Regence

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

**Regence BlueShield of Idaho Practitioner Credentialing Application**

Regence contracts with physicians, dentists and other health care professionals to form provider networks essential for the delivery of health care services to our members. Regence requires all providers to meet credentialing criteria prior to contracting and remain in compliance with those criteria at all times. Please refer to the *Practitioner Credentialing Criteria for Participation and Termination* for details.

You will receive an email confirmation once you have successfully completed credentialing. You will receive another email when your agreement documents are available for viewing and signature.

**NOTE:** If you practice at a clinic that has a Regence *Participating Medical Group Agreement*, you will be added to the group's agreement and you do not need to sign any additional documents.

To begin the credentialing verification process, please:

1. Provide the email address and name of the individual who is responsible for reviewing and electronically signing the agreement documents:

| **All agreement documents are sent electronically.** Please provide the following information to receive your documents electronically. Not completing this portion will delay processing of your documents. | |
|---|---|
| First Name: | |
| Last Name: | |
| Email: | Email address |

2. Complete the application online in its entirety and print it.
3. Attach a copy of your CP 575 or 147C letter, obtained from the Internal Revenue Service (IRS). If you do not have a 147C letter, please contact the IRS at 1 (800) 829-4933.
4. Sign pages 9, 10 and 11 and return them along with any supporting documentation to Regence via one of the following methods:
    a. Email: Sign and scan pages 9, 10 and 11. Attach the signed, scanned pages and supporting documentation to an email and send to **regence_credentialing@regence.com**. Your email should include the completed application, a copy of your CP 575 or 147C letter, pages 9, 10 and 11 which have been signed, and supporting documentation.
    b. Fax: Print your completed application. Sign pages 9, 10 and 11 and fax the entire application along with a copy of your CP 575 or 147C letter and any supporting documentation to 1 (888) 335-3002.
5. Retain the printed application for your records.

You have the right to review information submitted to support your credentialing application, including review of information submitted from outside sources, e.g., malpractice insurance and state licensing boards. You may also request information about the status of your application or reapplication. All requests should be submitted to our Credentialing department by email at **regence_credentialing@regence.com**. Application status requests are responded to and tracked in the provider's credentialing file. Information that is allowed to be shared includes the current status, outstanding requests and process timeframes. Peer-protected and confidential information prohibited by law cannot be disclosed.

In the event that erroneous or conflicting information is discovered in a credentialing application, you will be notified in writing of the right to dispute and/or correct the information (subject to any restrictions provided by a verification source, or otherwise prohibited by law). You must submit a detailed explanation of all clarifications and corrections in writing, within fifteen (15) business days of the request, to the Credentialing department via email or by fax at 1 (888) 335-3002. The credentialing staff documents receipt of corrected credentialing information in your credentialing file.

To learn more about the credentialing process and eContracting, visit the Contracting and credentialing section of our provider website at **regence.com.** If you have questions about the process or the status of your application, please contact our Credentialing department by email at **regence_credentialing@regence.com**.

# Idaho Practitioner Credentials Verification Application

**To use the Idaho Practitioner Application (IPA), follow these instructions**

- Complete the application in its entirety using black or blue ink. **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 9 and 11. Please document any YES responses on the Attestation Question page.
- Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. 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 IPA.

| This application is submitted to |
|---|
| |

## I. Instructions

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, 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). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ Idaho address
- ECFMG (if applicable)
- ISBP Certificate
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

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

## II. Practitioner Information

| Last name (include suffix; Jr., Sr., III) | First (do not abbreviate) | Middle (do not abbreviate) | |
|---|---|---|---|
| Other name(s) under which you have been known by reference, licensing and or educational institutions? | | Degree(s) | |
| Home telephone number | Pager number | Cell number | E-mail address |
| Home mailing address | City | State | Zip code |
| Birth date | Birth place (city, state, country) | Social security number | Citizenship |
| Languages spoken by practitioner | Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist | | Gender ☐ Male ☐ Female |
| NPI | Medicare UPIN | Medicare number (ID) | Medicaid number(s) |
| Other professional interests in practice, research, etc. | Taxonomy (10-digit code identifying specialty or subspecialty) | | Subspecialties |

## III. Practice Information

**Effective Date at Primary Practice location** _____

| Name of practice, affiliation or clinic name | | Department name (if hospital based) | |
|---|---|---|---|
| Primary office street address | City | State | Zip code |
| Patient appointment telephone number | Fax number | Name affiliated with tax ID number | Federal tax ID number |
| Mailing address (if different from above) | City | State | Zip code |

## III. Practice Information (Continued)

| Billing address (if different from above) | City | State | Zip code |
|---|---|---|---|
| Office manager / Administrator name | Administration telephone number | Fax number | E-mail address |
| Credentialing contact (if different from above) | Credentialing telephone number | Fax number | E-mail address |

**Effective Date at Secondary Practice location** _____

| Name of secondary practice, affiliation or clinic name | | Department name (if hospital based) | |
|---|---|---|---|
| Secondary office street address | City | State | Zip code |
| Patient appointment telephone number | Fax number | Name affiliated with tax ID number | Federal tax ID number |
| Mailing address (if different from above) | City | State | Zip code |
| Billing address (if different from above) | City | State | Zip code |
| Office manager / Administrator name | Administration telephone number | Fax number | E-mail address |
| Credentialing contact (if different from above) | Credentialing telephone number | Fax number | E-mail address |

**List other office locations with above information on a separate sheet.**

## IV. Professional Licensure

| Idaho State professional license/registration/certificate number | | Status ☐ Active ☐ Inactive ☐ Temporary |
|---|---|---|
| Issue date | Expiration date | **Name of sponsor if required by licensure, (i.e. Physician's Assistant).** |
| Drug Enforcement Administration (DEA) registration number | Issue date | Expiration date |
| State controlled substance certificate number | Issue date | Expiration date |
| ECFMG number (applicable to foreign medical graduates) | | Date issued |

## V. All Other Professional Licenses

| State | License/registration/certificate number | Date issued |
|---|---|---|
| Expiration date | Year relinquished | Reason |
| State | License/registration/certificate number | Date issued |
| Expiration date | Year relinquished | Reason |
| State | License/registration/certificate number | Date issued |
| Expiration date | Year relinquished | Reason |

## VI. Undergraduate Education

| Name of college or university | | | **Does Not Apply** ☐ |
|---|---|---|---|
| Degree received | Graduation date | | |
| Mailing address | City | State | Zip code |
| Name of college or university | | | |
| Degree received | Graduation date | | |
| Mailing address | City | State | Zip code |



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

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## VII. Medical/Professional Education

| | | | | |
|---|---|---|---|---|
| Medical/Professional school | | | | |
| Start date | Graduation date | Degree received | | |
| Mailing address | | City | State | Zip code |
| | | Phone | Fax | |
| Medical/Professional School | | | | |
| Start date | Graduation date | Degree received | | |
| Mailing address | | City | State | Zip code |
| | | Phone | Fax | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## VIII. Graduate Education

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program or course of study | Faculty director | | |
| Mailing address | City | State | Zip code |
| Dates attended | Phone | Fax | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## IX. Internship/PGYI

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of internship | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## X. Residencies

| | | | |
|---|---|---|---|
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of residency | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |
| Institution **Does Not Apply** ☐ | | | |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date / Completion date | Phone | Fax | |
| Type of residency | Specialty | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |



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(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XI. FELLOWSHIPS

| | | | |
|---|---|---|---|
| Institution | | | **Does Not Apply** ☐ |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date | Completion date | Phone | Fax |
| Course of study | | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |
| Institution | | | **Does Not Apply** ☐ |
| Program director | | | |
| Mailing address | City | State | Zip code |
| Start date | Completion date | Phone | Fax |
| Course of study | | | |
| Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.) | | | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XII. PRECEPTORSHIP

| | | | |
|---|---|---|---|
| Institution | | | **Does Not Apply** ☐ |
| Department chairman | | | |
| Mailing address | City | State | Zip code |
| Start date | Completion date | Phone | Fax |
| Training | | | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XIII. FACULTY APPOINTMENT

| | | | |
|---|---|---|---|
| Institution | | | **Does Not Apply** ☐ |
| Faculty director | | | |
| Mailing address | City | State | Zip code |
| Start date | Completion date | Phone | Fax |
| Position | | | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XIV. BOARD CERTIFICATION

**Are you board or otherwise professionally certified?** **Does Not Apply** ☐

☐ **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 | 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



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(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XV. Other Certifications

| ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable) | | Does Not Apply ☐ |
|---|---|---|
| Type | Number | Expiration date |
| Type | Number | Expiration date |
| Type | Number | Expiration date |
| Type | Number | Expiration date |

## XVI. Hospital and Other Institutional Affiliations

**Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. 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.

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

### A. Current Affiliations

| | | | |
|---|---|---|---|
| Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)** | | | |
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |
| Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)** | | | |
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |
| Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)** | | | |
| Department | Department / Clinical Chair | Status (active, provisional, courtesy, temporary, etc.) | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Appointment date | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

### B. Applications In Process

| | | | |
|---|---|---|---|
| Hospital/Institution | | | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Date application submitted | |
| Hospital/Institution | | | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Date application submitted | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## C. Previous Affiliations

| | | | |
|---|---|---|---|
| Name of facility | | | **Does Not Apply** ☐ |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |
| Name of facility | | | |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |
| Name of other facility | | | |
| Department | | Department / Clinical Chair | |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Previous status (active, provisional, courtesy, temporary, etc.) | |
| Reason for leaving | | Appointment date (from– to) | |

**(for those without admitting privileges)**

## D. Inpatient Coverage Plan

**Please attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients.** **Does Not Apply** ☐

| Name of admitting physician/practice/clinic/group | Hospital where privileged |
|---|---|
| | |
| | |
| | |

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

## XVII. Work History

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

| | | | | |
|---|---|---|---|---|
| Name of current practice/employer | | | | |
| Contact name | Telephone number | Fax number | From | To |
| Mailing address | City | State | Zip code | |
| Name of practice/employer | | | | |
| Contact name | Telephone number | Fax number | From | To |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |



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## XVII. Work History (Continued)

| Name of practice/employer | | | | |
|---|---|---|---|---|
| Contact name | Telephone number | Fax number | From | To |
| Mailing address | City | State | Zip code | |
| Reason for leaving | | | | |

**Please account for all gaps in time between date of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.**

| Activity / Name | From | To |
|---|---|---|
| | | |
| | | |
| | | |

## XVIII. Professional Affiliations

**(*Do not abbreviate*)**

| Please list membership in all professional societies. Complete Name of Society | Date Joined | Current Member | |
|---|---|---|---|
| | | Yes | No |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## XIX. Peer References

List **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. One reference must be from same discipline.

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number (optional) |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number (optional) |

| Name of reference | | Title and specialty | |
|---|---|---|---|
| Mailing address | City | State | Zip code |
| E-mail address | Telephone number | Fax number | Cell phone number (optional) |

(***Do not abbreviate***)

## XX. Professional Liability

| | | | |
|---|---|---|---|
| Current insurance carrier | | | Policy number |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | Origination (retroactive) date | |
| Per claim amount | Aggregate amount | Effective date | Expiration date |

Please list **ALL** professional liability carriers within the past ten years

| | | | |
|---|---|---|---|
| Name of carrier | | | Policy number |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | From | To |
| Name of carrier | | | Policy number |
| Mailing address | City | State | Zip code |
| Phone number | Fax number | From | To |
| Name of carrier | | | Policy number |
| Mailing Address | City | State | Zip code |
| Phone number | Fax number | From | To |

## XXI. Professional Liability Action Detail – Confidential

Practitioner name(print or type) **Does Not Apply** ☐

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 health information (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? **$**

# IDAHO 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.*

| | | | Yes | No |
|---|---|---|---|---|
| **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 | | |
| | b. | Other professional registration or certification in any jurisdiction | | |
| | c. | Specialty or subspecialty board certification | | |
| | d. | Membership on any hospital medical staff | | |
| | e. | Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc. | | |
| | f. | Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program | | |
| | g. | Professional society membership or fellowship | | |
| | h. | Participation/membership in an HMO, PPO, IPA, PHO or other entity | | |
| | i. | Academic Appointment | | |
| | j. | Authority to prescribe controlled substances (DEA or other authority) | | |
| 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? | | | |
| ③ | Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions? | | | |
| ④ | Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity? | | | |
| **B.** | **CRIMINAL HISTORY** | | **Yes** | **No** |
| 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? | | | |
| | a. | Do you have notice of any such anticipated charges? | | |
| | b. | Are you currently under governmental investigation? | | |
| **C.** | **AFFIRMATION OF ABILITIES** | | **Yes** | **No** |
| ① | Do you presently use any drugs illegally? | | | |
| ② | Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could 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. | | | |
| 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? | | | |
| **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? | | | |
| 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? | | | |
| ③ | Are there any such claims being asserted against you now? | | | |
| 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)? | | | |
| ⑤ | Are any of the privileges that you are requesting not covered by your current malpractice coverage? | | | |
| **E.** | **ATTESTATION** | | | |
| | 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. | | | |

Typed or printed name _____ Signature _____ Date _____



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

| XXII. 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 |
|---|
| |
| |
| |
| |
| |
| |

# **Provider Release/Authorization**

(Modified releases will not be accepted)

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the Healthcare Organization(s)** indicated in this application (initial credentialing/recredentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as a part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities of other hospitals or institutions with which I have been associated, and all professional liability insurers with which I have had or currently have professional liability insurance who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the Healthcare Organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

10. I grant permission for the release of the credentials information contained in the practitioner application to the entities listed below.

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

Name: _____

**Entity Release Name: Regence BlueShield of Idaho