KAISER PERMANENTE®

As a health care organization that maintains a coordinated quality improvement program under applicable state laws, Kaiser Foundation Health Plan of Washington reviews the credentials and competence of practitioners who provide care to health plan members enrolled with the various Kaiser Permanente affiliated entities, including Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. **In order to expedite the credentialing process the attached application and forms must be signed and completed in their entirety.** The credentialing process must be successfully completed prior to providing care to health plan members. Please return the completed application with a copy of the following documents (if applicable) within 10 working days of receipt.

- ☐ Copy of current malpractice liability insurance face sheet.
- ☐ Curriculum Vitae with work history in a month/year format.
- ☐ Submit three professional peer references in your same discipline/specialty who can attest to clinical expertise within the past three years. Non-board certified physicians must provide at least two board certified physician references. No more than one reference may be a current business/professional partner. Please provide contact information including email addresses.
- ☐ Copy of Drug Enforcement Administration (DEA) certificate, if applicable.
- ☐ Non-board certified physicians must provide documentation in the form of a certificate or record from a professional organization of 200 hours of Continuing Medical Education (CME) for the past four years. Podiatric physicians must submit 75 hours of CME for the past three years. At least 50% of the CME's must be Category I and in the specialty or subspecialty in which the physician will be employed or contracted. Please also note that physicians must have successfully completed an ACGME, AOA, RCPSC, or CFPC approved residency in the specialty or subspecialty in which the physician will be employed or contracted.

Practitioners have the right to correct erroneous information as well as review information (excluding references, or recommendations or other information that is peer review protected) obtained to evaluate their credentialing application. At any time during the process, practitioners have the right to receive the status of their application upon request. You will be notified of the credentialing decision within 10 days of the Credentialing Committee's determination.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- Please sign and date pages 11 and 13 .
- Please document any YES responses on the Attestation Question page.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:	City:		
	State:	Zip Code:	
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	☐ Male ☐ Female	Languages Fluently Spoken by Practitioner:	
Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty primarily practicing:	Sub specialties primarily practicing:		
Other Professional Interests in Practice, Research, etc.:			

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

3. PRACTICE INFORMATION **CHECK ALL THAT APPLY**

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting

☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile

☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		
Is the office wheelchair accessible? ☐Yes ☐No	Office Hours		
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: _____ _____ Please list languages fluently spoken by office staff: _____ _____	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours: _____ _____		

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Effective Date at Secondary Practice location (MM/YY) _____ **CHECK ALL THAT APPLY**

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____
Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____
Please list languages fluently spoken by office staff:
_____
_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday:_____
Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____
_____

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS
(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (*Do not abbreviate*) **Does Not Apply** ☐

:School/College/University/Vocational Education:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

8. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION **Does Not Apply** ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

11. FELLOWSHIPS (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)				**Does Not Apply** ☐
Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Training:		Department Chairman:	

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)			**Does Not Apply** ☐
Institution:	Address:	City:	State: Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address	
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Position:	Faculty Director:	

14. BOARD CERTIFICATION				**Does Not Apply** ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date:

If you participate in a specialty which does not have board certification, please indicate specialty:

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILITATIONS	**Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)	
Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ **Primary practice admits only** ☐ **Secondary Practice admits only** ☐ **can admit to for all locations**	
Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date (mm/yyyy):
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all location**s**	

Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date (mm/yyyy):

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations

B….PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

E. APPLICATIONS IN PROCESS (*Do not abbreviate*)			
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted(mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

17. WORK HISTORY (*Do not abbreviate*

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

18. GAPS IN HISTORY Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency or fellowship for a period of less then three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began mm/yyyy):	Expiration Date (mm/yyyy):

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)
(Attach Additional Sheet if Necessary)

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date_____

Type or Print name here_____

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	**Does Not Apply** ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

_____

_____

_____

_____

_____

_____

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

KAISER PERMANENTE®

AGREEMENT AUTHORIZING OBTAINING AND RELEASE OF INFORMATION; LIABILITY WAIVER

This agreement allows for the collection of information to evaluate my eligibility for initial credentialing/appointment or recredentialing/ reappointment to Kaiser Foundation of Washington Health Plan or employment with Washington Permanente Medical Group (collectively, "credentialing/employment"). Should I be credentialed with the Health Plan and/or employed by Washington Permanente Medical Group, this authorization will be used to obtain information for ongoing evaluation, annual performance evaluation, and periodic reappointment. A photocopy of this agreement is as valid as the original.

I acknowledge that I have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications and for resolving any questions about such qualifications.

I UNDERSTAND THAT MISSTATEMENTS IN, OR OMISSIONS FROM, THIS APPLICATION MAY BE CAUSE FOR DENIAL OF CREDENTIALS/APPOINTMENT OR RECREDENTIALS/REAPPOINTMENT OR CAUSE FOR SUMMARY DISMISSAL FROM KAISER FOUNDATION HEALTH PLAN OF WASHINGTON AND/OR WASHINGTON PERMANENTE MEDICAL GROUP. I understand that in making the above request(s) I am bound by applicable Washington Permanente Medical Group Bylaws and/or Kaiser Foundation of Washington Health Plan Policies and Procedures, by any other applicable Policies and Procedures and, throughout my appointment/employment agree to abide by all such requirements, as they may be modified from time to time. Further, I will comply with Kaiser Foundation of Washington Health Plan's HIPAA privacy practices as set forth in applicable policies and in the *Notice of Privacy Practices*.

Authorization to Obtain and/or Release Information

I authorize Kaiser Foundation of Washington Health Plan/Washington Permanente Medical Group, their agents and employees, to contact references named in my application, including individuals and institutions with which I have been associated, to obtain information and to receive and review all pertinent records and documents regarding my: professional competence and conduct; ability to deliver high-quality care safely and efficiently; character; ethical qualifications; ability to work cooperatively with others; and professional liability claims history. Such information may be requested as part of initial credentialing/ appointment, recredentialing/reappointment, or ongoing evaluation. I further authorize Kaiser Foundation of Washington Health Plan/Washington Permanente Medical Group, their agents and employees, to discuss with my current and prior insurers and legal counsel my professional liability insurance and my professional liability claims history, if any.

I authorize Kaiser Foundation of Washington Health Plan/Washington Permanente Medical Group, their agents and employees, to release to health care institutions or government agencies such information as may be permitted or required by law to be disclosed concerning my professional competence and conduct, and other professional qualifications. This authorization will remain in effect until it is revoked in writing by me and the revocation is received by the Kaiser Foundation of Washington Health Plan Credentialing Department.

I agree to permit the Health Plan to perform an Office Environmental Assessment and/or Medical Record Review, as deemed necessary by Kaiser Foundation of Washington Health Plan. I agree to provide or arrange for the continuous care of my patients.

I certify that I have met all Washington State licensure requirements for continuing education in the field of my specialty, and will furnish confirming documentation upon request from Kaiser Foundation of Washington Health Plan/Washington Permanente Medical Group.

I acknowledge that a criminal background inquiry will be made through the Washington State Patrol Criminal Identification System regarding any criminal convictions or other legally mandated offenses, civil adjudication proceedings related to child or Vulnerable Adult abuse or neglect, and other information as authorized by the Child and Adult Abuse Information Act, RCW 43.43.830 - 43.43.845. I understand that I may obtain, upon request to Kaiser Foundation of Washington Health Plan, a copy of the response to such criminal background inquiry.

Liability Waiver

I hereby waive any and all liability claims, to the maximum extent permitted by law, that could be asserted against Kaiser Foundation of Washington Health Plan and their respective agents and employees, in connection with evaluating my application for credentials/appointment, for recredentialing/reappointment, or for privileges, as applicable. I further waive any and all liability claims, to the maximum extent permitted by law, that could be asserted against individuals and organizations that provide information to Kaiser Foundation of Washington Health Plan concerning my professional competence and conduct, and other professional qualifications. I agree that this Liability Waiver section shall survive termination or revocation of any other portions of this agreement.

Attestation

By my signature below, I attest to the accuracy and completeness of the information contained in this application and agree to promptly notify Kaiser Foundation of Washington Health Plan/Washington Permanente Medical Group of any changes to information provided herein.

Signature _____ Date _____

Printed Name _____

KAISER PERMANENTE®

KAISER FOUNDATION HEALTH PLAN OF WASHINGTON DISCLOSURE FORM

Washington State law mandates that certain organizations solicit information from individuals who will or may have unsupervised access to children or to vulnerable adults. Accordingly, the Kaiser Foundation Health Plan of Washington credentialing process requires applicants to furnish the following information:

1. Have you ever been convicted of a "crime against children or other persons" as defined below?

   A "crime against children or other persons" includes the following:

   " 'Crime against children or other persons' means a conviction of any of the following offenses: Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, or third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promoting prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; endangerment with a controlled substance; child abuse or neglect as defined in RCW 26.44.020; first or second degree custodial interference; first or second degree custodial sexual misconduct; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; commercial sexual abuse of a minor; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they may be renamed in the future." [RCW 43.43.830(7).]

   Yes ☐ No ☐

2. Have you ever had finding made against you in any "civil adjudication proceeding" as that term is defined below?:

   " 'Civil adjudication proceeding' is a judicial or administrative adjudicative proceeding that results in a finding of, or upholds an agency finding of, domestic violence, abuse, sexual abuse, neglect, abandonment, violation of a professional licensing standard regarding a child or vulnerable adult, or exploitation or financial exploitation of a child or vulnerable adult under any provision of law, including but not limited to chapter 13.34, 26.44, or 74.34 RCW, or rules adopted under chapters 18.51 and 74.42 RCW. "Civil adjudication proceeding" also includes judicial or administrative findings that become final due to the failure of the alleged perpetrator to timely exercise a legal right to administratively challenge such findings." [RCW 43.43.830(4).]

   Yes ☐ No ☐

I certify under penalty of perjury under the laws of the State of Washington that the answers to the foregoing questions are true and correct.

_____ _____

Signature Date

_____

Printed Name