Highlands Health
Laurel Highlands Free & Charitable Medical Clinic

340 Main Street ● Johnstown, PA 15901
814-534-6242 ● FAX 814-534-6731
www.highlandshealthclinic.com

CREDENTIALING APPLICATION FORM
PHYSICIANS AND ALLIED HEALTH PROFESSIONALS

NAME: _____/_____/_____
Last First Middle

I certify that I have successfully completed the credentialing and privileging process at Conemaugh Memorial Medical Center and I understand that if I am not in good standing with Conemaugh Memorial Medical Center that I must complete the full credentialing and privileging process with JFMC. _____ (initial)

INSTRUCTIONS:

- Complete the application in blue or black ink. Incomplete applications will be returned and will delay processing.
- Include at least the month and year where dates are requested.
- Please enclose copies of the following items with your application.
  - ☐ Current Pennsylvania State License
  - ☐ Current DEA Registration
  - ☐ Current Professional Liability Face Sheet
  - ☐ ECFMG Certificate if applicable
  - ☐ Specialty Board Certification Certificate
  - ☐ Emergency Care Training Certificates (CPR, BLS, ACLS, HCPC, ATLS, NALS, PALS, Ect…)
  - ☐ Photo ID (copy of driver's license acceptable)
  - ☐ Curriculum Vitae or Resume

PERSONAL INFORMATION

Type of Practitioner: __ MD __ DO __DPM ___DMD ___DDS __CRNP __CRNA __PA __Other:_____

Personal Address:_____/_____/_____/_____
Street Address City State Zip

Personal Contact: _____ _____ _____
Home Phone Cell Phone E-mail Address

Business Name: _____

Business Address: _____/_____/_____/_____
Street Address City State Zip

SOCIAL SECURITY NUMBER: ____-____-_____ DATE OF BIRTH: ____/___/_____ **(Required for NPDB)**
MM DD YYYY

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PROFESSIONAL/MEDICAL SCHOOL EDUCATION

_____/_____/_____/_____/_____
PROFESSIONAL/MEDICAL SCHOOL NAME City State Zip Country (other than US)

_____/_____ _____/_____ Degree Awarded:_____
MM YYYY MM YYYY
Start Date Completion Date

ECFMG (Foreign Medical School Graduates) Certification Date:_____/_____/_____ Certification Number:_____
(*Attach a Copy of your ECFMG Certificate*) MM DD YYYY

__ **Internship** **OR** __ **Other Training (please check appropriate)**

Institution Name: _____ Specialty:_____

_____/_____/_____ Date of Entry: _____/_____
City State Country (other than US) MM YYYY

Program Completed: Yes:____ ____/_____ No:____ If no, please explain:_____
MM YYYY
Completion Date

Residency
Institution Name: _____ Specialty:_____

_____/_____/_____ Date of Entry: _____/_____
City State Country (other than US) MM YYYY

Program Completed: Yes:____ ____/_____ No:____ If no, please explain:_____
MM YYYY
Completion Date

Fellowship
Institution Name: _____ Specialty:_____

_____/_____/_____ Date of Entry: _____/_____
City State Country (other than US) MM YYYY

Program Completed: Yes:____ ____/_____ No:____ If no, please explain:_____
MM YYYY
Completion Date

LICENSURE

State License Number:_____ Issue Date:_____/_____ Expiration Date:_____/_____
MM YYYY MM YYYY

State License Number:_____ Issue Date:_____/_____ Expiration Date:_____/_____
MM YYYY MM YYYY

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DEA Number:_____ Issue Date:_____/_____ Expiration Date:_____/_____
MM YYYY MM YYYY

UPIN Number:_____ Medicare Number:_____ Medicaid Number:_____

BOARD CERTIFICATION (S)

Specialty: _____ Board Certified? ___ Yes ___ No

Certifying Board: _____ Dare of Certification: _____/_____
MM YYYY

Most Recent Certification Date: _____/_____ Expiration Date: _____/_____ Certification Number: _____
MM YYYY MM YYYY

Subspecialty: _____ Board Certified? ___ Yes ___ No

Certifying Board: _____ Dare of Certification: _____/_____
MM YYYY

Most Recent Certification Date: _____/_____ Expiration Date: _____/_____ Certification Number: _____
MM YYYY MM YYYY

Additional Certifications: (check appropriate)

BLS: ___ ACLS:___ CPR:___ Other:___ Please list: _____

If you have additional board certification(s), please make a copy of this page, fill out, and attach to this application.

AFFILIATION

_____/_____
PRIMARY Hospital Name Department

_____/_____/_____/_____
Street Address City State Zip Code

Specialty: _____ Status: _____ _____/_____ to _____/_____
MM YYYY MM YYYY
Start Date Reappointment Date

Do you currently admit and care for patients on your own hospital service? ___ Yes ___ No

If No, please explain your coverage arrangements for admitting patients: _____

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PROFESSIONAL LIABILITY INSURANCE

CURRENT Insurance Carrier:_____/_____/_____
City State

Policy #: _____ Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____
MM DD YYYY MM DD YYYY

___ Occurrence ___ Claims Made $_____/$_____
Limits of Coverage

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PRACTITIONER'S ATTESTATION AND RELEASE

By my signature, I hereby;

1. Attest that the information in this application is complete, accurate, truthful and correct in all aspects;

2. Understand that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the credentialing process;

3. Authorize Highlands Health representatives and the organization to consult with others who have been associated with me and/or who have information bearing on my competence and qualifications;

4. Consent to Highlands Health's representatives inspection of all records and documents that may be used to evaluate my professional qualifications and competence to carry out the practice privileges I request, my physical and mental health status, and my professional and ethical qualifications;

5. Release from any liability and promise not to sue Highlands Health and its representatives for their compilation and verification of my professional credentials;

6. Agree to provide and update the information requested on my initial application and subsequent reapplications and privilege request forms.

_____

Applicant Signature (Required)

_____ _____

Print Name (Required) Date (Required)