

VERIFICATION OF HEALTH CARE PROVIDER'S CREDENTIALING CHECKLIST

In addition to completing the attached Personal & Professional Information Application, provide copies of the following associated documents.

- Curriculum Vitae (signed & dated)
 - Full Name
 - Social Security
 - Date of birth
- Qualifying Degree
- ECFMG (where applicable)
 - Test date
 - Certificate number
- ACGME Certification if available (where applicable)
- Academic/Professional International Evaluation (for foreign graduates only)
- Professional Licenses, Board Certification, and resuscitation cards (i.e., BLS, ACLS, etc) must be provided including your signature if signature is applicable to the card.
 - All active U.S. Licenses
 - All expired/inactive U.S. Licenses within the past 10 years please explain why.
- All Post-Graduate Training (e.g. Residencies, Fellowships, Masters Degree, etc.) provide complete address.
- Prior military records if job experience was part of military service
- Professional Peer Inquiry (form included in attachment) – Ensure all addresses and phone numbers are complete and accurate. PEER is a person who has equivalent education and training, and has worked with you in same specialty.
- Drug Enforcement Agency Certificates (DEA) and/or Controlled Dangerous Substance Certificates (CDS) (as applicable)
- National Provider Identifier (NPI)

Navy Recruiting District (NRD) will:

- Scan the completed application and associated documents as a PDF file and name it “CCPD Appl-last name, first initial, and last 4 of SSN” (i.e. CCPD Appl-JacksonS-1212).
- Ensure all documents are **readable** once scanned and uploaded it OTOOLS.
- Task to PM340CPD (CCPD JAX user ID) and respective Program Manager in OTOOLS.
- Send an email notification to CCPD JAX at NMSC-recruiting@med.navy.mil to inform them that they have a task in OTOOLS.

CCPD JAX will:

- Conduct verification of credentials.
- Creates a Credentials Portfolio along with a completed letter.
- Name the file as “CCPD JAX Final- last name, first initial, and last 4 of SSN” (i.e. CCPD Final-JacksonS-1212).
- Upload it into OTOOLS.
- Task NRD and respective Program Manager in OTOOLS when it's completed.

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HINTS TO EXPEDITE THE PROCESSING OF YOUR CREDENTIALING APPLICATION

To avoid delays in processing your Credentialing application, we have included these "quick tips" to help the Centralized Credentialing and Privileging Department (CCPD) process your application in a timely manner.

1. All copies of current licenses, certificates, and resuscitation cards (i.e., BLS, ACLS, etc.) must be provided copied and include your signature (if signature is applicable to the card).
2. Include a valid daytime phone number and an e-mail address. Ensure you provide a valid email, phone/fax numbers for your points of contact (i.e. peer references, civilian employment, etc...), as we must contact them during the processing your package.
3. Peer references: A Peer **MUST** be of the same clinical specialty. For example:
 - a. FNP = FNP (No Staff/Registered Nurse)
 - b. Dentist = Dentist (No Flight Surgeon)
 - c. Psychologists = Psychologists (No Anesthesiologist)
 - d. Orthodontist = Orthodontist (No General Dentist)

Please note that the Peer Reference Forms are provided to help you expedite your credentialing process. Although it is not required that you forward the Forms on to your Peers, your assistance in helping CCPD by doing so is greatly appreciated.

If you are a sole practitioner working with no other Peers or work at a facility where you are the only person working in that specialty, please include a memo stating that fact.

4. Please provide all places of employment since conferring your qualifying degree.

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INSTRUCTIONS

USE ONLY BLACK INK

TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL TO THE RIGHT OF THE LINE.

DO NOT USE CORRECTION FLUID/TAPE UNDER ANY CIRCUMSTANCE

These guidelines should assist you with the completion of the package:

PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS):

1. DEMOGRAPHICS:

Complete all information requested. Complete day/month/year time frames in the "from-to" fields. If the information is not applicable, write "N/A" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding professional liability carrier and participation in continuing education.

Should you wish to attach a curriculum vitae/resume, ensure it is current. Please sign and date it with initials on each page in the lower right corner.

2. PROFESSIONAL EDUCATION AND TRAINING:

Provide copies of diploma for completed education/training (include Educational Commission for Foreign Medical Graduate (ECFMG) certificate as appropriate). Copies of Diplomas; Append official results of graduate/professional school entrance examinations (required for scholarship applicants (AFHPSP, FAP) and applicants currently in graduate/professional school or postgraduate training only); Append official letter of acceptance for applicants who are accepted to training programs; Appended letters certifying accreditation status of internship/residency programs as appropriate, for applicants who are entering or currently enrolled in training programs.

3. & 4. BOARD CERTIFICATIONS/LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY:

Please provide copies of all current licenses National certifications held. Should you allow any to licenses or certifications to lapse/expire, please note this on the application with an explanation.

DRUG ENFORCEMENT AGENCY CERTIFICATES (DEA)/CONTROLLED DANGEROUS SUBSTANCE CERTIFICATES (CDS):

Please submit a current copy of the DEA and/or CDS certificate (as applicable)

5. MEDICAL READINESS TRAINING:

Other contingency training documents may be submitted (BLS, ACLS, NRP, ATLS, etc).

6. HEALTH STATUS/ABILITY TO PERFORM:

Please respond to the questions that address this area. If you answer "yes" (except 6a) to any of the questions, provide a brief, factual response in the spaces below the questions.

Do not send a copy of a physical examination.

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7. MALPRACTICE, LICENSURE, PRIVILEGING ACTION, AND LEGAL HISTORY:

Please respond to the questions that address this area. If you answer "yes" to any of the questions, provide a brief, factual response in the spaces below the questions. In addition you will need to provide the malpractice carrier name, address and phone number, policy number, dates of coverage and coverage amount.

8. PROFESSIONAL LIABILITY: Self-explanatory.

9. OTHER INFORMATION: Self-explanatory.

10. CONTINUING EDUCATION HOURS: Self-explanatory.

11. DEPARTMENT DIRECTOR / CHIEF OF SERVICE REFERENCE: Please provide contact information.

12. PEER REFERENCES:

Ensure all addresses and phone numbers are complete and accurate.

PEER - is a person who has equivalent education and training, and has worked with you in same specialty.

13. PROFESSIONAL ASSIGNMENTS: Please complete the civilian employment/civilian facilities where privileges were held since completing the respective training program (i.e. Nursing School, Medical School, etc.). Provide the names, complete address and phone numbers of **two** peers who can attest to **current** competence for each specialty you qualify.

CONSENT and RELEASE/PRIVACY ACT and DISCLOSURE STATEMENT

Please read, sign and date in the appropriate space.

OTHER PROFESSIONAL DOCUMENTS:

You may submit copies of any other associated training relevant to your profession.