, an explanation must be provided.

Health Plan Information:

Primary Care:

Do you provide Primary Care? ☐

Patient Age Range (please choose one: ☐0-21 ☐0-12 ☐12-21 ☐0-99 ☐18+ ☐65+

Specialty Care:

Do you provide Specialty Care? (Yes/No): ☐

Patient Age Range (please choose one): ☐0-21 ☐0-12 ☐12-21 ☐0-99 ☐18+ ☐65+

Workers' Compensation (WC) Information:
Do you wish to treat WC patients from WC plans with which USF contracts? ___ Yes ___ No

Outside Activities Information:

Are you now, or do you plan to be, engaged in any professional practice apart from your USF faculty practice? (Yes/No): ____

If YES, what percentage of your patient care time does/will this practice entail? %

Describe the nature of this practice: _____

If YES, what is the name of your individual professional liability insurer?

_____

Limits of Coverage: Per Occurrence $_____ Aggregate $_____

Policy Number:_____ Effective Dates _____ /_____
From To

Job Performance Information:

Alcohol consumption or use of drugs while on the job, or being under the influence of drugs or alcohol while on the job, are prohibited at the University of South Florida. Members of the College of Medicine faculty will be held to the same standards of conduct as all other employees.

Do you currently engage in the illegal use of drugs? ____

Are you presently in a drug or alcohol rehabilitation program? ____

As a faculty member in the USF College of Medicine your job requirements may include the ability to practice medicine (or any given specialty) with reasonable skill and safety, being credentialed by managed care organizations under contract with the College, being credentialed by hospital affiliates and obtaining and maintaining a professional license in the State of Florida.

Are you able to practice medicine (or other given specialty) with reasonable skill and safety? ____

Do you believe you are able to meet the requirements for hospital or managed care organization credentialing? ____

Do you believe you are able to obtain and maintain a professional license in the State of Florida? ____

Are you aware of any current factors that would affect or likely affect your ability to perform professional or medical staff duties or how you would render quality care? ____

***Please attach complete details for any "YES" answers.**

VI. DISCIPLINARY ACTIONS

Attach COMPLETE DETAILS for any "YES" response to the following questions.

1) Have any of the following been or are currently in the process of being suspended, reduced, limited, placed on probation, not renewed, voluntarily relinquished, revoked, canceled, denied, or granted with stated limitations (either temporarily or permanently):

   a) Medical license in any state? ☐
   b) Other professional registration/license? ☐
   c) DEA registration? ☐
   d) Academic appointment? ☐
   e) Membership on any hospital medical staff or other medical staff? ☐
   f) Clinical privileges or hospital staff privileges? ☐
   g) Prerogatives/rights on any medical staff? ☐
   h) Other institutional affiliation or status thereat? ☐
   i) Hospital, HMO, PPO or other health care provider admitting privileges? ☐
   j) Professional society membership? ☐
   k) Fellowship/board certification? ☐

2) Has your provisional period at any hospital ever been extended? ☐

3) Have you ever received any official reprimand, censure, or other sanction from any state or federal government, any licensing agency or other subdivision thereof, any professional organization or association, or any medical organization or association? ☐

4) Have you had an application for membership or participation rejected, or any other contract or professional relationship suspended or terminated by any HMO, PPO, other prepaid or reduced fee-for-service health care plan, or any state or federal government program (including Medicare and Medicaid) or have you even been subject to any disciplinary hearing or review proceedings by any such organizations? ☐

5) Has any HMO, PPO, insurer, government agency, or other third party payor ever refused payment or reimbursement to you; sought repayment from you; or made any claim, allegation, or investigation on account of allegedly false, misleading, or fraudulent claim by you for payment or reimbursement? ☐

6) In the past two years, have any hospital days or services which you ordered or provided been denied for medical necessity by a PSRO, a Peer Review Organization, Medicare intermediary, carrier, or state medicaid agency? ☐

7) Have any hospital committee actions (other than for attendance at meetings or delinquent chart actions) been taken against you? ☐

8) Have there ever been any criminal charges (felony or misdemeanor) brought against you? ☐

9) Have you ever had any professional sanctions or disciplinary actions, not mentioned previously, taken against you? ☐

10) Have you ever been arrested for, or charged with a crime involving children? ☐

VII. PROFESSIONAL PEER REFERENCES

List three professional references familiar with your qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where you last furnished professional services.

Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone:_____ Fax:_____

Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone:_____ Fax:_____

Name:_____
Address:_____
City:_____State:_____Zip Code:_____
Phone:_____ Fax: _____

VIII. CERTIFICATION

I certify that all the information contained in this application is true, accurate and complete to the best of my knowledge. I further understand that if I have delegated the responsibility for completion of the information contained herein, that I assume full responsibility for its accuracy and completeness.

_____ _____

Applicant's Signature **Date**

_____

Applicant's Printed Name

Confidentiality of Patient/Member Information and Records Statement

I agree that I shall not disclose to any third party, except where authorized or required by law, any patient/member information or records, and I agree to comply with all federal and state laws and regulations, and all rules, regulations, and policies of the **USF College of Medicine/USF Physicians Group** regarding the confidentiality of such information and records. I acknowledge that **USF College of Medicine/USF Physicians Group** policy affords patients/members the opportunity to approve or deny the release of identifiable personal information by the **USF College of Medicine/USF Physicians Group**, except where such release is required by law. I further acknowledge that in receiving or otherwise dealing with any records or information about patients receiving treatment for alcohol or drug abuse, I am fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2, as amended from time to time).

_____

Provider Signature

_____

Printed Name

_____

Date

ASSIGNMENT OF INCOME FROM SERVICES

In consideration of my employment and as a condition of my continued employment by the University of South Florida Board of Trustees ("University") or University Medical Service Association, Inc. ("UMSA"), as applicable, I hereby assign to and acknowledge ownership by UMSA of any rights which I may now have or hereafter acquire to any fees or income which may be collected by myself, the University, or any other individual, firm or organization for Services rendered by me during the term of my employment by University or UMSA. As used herein, Services means the practice of my profession as a licensed health care practitioner, and the provision of medico-administrative services pursuant to my assigned duties at University sites and/or other institutions affiliated with the University.

I acknowledge that, while providing Services, I shall be under the exclusive supervision and control of the University, shall be subject to applicable University policies and procedures, in addition to those of UMSA, and shall perform services at locations as assigned by the University.

I agree to notify the University of any changes in my license, privilege or health status that affects or limits my ability to practice my profession as a licensed health care practitioner, and to comply with the applicable regulations, internal management memoranda, policies and procedures of the University. Without limitation of the foregoing, I acknowledge and agree that, in accordance with Florida law, the University is the owner of patient and/or medical records generated by me in the course of my University assigned duties.

_____ _____

Signature Date

_____

Print Name

ADDITIONAL INFORMATION Page:_____

(Indicate page in application to which information refers. Make as many copies of this page as necessary. Number Additional Pages. Staple numbered Additional Information pages in descending order inside rear cover of this application..) ***All additional pages need to be signed.***

Applicant's Signature Date

The University of South Florida is an
Affirmative action Equal Opportunity Institution

UNIVERSITY OF SOUTH FLORIDA ("USF") MORSANI COLLEGE OF MEDICINE ("MCOM")

USF PHYSICIANS GROUP ("USFPG")

AUTHORIZATION FOR RELEASE OF INFORMATION

Introduction.

As required by payor contracts, applicable laws, regulations and policies, the USFPG-MCOM must have access to certain information relevant to your eligibility for credentialing, re-credentialing, and assignment to participate in the provision of health care services for USF ("Participation"). This information enables USF to carry out its responsibility to evaluate and verify your education, training and experience, professional licensure, clinical skills and competence, professional liability experience, and other relevant criteria. The purpose of this document is to establish your written authorization for USF to access such information and for USF and third party sources to provide, receive and exchange such information which is relevant to the purpose of determining your eligibility for Participation.

1. I understand and agree that USF, its representatives, employees and/or designated agents (including, but not limited to, the USFPG Office of Professional Credentialing ("USFPG OPC"**)**, as well as other USF component units and their representatives, employees and/or designated agents) (the "Agents") may access and review information, including obtaining oral information and receiving, inspecting and copying all records and documents, relevant to my application, re-application, and/or continuing eligibility status for Participation.

2. I hereby authorize any non-USF third party, including, but not limited to, individuals, agencies, medical groups, corporations, employers, former employers, hospitals (including, without limitation, Tampa General Hospital and all other hospitals affiliated with USF), clinical facilities, insurance companies, health plans, health maintenance organizations, managed care organizations, law enforcement and licensing agencies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank (each a "Third Party"), and their representatives, employees and/or designated agents (the "Third Party Agents") to release to USF and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my education, training and experience, professional licensure and qualifications, credentials, clinical skills and competence, quality assurance and utilization data, professional liability experience, professional ethics and workplace behavior, and any other matter relevant to my qualifications, credentials and eligibility for Participation. I authorize my current and past professional liability carrier(s) to release the history of claims that have been made and/or are currently pending against me or involving my professional performance. I specifically waive written

notice from any Third Party or Third Party Agents who provide information based upon this Authorization.

3. Without limitation, I specifically authorize any Third Party and/or Third Party Agents to release "Disciplinary Information", as defined below, to USF and/or its Agent(s), and I authorize USF and/or its Agent(s) to release Disciplinary Information about any disciplinary action taken against me by USF to any Third Party and/or Third Party Agents. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such organizations, their administrators, or their medical or other committees, to revoke, deny, suspend, restrict, or condition my participation in the provision of health services to patients or impose a corrective action plan with respect to such participation; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

4. I hereby release from liability USF, its Agents, each Third Party and all Third Party Agents for acts performed without intentional fraud in connection with the request, gathering, release, exchange and evaluation of any records, documents and information pursuant to this Authorization. This release is in addition to any immunities provided by law.

5. I hereby certify that all information provided by me in my application for credentialing or re-credentialing is current, accurate and complete to the best of my knowledge and belief and is furnished in good faith. At any time after application, including during my entire USF employment, I will notify the USFPG OPC within twenty-four (24) hours of any material changes to the information I have provided in my application. I understand that corrections to the application are permitted at any time prior to a determination of credentialing or assignment for Participation by USF, and must be submitted in writing. I acknowledge that USFPG OPC will not process an application until it deems it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the credentialing process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation.

6. I understand that I have the right to make a written request to review certain information obtained by the USFPG OPC during the credentialing process; and in the event the information obtained by the USFPG OPC varies materially from the information provided by me, I will be afforded a period of seven (7) calendar days following my review in which to correct or clarify information by written request submitted to the USFPG OPC.

7. I acknowledge that I have read and understand the foregoing Authorization, and agree that a facsimile or photocopy of this signed Authorization shall be as effective as the original.

_____ _____

Signature Name (print)

_____

Date

Aetna

Release and Authorization

In order to more completely evaluate my application for inclusion in the Aetna panel of physicians and my continuing participation status with Aetna in the event my application is accepted, I authorize Aetna and its subsidiaries, affiliates, successors, employees and agents (hereinafter "Aetna") to consult with hospitals, members of medical staffs, professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my professional credentials and qualifications, including without limitation my professional competence and conduct. Specifically included in this authorization to obtain information, but not by way of limitation, is information about my quality of care and utilization statistics from the chiefs of the clinical departments of a hospital in which I have staff privileges, the FSMB, professional state boards, applicable state and federal agencies, and primary care and specialist physician colleagues participating with Aetna.

I consent to the release to Aetna of any and all information that may be relevant to an evaluation of my qualifications including information about disciplinary actions and information that might otherwise be considered confidential or privileged. I authorize Aetna to release this information, as well as quality assurance data relating to me: (1) to health benefit plans owned, managed or administered by Aetna, (2) to medical groups, independent practice associations and similar entities contracting with said health plans when health plan has delegated credentialing functions to such entities, and (3) as authorized under state or federal law or regulation. I release Aetna and any and all persons or entities providing information about me to Aetna, from any and all liability connected with or arising from the release of such information, provided that such party(ies) was (were) acting in good faith and without malice. I further release Aetna from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I have the burden of providing adequate information to Aetna to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by Aetna. If any material changes occur in the information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify Aetna or the appropriate subsidiary or affiliate within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care products or plans maintained or managed by Aetna.

I attest that the information contained in this application is correct and complete.

Name (First, Middle Initial, Last) - Please Print	
Signature (No Signature Stamp)	Date
X	

To: **ALL HEALTH PLANS**

From:

Effective _____, please terminate any contract/managed care agreements that are in place between your organization and myself from the state(s) of:

_____

Effective _____, I am a provider of physician services exclusively through the University of South Florida College of Medicine (d/b/a/ USF Physicians Group). As an employee of the University of South Florida College of Medicine, I will be providing services exclusively under contracts/managed care agreements held by the University of South Florida College of Medicine under tax ID number **23-7313346.**

Thank you.

Sincerely,

_____ _____

Provider's Signature Date

_____ _____

Print Name Provider's Social Security Number

USF PHYSICIANS GROUP
Department of Manged Care • Office of Professional Credentialing
Mailing Address: 12901 Bruce B. Downs Blvd., MDC62, Tampa, FL 33612 • Physical Address: 13220 USF Laurel Drive, MDF 3rd Floor, Tampa, FL 33612
(813) 974-8390 • FAX (813) 974-0483