**Tips for submitting a complete RPN Professional Staff Credentialing Application**

**Attach the following documentation to each application**

Copy of current professional License for the state in which applicant is practicing.
Copy of current professional liability coverage.
Copy of current general liability coverage.
Copy of current resume'. (All Dates must be in mm/yyyy or mm/dd/yyyy format.)

**General guidelines**

-All Dates must be in month/year format.

-All sections of the application must be completed with requested information; "See Resume" is not an acceptable response.

-Do not leave any sections blank, respond "N/A" if appropriate.

-Any work gaps of more than 90 days must be explained in an attached signed and dated statement.

-When providing work history on the application, please use a separate piece of paper if applicant's work history exceeds the space provided.

Rehab Provider Network

APPLICANT RIGHTS
(Retain these Applicant Rights for future reference)

**1. Information Discrepancies**

Should information be received during the primary source verification process, which differs from that received from you, you will be notified by phone or letter and given an opportunity to clarify or correct the information. Clarifications are to be submitted to RPN within 30 days of notification of a discrepancy. Your written response will be entered into the credentials file to clarify discrepancies.

Note: In the event, the information received is a report from the NPDB, you will be given the NPDB Help Line phone Number to obtain a copy of the report. Copies of the NPDB will NOT be made available to you by RPN.

2. **Review of Documentation Collected**

If at any point during the credentialing process, you wish to review any of the documentation collected in support of your credential review as well as request copies of credentials and recredentials policies, this request will be granted upon receipt of written request.

Internal memos, NPDB reports and work product are protected as peer review documentation and are not included.

**3. Status of your Credentials Application**

Requests for status of a credentials application will be granted upon receipt of a verbal or written request.

Rehab Provider Network

# *Professional Staff Application Form*

*The information requested on this form is required to certify your status as a licensed health care provider. Please complete all questions. We are not able to accept "See attached CV" in lieu of a completed application. All requested information must be completed on the application form. Please note that all information will be verified with originating organization, including State Licensing Agency and National Practitioner Databank. The provider signature attests to the document's accuracy.* ***Please attach a copy of your license renewal card, certification(s), curriculum vitae (CV) and professional & general (building) liability insurance forms.***

## *PERSONAL INFORMATION*

**Last Name** _____ **First Name** _____ **MI** _____

**Date of Birth** _____ **Gender** _____ **Specialty** ☐ **PT** ☐ **OT** ☐ **SLP**

**SS#** _____ **NPI:**_____ ☐ **Other** _____

## *PRIMARY WORK SITE INFORMATION*

**Facility Name**_____ **Facility Tax ID #**_____

**Street Address**_____ **City** _____ **State** _____ **Zip Code**_____

**Telephone** _____ **Fax**_____ **E-mail**_____

## *ADDITIONAL WORK SITE INFORMATION*

**Facility Name**_____ **Facility Tax ID #** _____

**Street Address**_____ **City** _____ **State** _____ **Zip Code**_____

**Telephone** _____ **Fax**_____ **E-mail**_____

## *PROFESSIONAL WORK HISTORY*

**List all professional work activities since licensure/certification. (Attach additional sheets if necessary)**

Employer Position City/State Phone # Date (MM/YY)

1. _____
2. _____
3. _____
4. _____

## *PROFESSIONAL LICENSES & CERTIFICATIONS*

**List all active professional licenses or certifications.**

**PLEASE ATTACH A COPY OF ALL LICENSES & CERTIFICATES**

**LICENSES**

| | License Number | State | Specialty | Expiration Date (MM/YY) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**CERTIFICATIONS**

| | Certificate Number | State | Specialty | Expiration Date (MM/YY) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## *EDUCATION*

**List all Undergraduate, Graduate and Additional Certifications/Specialty Training. Do not write "see attached CV". PLEASE ATTACH A COPY OF THE HIGHEST DEGREE AWARDED**

**UNDERGRADUATE**

| | Institution | City/State | Dates (MM/YY) | Degree |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

**GRADUATE**

| | Institution | City/State | Dates (MM/YY) | Degree |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**ADDITIONAL CERTIFICATIONS/ SPECIALTY TRAINING**

| | Institution | City/State | Dates (MM/YY) | Degree |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

4. _____

## *ACADEMIC APPOINTMENTS*

**Please list all teaching/university positions held to date. (Attach additional sheets if necessary)**

| | Institution | Position | City/State | Dates (MM/YY) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## *PROFESSIONAL AFFILIATIONS & MEMBERSHIPS*

**Please list all professional societies in which you are a member. (Attach additional sheets if necessary)**

| | Organization | Position | City/State | Dates (MM/YY) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## *PROFESSIONAL LIABILITY INSURANCE*

**PLEASE COMPLETE THIS INFORMATION FOR YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE.**

CARRIER NAME: _____ POLICY NUMBER: _____

IS THIS A POLICY INCLUDING ALL PROFESSIONAL AND SUPPORT STAFF? ☐ YES ☐ NO

COVERAGE SCOPE: _____ COPY ATTACHED: ☐ YES ☐ NO

AMOUNT AGGREGATE: _____ AMOUNT PER OCCURRENCE: _____

EFFECTIVE DATE: _____ RENEWAL DATE: _____

## *PROFESSIONAL COMPETENCE & LIABILITY INFORMATION*

*Please answer the following questions by circling **Y** or **N** as your response. Should you answer **Y (YES)** to any of the questions below, you must provide a detailed explanation with dates, circumstances and outcomes on the attached form titled **"Professional Liability Details"**.*

**Y or N** ☐ ☐ 1. Has any government agency ever investigated, suspended, stayed in action, imposed payment of a fine, reprimanded, censured, required non-routine training or monitoring, placed on probation, revoked, placed a condition or conditions, limit or limitation upon, or taken any adverse action of any kind against any professional license, certification or registration that you currently or have ever held?

**Y or N** ☐ ☐ 2. Are you currently under investigation by any government agency, hospital, health maintenance organization, group practice, provider network, facility, or any other health care organization for any matter?

**Y or N** ☐ ☐ 3. Have you ever surrendered your professional license to a regulatory agency, such as, but not limited to, professional licensing agencies, or any other governmental agency?

**Y or N** ☐ ☐ 4. Has any government agency ever denied your application for any professional license, certification or registration?

**Y or N** ☐ ☐ 5. Have you ever been expelled, suspended or subject to any other disciplinary action in connection with Medicare, Medicaid, or any other governmental program?

**Y or N** ☐ ☐ 6. Have you ever had a matter referred to a peer review, disciplinary or credentialing committee of a hospital, health maintenance organization, group practice, provider network, facility, licensing authority , or any other health care organization?

**Y or N** ☐ ☐ 7. Have you ever been denied membership or renewal thereof, or been subject to any disciplinary action by any professional organization?

**Y or N** ☐ ☐ 8. Have you ever been arrested, indicted, convicted, or pled guilty to a criminal offense?

**Y or N** ☐ ☐ 9. Do you currently use unlawful drugs?

**Y or N** ☐ ☐ 10. Has your professional clinical practice ever been impaired or limited by the use of chemical substances, including alcohol, drugs and medications?

**Y or N** ☐ ☐ 11. Is your professional clinical practice adversely impacted by any factor?

**Y or N** ☐ ☐ 12. Are your currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not abusing or illegally using controlled dangerous substances?

**Y or N** ☐ ☐ 13. Do you have a medical condition (i.e., physiological or psychological condition or disorder) which in any way impairs your professional clinical practice with all due care and appropriate and reasonable skill and safety? **If "Y" please answer questions "13a" and "13b"**

**Y or N** ☐ ☐ 13a. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

**Y or N** ☐ ☐ 13b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participated in a monitoring program?

## *PROFESSIONAL COMPETENCE & LIABILITY INFORMATION* *continued*

| Y or N | |
|---|---|
| ☐ ☐ | 14. Have you ever been the subject of an administrative, civil, or criminal complaint or investigations regarding sexual misconduct or child abuse? |
| ☐ ☐ | 15. Have you had any gaps in your professional work history? |
| ☐ ☐ | 16. Has any judgment ever been entered against you in a professional liability case? |
| ☐ ☐ | 17. Have you ever been involved in a professional liability matter that has been settled partially or wholly in favor of an adverse party? |
| ☐ ☐ | 18. Is any formal or informal professional liability claim or lawsuit now pending against you? |
| ☐ ☐ | 19. Have you ever been assessed an individual surcharge based upon your specific claims history by any malpractice carrier? |
| ☐ ☐ | 20. Have you ever been denied malpractice coverage? |

## *CERTIFICATION & RELEASE*

All the information submitted in this application is true and complete. I understand that misleading statements or material omissions may constitute cause to reject this application, or if subsequently discovered, to terminate my contract with Rehab Provider Network.

I release from liability all representatives of Rehab Provider Network, any corporate affiliate of such corporation, and all officers, directors, employees, agents and representatives for their acts performed in good faith and without malice in connection with evaluating the information provided in this Credential Application & Enrollment Form, my credentials and qualifications, and with delivering such information, credentials and qualifications to any third party in the course of business. I release from any liability any individuals or organizations who provide information for verification of this Application in good faith and without malice concerning my professional competence, ethics, character and other suspensions, curtailment of privileges by any hospital, or other healthcare provider and by any federal or state licensing or regulatory authority. I further consent to the release of professional liability, malpractice, or other insurance information to Rehab Provider Network.

**Signature** _____ **Date** _____

**Printed Name** _____ **Title** _____

## *CONFIDENTIALITY AGREEMENT*

**In the course of your contract with Rehab Provider Network Rehabilitation, A Division of Select Medical Corporation. or its subsidiaries or affiliates Rehab Provider Network will identify clients, which may include individuals, hospitals, nursing homes or other facilities that require clinical services. Clinical services may include speech/language pathology, physical therapy and/or occupational therapy. While you are contracted with Rehab Provider Network, you will gain close contact with clients of Rehab Provider Network.**

In consideration of your contract with Rehab Provider Network, you agree that, during the course of the contract and thereafter, you will not disclose to anyone not employed by Rehab Provider Network any confidential information concerning the business of Rehab Provider Network. For purposes of this Agreement, confidential information includes, but is not limited to:

- Name and address of clients or employees of Rehab Provider Network,
- Information concerning the marketing of clinical services by Rehab Provider Network,
- Manuals and training materials provided by Rehab Provider Network,
- Financial, planning or new business development information or materials of Rehab Provider Network.

This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, without giving effect to the principles of conflicts of law under Pennsylvania law. This Agreement shall be deemed to be made in the Commonwealth of Pennsylvania, where the execution of this Agreement by Rehab Provider Network will be finally approved. You recognize that Rehab Provider Network employs various people throughout the country, and that it is within the legitimate interest of Rehab Provider Network to have agreements construed in a uniform fashion under the laws of Pennsylvania, where Rehab Provider Network is headquartered. You agree that the federal and state courts in Pennsylvania have jurisdiction over you with respect to any litigation arising out of or relating to this agreement.

You acknowledge that you have read this Agreement in its entirety, that you have entered into it voluntarily, with full knowledge of its significance, meaning and binding effect, and that you intend to be legally bound by this Agreement.

**Signature** _____ **Date** _____

**Printed Name** _____ **Title** _____

## *PROFESSIONAL LIABILITY DETAILS*

If you answered "Y" (YES) to any of the questions on the **"Professional Competence & Liability Information"** section, you must provide the following information. (Attach additional sheets if necessary)

In Reference to Question Number _____ Occurrence Date _____

Provider Entity _____

Insurance Carrier _____

Provide detail factual description of the case giving rise to litigation, suspicion.

_____
_____
_____
_____
_____
_____

Provide a detail, factual description of your role in the case (explain in detail).

_____
_____
_____
_____
_____
_____

What is/was your specific involvement with the care of the patient?

_____
_____
_____
_____
_____

| | **Last Name** | **First Name** |
|---|---|---|
| Primary Defendant | _____ | _____ |
| Co-Defendant | _____ | _____ |
| Other: | _____ | _____ |

Specify any subsequent actions which have been or may be taken.

_____

What is the current status of the dispute?

_____

What is/was the outcome of the patient?

_____

The dollar amount reserved (or paid) by your carrier for this claim? $_____