## Yale Medicine Provider

Last Name:

First Name:

Middle Name:

Degree Suffix:

Name Suffix:

Soc. Sec. Num.:

Date Of Birth:

Birth City, State & Country:

Gender:

UPIN Number:

NPI Number:

Group Name:

Department Name:

Section Name:

Credential Specialty 1:

Taxonomy Code 1:

Credential Specialty 2:

Taxonomy Code 2:

Academic Office Address 1:

Academic Office City:

Academic Office State:

Academic Office Zip:

Academic Office Phone:

Academic Office Fax:

Academic E-mail:

ECFMG Certificate Number:

ECFMG Certification Date:

Federal Tax ID Number: 06-0646973

Provider Signature Date

# Provider's Educational History

Last Name:

First Name:

F1

Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Country:

Date Graduated:

Degree

Major:

RES2

Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Country:

Date Graduated:

Degree

Major:

Please initial:_____

## Provider's Educational History

RES1

Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Country:

Date Graduated:

Degree

Major:

MED

Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Country:

Date Graduated:

Degree

Major:

UG

Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Country:

Date Graduated:

Degree

Major:

Please initial:_____

## Provider's Certifications

Last Name:

First Name:

Board Certification 1

Board Certification Specialty Name:

Board Organization Name:

Board Certificatation Number:

Board Certificatation Date:

Board Cert Last Recertification Date:

Board Cert Currently Seeking:

Certif Special Type:

Exam Date:

Explanation:

Board Certification 2

Board Certification Specialty Name:

Board Organization Name:

Board Certificatation Number:

Board Certificatation Date:

Board Cert Last Recertification Date:

Board Cert Currently Seeking:

Certif Special Type:

Exam Date:

Explanation:

Please initial:_____

## Provider's Certifications

Board Certification 3

Board Certification Specialty Name:

Board Organization Name:

Board Certificatation Number:

Board Certificatation Date:

Board Cert Last Recertification Date:

Board Cert Currently Seeking:

Certif Special Type:

Exam Date:

Explanation:

Please initial:_____

## Provider's Employment History

Last Name:

First Name:

Employment Position I-Institution Name:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Position Start Date:

Position End Date:

Phone:

Employment Title:

Please initial:_____

## Provider's Licenses

Last Name:

First Name:

License 1

License Type:

State Of Licence:

License Number:

Expiration Date:

Federal DEA License Number:

Expiration Date:

State of CT Controlled Subs. Certificate Number:

Expiration Date:

Please initial:_____

## Provider's Affiliations

PA3- Institution Name:

Affiliation Type:

Affiliation Title:

Organization Type:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Institution Percent Of Admissions:

Appointment Start Date:

Appointment End Date:

Please initial:_____

## Provider's Office/Clinical Locations

Last Name:

First Name:

Campus Mail

Company Name:
Office Address 1:
Office Address 2:
Office City:
Office County:
Office State:
Office Zip:
Office Phone:
Office Fax:

Home Address

Company Name:
Office Address 1:
Office Address 2:
Office City:
Office County:
Office State:
Office Zip:
Office Phone:
Office Fax:

Please initial:_____

## Provider's Office/Clinical Locations

**Clinical Location 1**

**Company Name:**

**Office Address 1:**

**Office Address 2:**

**Office City:**

**Office County:**

**Office State:**

**Office Zip:**

**Office Phone:**

**Office Fax:**

**Please initial:_____**

## Clinical Coverage

Last Name:

First Name:

Coverage Type -L1:

24 Hour Coverage-L1:

Evening Hours-L1:

Weekly Office Hours:

Hours-MONDAY-L1:

Hours-TUESDAY-L1:

Hours-WEDNESDAY-L1:

Hours-THURSDAY-L1:

Hours-FRIDAY-L1:

Please initial:_____

## Provider w/Covering Providers

Last Name:

First Name:

Covering Physician 1

Covering Provider Last Name:

Covering Provider First Name:

Covering Provider Middle Initial:

Credential Spec 1:

Credential Spec 2:

Covering Provider Phone:

Covering Provider In-Group: Y

Covering Provider Coverage 24 Hour: Y

Please initial:_____

## Provider's Affiliations

Last Name:

First Name:

H1- Institution Name:

Affiliation Type:

Affiliation Title:

Organization Type:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Institution Percent Of Admissions:

Appointment Start Date:

Appointment End Date:

H2- Institution Name:

Affiliation Type:

Affiliation Title:

Organization Type:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Institution Percent Of Admissions:

Appointment Start Date:

Appointment End Date:

Please initial:_____

## Provider's Affiliations

PA1- Institution Name:

Affiliation Type:

Affiliation Title:

Organization Type:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Institution Percent Of Admissions:

Appointment Start Date:

Appointment End Date:

PA2- Institution Name:

Affiliation Type:

Affiliation Title:

Organization Type:

Institution Address 1:

Institution Address 2:

Institution City:

Institution State:

Institution Zip:

Institution Percent Of Admissions:

Appointment Start Date:

Appointment End Date:

Please initial:_____

## Provider's References

| | |
|---|---|
| Last Name: | |
| First Name: | |
| Malpractice Carrier Name: | MCIC Vermont, Inc |
| Amt of Covrge (Per Occur/Annual Aggregate): | |
| Malpractice Policy Number: | |
| Years With Malpractice Carrier: | |
| Previous Malpractice Carrier: | |
| Previous Malpractice Policy Number: | |
| Society Membership: | |

Reference I

| | |
|---|---|
| Reference Last Name: | |
| Reference First Name: | |
| Reference Middle Initial: | |
| Reference Degree Suffix: | |
| Reference Title: | |
| Corporate Name: | |
| Address 1: | |
| Address 2: | |
| City: | |
| State: | |
| Zip: | |
| Phone: | |

Please initial:_____

## Provider's References

Reference II

Reference Last Name:

Reference First Name:

Reference Middle Initial:

Reference Degree Suffix:

Reference Title:

Corporate Name:

Address 1:

Address 2:

City:

State:

Zip:

Phone:

Reference III

Reference Last Name:

Reference First Name:

Reference Middle Initial:

Reference Degree Suffix:

Reference Title:

Corporate Name:

Address 1:

Address 2:

City:

State:

Zip:

Phone:

Please initial:_____

## Provider's References

Reference IV

Reference Last Name:

Reference First Name:

Reference Middle Initial:

Reference Degree Suffix:

Reference Title:

Corporate Name:

Address 1:

Address 2:

City:

State:

Zip:

Phone:

Please initial:_____

Yale Medicine

Credentialing/Re-Credentialing Application

Name: _____ _____
Last First MI (Maiden)

Department: _____ Section Name: _____

Credential Specialty (ies): _____

*If you answer **YES** to question #10, please complete the YM Claim/Suit Report attached.*
*For any other questions that you answer **YES**, please attach a detailed explanation.*

| No. | Question | Yes | No | N/A |
|---|---|---|---|---|
| 1. | Have you ever had a medical license refused, restricted, suspended, or revoked by any state licensing authority or have you surrendered your medical license while a formal disciplinary proceeding was pending before a state licensing authority? | | | |
| 2. | Have you ever had revocation or suspension of accreditation? | | | |
| 3. | Have you ever had any suspension, exclusion or denial from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branchprocurement or non-procurement program? | | | |
| 4. | Has there beenanydisciplinary, administrative, civil, or criminal actions taken against you, a familymember, partner, member, director, officer or managing employee in any way related to the provision of health care goodsor services, including but not limited to those good or services covered by Medicare or Medicaid? | | | |
| 5. | Have you ever had anycurrent Medicare payment suspension under any Medicare billing number? | | | |
| 6. | Has any action(s) ever beentaken against you by the Licensing Board of any State or are you currently under investigation by a Licensing Board of any State? | | | |
| 7. | Have you ever had your license to prescribeor dispensenarcotics refused, suspended or revoked? | | | |
| 8. | Have you ever resigned fromor had your privileges suspended, restricted, or revoked by any hospital (other than for medical records, administrative rules and regulations)? | | | |
| 9. | Have you ever been reprimanded by or had your membershiprefused, suspended or revoked by any professional organization? | | | |
| 10. | Provider must answer **ONLY ONE – either A or B**<br>**A. New faculty or provider: (New or returning Provider to the practice)**<br>Have you ever been named as a party in a malpractice action, settlement(s) of professional claim(s) been paid by or on your behalf or do you currently have a case(s) pending? | | | |
| | **B. Faculty or Provider requesting re-credentialing:**<br>Have you been named as a party in a malpractice action in which the date of incident or settlement tookplace withinthe last ten (10) years, settlement(s) of professional claim(s) been paid by or on your behalf or do you currently have a case(s) pending? | | | |
| 11. | Has your malpracticeinsurance everbeencancelled, suspended, not renewed, restricted, or special rated? | | | |
| 12. | Have you ever had anyfelonyconviction under Federal or Statelaw, regardless of whether it was health care related? | | | |

Yale Medicine

Credentialing/Re-Credentialing Application

Name: _____ _____
Last First MI (Maiden)

Department: _____ Section Name: _____

| | | | | |
|---|---|---|---|---|
| 13. | Have you ever had any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an itemor service under Medicare or a State health careprogram, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? | | | |
| 14. | Have you ever had any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? | | | |
| 15. | Have you ever had any misdemeanor conviction, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in 42C.F.R. Section 1001.202 or 1001.201? | | | |
| 16. | Have you ever had any misdemeanor conviction under Federal or State law, related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? | | | |
| 17. | Are your currently engaged in the illegal use of drugs? | | | |
| 18. | Have you ever been treated for alcoholism or narcotics addiction? | | | |
| 19. | Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of payment practice standards? | | | |
| 20. | Do you have any physical, mental, or addictive problems with or without accommodation that may interfere with your ability to carry out the duties and responsibilities of your profession? | | | |
| 21. | Have you ever been refusedparticipation in, been disenrolled or voluntarilyresigned from any IPA, HMO, PPO, and /or any other managed care organization? | | | |
| 22. | Have you ever been the subject of investigation by any peer review Committee? | | | |
| 23. | Are, or were, you a Medicaid provider in any other state? If yes, complete below. State/Date:_____State/Date:_____State/Date: _____ | | | |
| 24. | Are, or were, you a provider of any other Federal program? If yes, complete below: Name of Program:_____ Name of Program: _____ | | | |
| 25. | **FOR PCPs ONLY**<br>a. Do you adhere to the principlesof Ethics of the American Medical Association, the American Osteopathic Associationor other appropriate professional organization? | | | |
| | b. Do you performor directly supervise the ambulatory primary care services of Members? | | | |
| | c. Do you participate in CME in accordance with theconditions of your Connecticut Physician licensure? | | | |
| | d. Do you assure that any Advance Practice Registered Nurses (APRN), Nurse Midwives or Physician Assistants are performing within the scope of their licensure? | | | |

**CLAIM/SUIT REPORT FORM**
**(If not applicable, indicate "N/A" or "NONE")**

**New Faculty or Provider:** Please complete a form for each claim/suit.

**Faculty or Provider requesting re-credentialing:** Please complete a form for each claim/suit in which the date of incident took place within the past ten (10) years.

All applicable sections **must** be completed in order for your application for credentialing/re-credentialing to be processed. Please contact the **Yale Risk Management Office at 203.688.2291** to obtain further details of a case.

**TYPE OF ACTION**
☐ Suit ☐ Notice of Claim from Attorney or Patient/Guardian

**CURRENT STATUS**
☐ Pending ☐ Settled ☐ Plaintiff Verdict ☐ Defendant Verdict ☐ Withdrawn with No Payment

**If settled or Plaintiff Verdict:**
Date of Settlement/Judgement:_____ Amount of Settlement/Judgement: _____

**CHRONOLOGY**
Dates of Treatment: From:_____ To: _____

Dates of Occurrence: From:_____ Date: Claim/Suit Received: _____

**LEGAL REPRESENTATION**
Plaintiff Attorney:_____ Your Attorney: _____
Your Insurance Carrier: _____

**STANDING IN CASE**
☐ Sole Defendant
☐ Primary defendant – Total Number of Co-Defendants _____
☐ Co-Defendant – Total Number of Defendants _____

**LEVEL OF INVOLVMENT**
☐ Attending Physician ☐ Consulting Physician ☐ Resident ☐ Chief Resident ☐ Other

**Case History:**_____

**Malpractice Alleged:** _____

**Damages Alleged:**_____

**Comments:** _____

**STATE OF CONNECTICUT**
**DEPARTMENT OF PUBLIC HEALTH**

## CONSENT FOR RELEASE OF CONFIDENTIAL DISCIPLINARY RECORDS

This is to certify that I hereby give myconsent and authorize the Department of Public Health to confirmthe existence of any pendingpetitions to release anyrecordsof disciplinaryaction maintained by that Department (with the exception of any documents I have identified below) to:

**SEND VERIFICATION TO:**

Richard A. Martinello MD
Yale University - Yale Medicine
50 Division Street
New Haven, CT 06519

I understand that these records areconfidential pursuant to the provisions of Connecticut General Statues §20-13e and may not be disclosed without my permission. This information will only be disclosed whenthis release is executedby me. I also understand that if I am a participant in a rehabilitation programsponsored bya county Medical Association or by the Connecticut State Medical Society that I have the right to contact the Association or Society prior to signing this release. Please honor a mechanically reproduced copy of this release.

**Documents the Department is not authorized to release include:**

Signature:_____Date: _____

Name – Printed or Typed: _____

CT Physician License Number _____

**THIS RELEASE FORM IS FOR USE BY PHYSICIANS/SURGEONS ONLY AND EXPIRES ONE YEAR FROM THE DATE SIGNED BY THE PHYSICIAN.**

Revised 2/2020

## Authorization and Release of Information

I authorize **Yale Medicine**, its agents and employees to request and obtain information deemed relevant to my professional credentialsandqualificationsfrom anyhospital, healthcare facility, professional liability carrier, managed care organization, medical school, medical associationor society, organization or entity, or other person. Specifically included in this authorization to obtain information, but not by wayof limitation, is information regarding my quality of care and professional competence fromthe chiefsof theclinical departments of Yale School of Medicine, hospital in which I have staff privileges, professional state boards or applicable state and federal agencies, even if otherwise privileged and confidential.

I consent to the release to **Yale Medicine**, its agents and employees, any information deemed relevant to my professional credentials and qualifications from any hospital, healthcare facility, professional liability carrier, managed care organization, medical school, medical associationor society, organization, or entity, or other person for the purpose of evaluatingthis application, re-application, and/or continuedparticipationwith **Yale Medicine**. Thisrelease is granted with the understanding the **Yale Medicine**, its agents and employees will take responsible measure to maintain the confidentially of this information.

I consent to therelease by **Yale Medicine**, its agents and employees, any information related to, or arising out of, or impacting upon my practice of medicine to any person, entity, or governmental agency which (A) provides **Yale Medicine** with an authorization signed by me; or (B) has a legal right to know under any state or federal law. I agree to hold **Yale Medicine**, itsagentsand employeesharmless fromany liabilityfor providing such information as specified herein.

I understand and agree that these authorizations and releases shall remain in force for so long as this application is pending, and, if acceptedfor participation, for solongas I remain an active **Yale Medicine** faculty member or provider. In addition, I understand and agree that I have the burden of producing all information required or requested by **Yale Medicine**, its agents and employees, in connection with this application. **Yale Medicine** is under no obligation to complete the processing of this application until such information is provided by me.

I hereby affirmand represent that all statements and informationcontained in this application are correct andcomplete to the best of my knowledge and belief. I agree to inform **Yale Medicine** of any change in the information provided in this application. I understand I have the right to, upon written request: (1) review any information collected as part of my application, unless affordedconfidentialityunder stateor federal law, (2) correct erroneousinformationobtained byother sources, (3) request the status of my application. I understandthat false or misleadinginformation or the withholding of information deemed relevant by **Yale Medicine** will disqualify me from consideration as a **Yale Medicine** faculty member or provider.

**Provider:** _____
(Please print)

**Signature:** _____

**Date:** _____

**Yale University School of Medicine**

***Certification Regarding***

***Appropriate Use of Electronic Signatures***

Patient medical records, services, andother clinical information that are documented, reviewed, approvedandmaintained in an electronicformat are authenticatedthrough the useof an electronic signature, which is an electronic sound, symbol, or process logically associated with an entrythat is executedby an individual with theintent to sign the record. Each user of an electronic signature is assigned a unique codecomprised of a user identification code and password. The Unique code is critical to safeguarding the User's electronic signature.

- I understand that myelectronicsignature is the legally bindingequivalent of mytraditional handwritten signature.
- I agree to exercise appropriate safeguards to ensurethe security and integrityof my unique code, including compliancewith organization policiesand procedures related to securepasswordselectionand rotation, and preventing and reporting unauthorized medical record access using my identity.
- I further agree that will not share or release myuser identificationcode or password to any other individual, or allow them to access or alter electronic medical information using my identity.
- I also understand that activities on electronic medical records systems are recorded and logged for audit trail and systemrecoverypurposes, and may be reviewed byauthorized officials asrequired for system security or statutory compliance purposes.

I hereby certify that I have read, understand and agree to the statements and requirements set forth above.

_____ _____

***Signature*** ***Date***

_____

***Printed Name***