COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Alexandra Haas, Board of Health Administrator

Date: November 16, 2022

Subject: Request for a Rulemaking Hearing concerning 6 CCR 1014-4 Colorado Health Care Professional Credentials Application

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Senate Bill 22-226 repealed the Health Care Credentials Uniform Application Act ("Act"), effective May 18, 2022. Prior to the bill's enactment, the Health Care Professional Credentials Application was written and reviewed by the Health Care Credentials Applications Review Committee, whose members were appointed by the State Board of Health, but work was done by staff at COPIC. In May 2021, the Review Committee recommended a repeal of the Act, as the Committee was no longer meeting it the goal of efficient credentialing with technological progress. Since the statutory basis for the Board of Health's rule has been eliminated, the regulation has become obsolete.

"Credentialing" means obtaining, verifying, and assessing the qualifications of a health care provider to provide treatment, care, or services in or for a health care facility. This is separate from "privileging", which means to authorization by a governing body (for example, the Department of Regulatory Affairs) to provide treatment, care, or services at a health facility.

In 2004, the legislature passed the Act to simplify the credentialing process: mandating that the uniform application was to be accepted by all health facilities, so that a health care provider would only need to submit one form. Additionally, insurance companies offering professional liability insurance also may require credentialing to ensure qualifications prior to providing coverage. However, the uniform application was created and maintained only in a downloaded pdf format and there was no centralized database for credentialing entities to maintain credentials. In the intervening years, credentialing entities have developed electronic fillable database and forms that were easier to track and maintain for both facilities and companies and the health care provider.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Repeal to
6 CCR 1014-4 Colorado Health Care Professional Credentials Application

Basis and Purpose.
The regulation pertaining to the Health Care Professional Credentials Application is being repealed to conform to legislation enacted in 2022. Senate Bill 22-226 repealed the Health Care Professional Credential Act completing, including the authority of the Board of Health to promulgate regulations.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Senate Bill 22-226 repealed the authority, formally located at 25-1-108.7, C.R.S.

Is this rulemaking due to a change in state statute?

X Yes, the bill number is 22-226. Rules are ___ authorized X required.

_____ No

Does this rulemaking include proposed rule language that incorporate materials by reference?

_____ Yes ___ URL

X No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

X No

Does the proposed rule language create (or increase) a state mandate on local government?

X No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

___ Yes.

REGULATORY ANALYSIS
for Repeal to
6 CCR 1014-4 Colorado Health Care Professional Credentials Application

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
Licensed health care facilities	~3800	C
Insurance companies	UNK	C

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The statutory obligation to use the Uniform Application was repealed, effective May 18, 2022. Since the statute was first enacted in 2004, health facilities and insurance companies have been able to create and maintain their own forms and database which have been easier to maintain then the Uniform Application. The repeal of the regulation will have no impact on health facilities or insurance operations.

<u>Economic outcomes</u>
Summarize the financial costs and benefits, include a description of costs that must be incurred, costs that may be incurred, any Department measures taken to reduce or eliminate these costs, any financial benefits.

None, organizations that were subject to the mandate to use the uniform application have already developed their own forms that were modeled after the uniform application.

Non-economic outcomes

Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

None, organizations will continue to use their own credentialing forms and databases to ensure the same level of review of health providers takes place.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A. Anticipated CDPHE personal services, operating costs or other expenditures:

      N/A

   B. Anticipated personal services, operating costs or other expenditures by another state agency:

      Anticipated Revenues for another state agency:

      N/A

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Along with the costs and benefits discussed above, the proposed revisions:

   _X_ Comply with a statutory mandate to promulgate rules.
   ___ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
   ___ Maintain alignment with other states or national standards.
   ___ Implement a Regulatory Efficiency Review (rule review) result
   ___ Improve public and environmental health practice.
   ___ Implement stakeholder feedback.

   Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023.

___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry. ___ Supports local agencies and COGCC in oil and gas regulations. ___ Reduces VOC and NOx emissions from non-oil and gas contributors
3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023. ___ Increases the consumption of healthy food and beverages through education, policy, practice and environmental changes. ___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation. ___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.
4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023. ___ Ensures access to breastfeeding-friendly environments.
5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Performs targeted programming to increase immunization rates. ___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).
6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023. ___ Creates a roadmap to address suicide in Colorado. ___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate. ___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries. ___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.
7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020. ___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps.

___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 20, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include:

N/A

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

This is a repeal driven by SB 22-226 removal of the Board of Health authority to promulgate the regulation.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

This is a repeal driven by SB 22-226 removal of the Board of Health authority to promulgate the regulation.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

N/A

STAKEHOLDER ENGAGEMENT
for Repeal to
6 CCR 1014-4 Colorado Health Care Professional Credentials Application

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

This repeal is due to a statutory change eliminating the Board of Health's authority to promulgate rules as of May 18, 2022. The Health Care Professional Credentials Application Review Committee, which was made up of representatives of statewide credentialing entities and other key stakeholders, first recommended that the mandatory application use requirement be removed in 2019. Due to the COVID-19 global pandemic, the Review Committee did not meet again until May 2021, at which time the consensus was that the requirement for a single uniform application interferes with efficient credentialing. On January 19, 2022, the Review Committee presented this recommendation to the Board of Health, which agreed with the assessment and wrote a letter of support for legislative changes to take place. A copy of that letter, as well as an explanation as to the statutory change, is attached.

Stakeholder Group Notification
The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

X Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

None

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

This change has no impacts to the determinants of health equity and environmental justice.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.		Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

State Board of Health

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION

6 CCR 1014-4

~~**Adopted by the State Board of Health 8/16/17; effective 12/15/17**~~

~~This is the Colorado healthcare professional credentials application. The Colorado legislature has mandated that all health care entities and all health care plans engaged in the collection of information to be used in the process of credentialing of health care professionals use this form (C.R.S. § 25-1-108.7).~~

~~This uniform application has been designed to allow each credentialing entity to receive from you core credentialing information needed in common by all of them, without duplication.~~

~~THIS UNIFORM APPLICATION HAS BEEN DESIGNED TO ALLOW EACH PRACTITIONER TO COMPLETE A SINGLE FORM WITH CORE INFORMATION FOR SUBMISSION TO EACH CREDENTIALING ENTITY TO WHICH THE PRACTITIONER IS APPLYING. This application need not be used for case specific temporary privileges.~~

~~Each credentialing entity may require additional, non – duplicative credentials information, if it is deemed by them to be essential to the completion of their credentialing process.~~

~~A healthcare professional by law, means any physician, dentist, dental hygienist, chiropractor, podiatrist, psychologist, advanced practice nurse, optometrist, physician assistant, licensed clinical social worker, child health associate, marriage and family therapist, or any other health care professional who is registered, certified or licensed by the state of Colorado, who practices, or intends to practice, in Colorado, and who is subject to credentialing.~~

~~Those credentialing entities that are required to use this uniform application are:~~

~~1) A health care facility or other health care organization licensed or certified to provide medical or health services in Colorado;~~

~~2) A health care professional partnership, corporation, limited liability company, professional services corporation or group practice;~~

~~3) An independent practice association or physician-hospital organization;~~

~~4) A professional liability insurance carrier; or~~

~~5) An insurance company, health maintenance organization, or other entity that contracts for the provision of health benefits.~~

~~No State of Colorado licensing or certification board is required to use this uniform application.~~

~~The reason Colorado has mandated the use of this uniform application is to reduce health care costs and duplication.~~

~~**COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION**~~

This application form should be used for both initial credentialing and re-credentialing purposes. PRIOR TO COMPLETING THIS APPLICATION FORM, PLEASE READ AND OBSERVE THE FOLLOWING:

GENERAL INSTRUCTIONS

1. Please type or print your responses legibly.

2. Please note that modification to the wording or format of this Application will invalidate it. Use of any form of correctional fluid or tape is not acceptable.

3. All information requested must be FULLY and TRUTHFULLY provided.

4. Any changes to your responses must be lined through, initialed and dated. Use of any form of correctional fluid or tape is not acceptable.

5. If an entire section does not apply to you, then please check the box provided at the top of that section to indicate that the section does not apply to you.

6. If a particular question does not apply to you, then write "N/A" in the answer blank. If there are multiple, repetitive answer blanks in a particular section (as, for example, in the section entitled "Residencies and Fellowships"), it is not necessary to mark "N/A" in each unneeded answer blank.

7. Unless *specifically permitted* by a particular question, please understand that a reference to "See CV" for an answer is not appropriate.

8. **If you need more space to answer a question completely, please attach additional paper. Include the section and page number of the question being answered as well as your name (printed), on each additional sheet. Attach all additional sheets to this application.**

9. After the Application has been completed in its entirety but *before* you sign and date it, MAKE A COPY OF THE APPLICATION TO RETAIN IN YOUR FILES AND/OR COMPUTER FOR FUTURE USE. In so doing, at the time of a submission to all Credentialing Entities as identified on Page 1, all you will need to do is to check to ensure that all the information remains complete, current and accurate before signing and forwarding the Application as needed.

10. Any gaps of time greater than thirty (30) days during the last ten years to the present date must be accounted for before your Application will be considered complete.

11. Please sign and date the Application prior to mailing.

12. Please sign and date Schedule A.

13. Mail the Application, Schedule A, any attached sheets prepared in order to answer any question(s) completely as well as a copy of all applicable enclosures listed on pages 3 and 26 to the Healthcare Entity to which you are submitting this application.

14. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law and that they will conform to both HIPAA, ADA and other applicable laws and regulations.

15. All signatures *must be* original or electronic equivalent. Stamp signatures are not acceptable.

GENERAL INSTRUCTION – continued

~~**If requested by your credentialing entity for purposes of credentialing or re-credentialing, please include a current copy of the following documents:**~~

~~A. State Professional License(s).~~

~~B. Federal Narcotics License (DEA Registration).~~

~~C. All applicants must submit a resume or curriculum vitae, whichever is appropriate, with complete professional history in chronological order (month and year).~~

~~D. Diplomas and/or certificates of completion (e.g., medical school, internship, residency, fellowship, nursing, dental or other healthcare professional school).~~

~~E. Diplomat of National Board of Medical Examiners or Educational Commission for Foreign Medical Graduates (ECFMG) Certificate (if applicable).~~

~~F. Specialty/Subspecialty Board Certification or letter from Board(s) stating your status (if applicable).~~

~~G. Certificate of Insurance.~~

~~H. Military Discharge Record (Form DD-214) (if applicable).~~

~~I. Certificates for Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP).~~

~~J. CME transcripts/certificates~~

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION FORM

I. Identifying Information *Please provide your full legal name.*

A. Last Name(include suffix, Jr., Sr., III): First: Middle: Title:

B. Other name used (e.g., maiden name, nickname)? ☐ Yes ☐ No
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:
Name: Dates used (mm/dd/yyyy): From: To:

C. Home Address:

City: State: Zip:

D. Home Telephone Number: Cell Phone: Email Address:

E. Social Security Number: Place of birth: National Provider Identifier Number:

II. Current Practice Setting(s) *Use additional copies of this Part II to list any additional practice sites*

A. Primary Practice Location

Name of Clinical Practice:

Type of Practice Setting:
- ☐ Solo
- ☐ Group/Single Specialty
- ☐ Group/Multi-Specialty
- ☐ Hospital Based
- ☐ Other

Clinical Practice Street Address:

Start Date at Location (mm//yy):

City: County: State: Zip:

Office Telephone Number: Office Fax Number: Patient Appointment Telephone Number:

Mailing Address (if different from above):

City: St: Zip:

Office Manager/Administrative Contact:
Office Manager's Telephone Number:
Office Manager's Fax Number:
Email Address:

Credentialing Contact:
Telephone Number:
Fax Number:
Email Address:

Answering Service Number: Pager Number:

Office Email Address: Practice Website:

Federal Tax ID Number for this Practice Address:

Name Affiliated with Tax ID Number:

Practice National Provider Identifier Number:

Applicant's Medicare Provider Number:

Applicant's Colorado Medicaid Provider Number:

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday	____ am pm . . . to ____ am pm	Thursday	____ am pm . . . to ____ am pm
Tuesday	____ am pm . . . to ____ am pm	Friday	____ am pm . . . to ____ am pm
Wednesday	____ am pm . . . to ____ am pm	Saturday	____ am pm . . . to ____ am pm
		Sunday	____ am pm . . . to ____ am pm

Languages:
Please list all languages other than English (including sign language and type) available in this office.

Billing Address – *if different from your primary practice site address*:
City: St: Zip:

B. Other Practice Location ☐ Not Applicable

Name of Clinical Practice:

Type of Practice Setting: ☐ Group/Multi-Specialty ☐ Solo ☐ Hospital Based ☐ Group/Single Specialty ☐ Other

Clinical Practice Street Address:

Start Date at Location (mm/yy):

City: County: State: Zip:

Office Telephone Number: Office Fax Number: Patient Appointment Telephone Number:

Mailing Address (if different from above):
City: St: Zip:

Name of Office Manager/Administrative Contact:
Office Manager's Telephone Number:
Office Manager's Fax Number:

Answering Service Number: Pager Number:
Office Email Address:

Federal Tax ID Number for this Practice Address:

Name Affiliated with Tax ID Number:

Practice National Provider Identifier Number:
Applicant's Medicare Provider Number:
Applicant's Colorado Medicaid Provider Number:

Office Hours (enter time as Hour:Minute and indicate am or pm for each):

Monday	am pm . . . to am pm	Thursday	am pm . . . to am pm
Tuesday	am pm. . . to am pm	Friday	am pm . . . to am pm
Wednesday	am pm . . . to am pm	Saturday	am pm . . . to am pm
		Sunday	am pm. . . .to am pm

Languages: *Please list all languages other than English (including sign language & type) available in this office.*

Billing Address – *if different from your primary practice site address*:

City: St: Zip:

III. Call Coverage ***Please list all persons with whom you have made arrangement for call coverage.***

☐ Not Applicable If not applicable, please explain why:

Name/Address: Specialty:

IV. Licenses/Registrations/Certificates ***List all state health care licenses, registrations, certificates and advanced practice registry as well as other relevant numbers, including pending, expired and inactive.***

Practice Type–MD, DO, RN, APN etc: Specialty:

List all sub specialties or areas of interest/emphasis:

Type of License, Certificate or Registration: ☐ Active ☐ Inactive/Expired ☐ Pending
Number:
State/Institution:
Expiration Date (mm/yy): Year Obtained: Year Relinquished:

Type of License, Certificate or Registration: ☐ Active ☐ Inactive/Expired ☐ Pending
Number:
State/Institution:
Expiration Date (mm/yy): Year Obtained: Year Relinquished:

Type of License, Certificate or Registration: ☐ Active ☐ Inactive/Expired ☐ Pending
Number:
State/Institution:
Expiration Date (mm/yy): Year Obtained: Year Relinquished:

DEA Registration Number: Expiration Date (mm/yy):

Prescriptive Authority Number: (APN, NP, CNM, CNS, CRNA only) Date Issued(mm/yy):

V. Education Since High School. Check the appropriate box (i.e., undergraduate, graduate, medical/professional) for each school attended.

A. Foreign Medical Graduate ☐ Not Applicable

Educational Commission for Foreign Medical Graduates (ECFMG) Number: ____ Date Issued (mm/yy): ____

Other:
Fifth Pathway ☐ Yes ☐ No If Yes, please provide name and address of institution:
____

Date of Attendance: From (mm/yy): ____ To: ____

B. Education *List in chronological order beginning with the earliest. Use additional copies of this Part V B. to list additional education other than post graduate, CME or clinical training courses.*

☐ Undergraduate ☐ Graduate ☐ Medical /Professional

Complete School Name: ____
Degrees/Certification Received: ____ Graduation Date(mm/yy): ____
Course of Study or Major: ____
Address: ____
Email: ____ Telephone Number: ____ Fax Number: ____
Dates Attended: From (mm/yy): ____ To: ____ Program Completed? ☐ Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐ Medical /Professional

Complete School Name: ____
Degrees/Certification Received: ____ Graduation Date(mm/yy): ____
Course of Study or Major: ____
Address: ____
Email: ____ Telephone Number: ____ Fax Number: ____
Dates Attended: From (mm/yy): ____ To: ____ Program Completed? ☐ Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐ Medical /Professional

Complete School Name: ____
Degrees/Certification Received: ____ Graduation Date(mm/yy): ____
Course of Study or Major: ____
Address: ____
Email: ____ Telephone Number: ____ Fax Number: ____
Dates Attended: From (mm/yy): ____ To: ____ Program Completed? ☐ Yes ☐ No
If no, please attach Explanation Form(s).

☐ Undergraduate ☐ Graduate ☐ Medical /Professional

C. Post Graduate Training *Check the appropriate box (i.e., internship, residency, fellowship) for each type of training. Use additional copies of this Part V C. to list additional post graduate training.* ☐ Not Applicable

☐ Internship ☐ Residency ☐ Fellowship

Institution Name:
Address: City:
State/Country: Zip:
Dates Attended (mm/yy): From: To: Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).
Specialty: Date of Completion (mm/yy):
Name of Program Director: Fax Number:
Telephone Number: Email:

☐ Internship ☐ Residency ☐ Fellowship

Institution Name:
Address: City:
State/Country: Zip:
Dates Attended (mm/yy): From: To: Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).
Specialty: Date of Completion (mm/yy):
Name of Program Director: Fax Number:
Telephone Number: Email:

☐ Internship ☐ Residency ☐ Fellowship

Institution Name:
Address: City:
State/Country: Zip:
Dates Attended (mm/yy): From: To: Program Completed? ☐Yes ☐ No
If no, please attach Explanation Form(s).
Specialty: Date of Completion (mm/yy):
Name of Program Director: Fax Number:
Telephone Number: Email:

D. Other Clinical Training Programs *List those that are pertinent to your required privileges/practice (For example, preceptorship, procedural certificate course, etc.). Use additional copies of this part V. D to list additional clinical training.* ☐ Not Applicable

Institution Name:

Address: City:

State/Country: Zip:

Dates Attended (mm/yy): From: To: Date of Completion(mm/yy):

Specialty: Certificate Awarded:

Did you complete the program? ☐ Yes ☐ No If no, please attach Explanation Form(s).

Name of Program Director: Fax Number:

Telephone Number: Email:

Institution Name:

Address: City:

State/Country: Zip:

Dates Attended (mm/yy): From: To: Date of Completion(mm/yy):

Specialty: Certificate Awarded:

Did you complete the program? ☐ Yes ☐ No If no, please attach Explanation Form(s).

Name of Program Director: Fax Number:

Telephone Number: Email:

List Certifications (*provide copies – see page 3*)

☐ BLS (Basic Life Support)	Expiration Date (mm/yy):
☐ ACLS (Advanced Cardiac Life Support)	Expiration Date (mm/yy):
☐ ATLS (Advanced Trauma Life Support)	Expiration Date (mm/yy):
☐ PALS (Pediatric Advanced Life Support)	Expiration Date (mm/yy):
☐ NRP (Neonatal Resuscitation Program)	Expiration Date (mm/yy):
☐ Other	Expiration Date (mm/yy):
	Expiration Date (mm/yy):
	Expiration Date (mm/yy):
	Expiration Date (mm/yy):

E. Faculty Positions *List all compensated academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments. Use additional copies of part V. E and/or F to list additional faculty positions or CME.* ☐ Not Applicable

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From : _____ To: _____ Specialty: _____

Contact: _____ Email: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Institution Name: _____ Academic Rank/Title: _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Dates Attended(mm/yy): From : _____ To: _____ Specialty: _____

Contact: _____ Email: _____

Address: _____

Telephone Number: _____ Fax Number: _____

F. Continuing Medical Education *State the number of relevant CME or CEU credit hours you have received in the last 36 months.* ☐ None

_____

VI. Board and Professional Certification/Recertification *List all current and past Board certifications.*

Physicians: Please enter all Board Certifications and answer the questions below regarding such Board Certifications

Allied Health Professionals: Please enter all Professional and National Certifications and answer the questions below regarding such Certifications

Are you Board certified? ☐ Yes ☐ No ☐ Not Applicable

Name of Issuing Board	Specialty	Dt Certified	Dt Recertified	Expiration

Please answer the following questions. Attach explanation form(s) if necessary.

A. 1. If you are not currently certified, have you applied for the certification examination? ☐ Yes ☐ No

2. If you have not applied for the certification examination, do you intend to apply for the certification examination? If yes, when? ☐ Yes Date: ☐ No

3. If you have applied for the certification examination, have you been accepted to take the certification examination? ☐ Yes ☐ No

4. If you have been accepted, when do you intend to take the examination? Date: ____

5. If you do not intend to apply for the certification examination, please attach reason on Explanation Form(s).

6. If you are not currently certified, please provide the expiration date of admissibility. Date: ____

B. Have you ever had certification denied, revoked, limited, restricted, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty Board, or is any such action currently pending or under review? If yes, please attach Explanation Form(s). ☐ Yes Date: ☐ No

C. Have you ever voluntarily relinquished a certification, including any voluntary non-renewal of a time limited certification? If yes, please attach an Explanation Form(s). ☐ Yes Date: ☐ No

D. Have you ever failed a certification exam? ☐ Yes ☐ No
If yes, explain: ____

VII. Current Hospital and Other Facility Affiliations

Please list in <u>reverse</u> chronological order the past ten years of all hospital and other facility affiliations beginning with all hospital applications in process: current hospital affiliation(s) second, previous hospital affiliations third and other current facility affiliations (which includes surgery centers, dialysis centers, nursing homes and other health care related facilities) fourth. <u>Do not list residencies, internships, fellowships, or employment</u>. A resume is not sufficient for a complete answer to these questions. Submission date only required if pending.

Facility Name:

Department: Staff Status:
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): To (mm/yy):

Address:

Medical Office Contact: Phone Number:

Email: Fax Number:

Facility Name:

Department: Staff Status:
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): To (mm/yy):

Address:

Medical Office Contact: Phone Number:

Email: Fax Number:

Facility Name:

Department: Staff Status:
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): To (mm/yy):

Address:

Medical Office Contact: Phone Number:

Email: Fax Number:

Facility Name:

Department: Staff Status:
(e.g., active, courtesy, provisional, pending)

Appointment Date: From (mm/yy): To (mm/yy):

Address:

Medical Office Contact: Phone Number:

99 Email: Fax Number:

VII. Current Hospital and Other Facility Affiliations - continued

Facility Name:
Department: Staff Status: (e.g., active, courtesy, provisional, pending)
Appointment Date: From (mm/yy): To (mm/yy):
Address:
Medical Office Contact: Phone Number:
Email: Fax Number:

Facility Name:
Department: Staff Status: (e.g., active, courtesy, provisional, pending)
Appointment Date: From (mm/yy): To (mm/yy):
Address:
Medical Office Contact: Phone Number:
Email: Fax Number:

Facility Name:
Department: Staff Status: (e.g., active, courtesy, provisional, pending)
Appointment Date: From (mm/yy): To (mm/yy):
Address:
Medical Office Contact: Phone Number:
Email: Fax Number:

VIII. Professional Work History

Please list in reverse chronological order all professional work history during the past ten years not listed previously. Include any previous office addresses and any military experience and public health service. Explain below any gaps greater than thirty (30) days. Use additional copies of this part VIII to list additional professional work history. A curriculum vitae is not sufficient for a complete answer to these questions.

☐ Not Applicable

Name of Practice/Employer:
Title/Position held:
From (mm/yy): To (mm/yy): Reason for leaving?

Eligible for rehire? ☐ Yes ☐ No If No why, please attach Explanation Form.

Address: City:
State/Country: Zip:
Contact: Fax Number:
Email: Telephone Number:

VIII. Professional Work History - continued

Name of Prior Practice/Employer:
Title/Position held:
From (mm/yy): To (mm/yy): Reason for leaving?

Eligible for rehire? ☐ Yes ☐ No If No why, please attach Explanation Form.

Address: City:
State/Country: Zip:
Contact: Fax Number:
Email: Telephone Number:

Name of Prior Practice/Employer:
Title/Position held:
From (mm/yy): To (mm/yy): Reason for leaving?

Eligible for rehire? ☐ Yes ☐ No If No why, please attach Explanation Form.

Address: City:
State/Country: Zip:
Contact: Fax Number:
Email: Telephone Number:

IX. Peer References

Please list three (3) references, from professional peers (preferably no more than 1 partner) who through recent (last two years) observations have personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives. Prefer references be practitioners in your same professional discipline. Allied Health Professionals must list at least one physician reference.

Name of Reference: Relationship:
Specialty: Dates of Association: From (mm/yy): To (mm/yy):
Address: City:
State/Country: Zip:
Telephone Number: Fax Number:
Email:

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: From (mm/yy): _____ To (mm/yy): _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email: _____

Name of Reference: _____ Relationship: _____

Specialty: _____ Dates of Association: From (mm/yy): _____ To (mm/yy): _____

Address: _____ City: _____

State/Country: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Email: _____

X. Professional Liability Insurance (*yours or your supervising agent*)

Insurance Carrier / Provider of Professional Liability Coverage: _____

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

_____

Name of Local Contact : _____

(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

Claims History Contact: _____ Fax Number: _____ Email: _____

X. Professional Liability Insurance - continued

Please list all previous professional liability carriers within the past ten (10) years including any carriers during professional training if within the ten year period. Use additional copies of this Part X to list additional professional liability insurance. ☐ Not Applicable

Insurance Carrier / Provider of Professional Liability Coverage:

Policy Number: _____ Type of Coverage (check one): ☐ Claims-Made ☐ Occurrence

Per claim limit of liability: $_____ Aggregate amount: $ _____

Dates (mm/dd/yyyy): Effective: _____ Expiration: _____ Retroactive: _____

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage? ☐ Yes ☐ No

If yes, please provide details/supporting data. If no, please explain why not.

Name of Local Contact : _____
(e.g., insurance agent or broker)

Mailing Address: _____

Telephone Number: _____ Ext: _____

Professional Insurance History: ***Please answer each of the following questions in full. If the answer to any question is "YES", or requires further information, please give a full explanation of the specific details and attach to the Application.***

1. Has your professional liability insurance coverage ever been terminated, not renewed, cancelled, limited, restricted, modified, or altered by action of the insurance company? ☐ Yes Date:_____ ☐ No

   If yes, please provide date, name of company(s), and basis for coverage change.

2. Have you ever been denied coverage? ☐ Yes Date:_____ If yes, please provide details. ☐ No

3. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes Date:_____ If yes, please identify procedures and provide details. ☐ No

Professional Claims History: ***If the answer to any of these questions is "Yes", please give a full explanation and attach to the Application.***

1. Have there *ever* been any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceeding involving you? ☐ Yes Date:_____ ☐ No

2. Are any professional liability (i.e., malpractice) claims, suits, judgments, settlements or arbitration proceedings involving you *currently pending?* ☐ Yes Date:_____ ☐ No

3. Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? ☐ Yes Date:_____ ☐ No

XI. QUESTIONS FOR HEALTH PLANS ONLY ***Answer these questions only if you are applying to a Health Plan.***

1. Do you wish to be listed in the Health Plan Directory as a primary care practitioner? ☐ Yes ☐ No

2. Do you wish to be listed in the Health Plan Directory as a specialist? ☐ Yes ☐ No

3. List which specialty: _____

4. Please furnish a copy of your W-9 Federal Tax Form.

5. Does this site offer handicapped access for the following:

Building?	☐ Yes	☐ No
Parking?	☐ Yes	☐ No
Restroom?	☐ Yes	☐ No

Does this site offer other services for the disabled? ☐ Yes ☐ No

Text Telephone (TTY)?	☐ Yes	☐ No
American Sign Language?	☐ Yes	☐ No
Mental/Physical Impairment Services?	☐ Yes	☐ No

Accessible by public transportation? ☐ Yes ☐ No

Bus?	☐ Yes	☐ No
Light rail?	☐ Yes	☐ No
Regional train?	☐ Yes	☐ No

XII. Attestation Questions

This section to be completed by the Practitioner. Modification to the wording or format of these Attestation Questions will invalidate the Application..

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons including dates, as specified in each question, on an Explanation Form and attach to the Application.

For the purpose of the following questions, the term "adverse action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial, surrender, resignation, relinquishment, reprimand, censure, sanction, subject to probation, placed under special or intensified review, withdrawn or failed to proceed with an application, denied or recommended for denial, any such action pending or in progress, or non-renewal of membership, clinical privileges, academic affiliation or appointment or employment. "Adverse action" also means, with respect to professional licensure registration or certification, any previously successful or currently pending challenges to such licensure, registration or certification including any voluntary or involuntary restriction, suspension, revocation, denial, surrender, non-renewal, admonishment, public or private reprimand, probation, consent order, reduction, withdrawal, limitation, relinquishment, or failure to proceed with an application for such licensure, registration or certification.

A. To your knowledge, have you ever been the subject of an **adverse action** (or is an investigation or **adverse action** currently pending) by:

1. a hospital or other healthcare facility (e.g., surgical center, nursing home, renal dialysis facility, etc.)? ☐ Yes Date: ____ ☐ No

2. an education facility or program (e.g., dental or other health care professional school, residency, internship, etc.)? ☐ Yes Date: ____ ☐ No

3. a professional organization or society? ☐ Yes Date: ____ ☐ No

4. a professional licensing body (in any jurisdiction for any profession)? ☐ Yes Date: ____ ☐ No

5. a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Preferred Hospital Organization (PHO), Provider-Sponsored Health Care Corporations (PSHCC), network, system, managed care organization, etc.)? ☐ Yes Date: ____ ☐ No

6. a state or federal agency (DEA, etc.) regarding your prescription of controlled substances? ☐ Yes Date: ____ ☐ No

B. To your knowledge, have you ever been the subject of any report(s) to a state or federal data bank or state licensing or disciplining entity? ☐ Yes Date: ____ ☐ No

XII. Attestation Questions - continued

C. 1.Have you ever involuntarily resigned, terminated or surrendered medical staff privileges or employment from a hospital, group practice or other health care facility or medical staff?
☐ Yes Date: _____
☐ No

C. 2. Have you ever voluntarily resigned, terminated, or surrendered medical staff privileges or employment from a hospital, group practice or other healthcare facility or medical staff to avoid disciplinary action or investigation, or while under investigation, or while such an investigation is/was pending?
☐ Yes Date: _____
☐ No

D. Have you ever been suspended, fined, disciplined, investigated, expelled, sanctioned or otherwise restricted or excluded from participating in any private, federal or state health insurance program (for example, Medicare or Medicaid) or are any such proceedings in progress? ☐ Yes Date: _____
☐ No

E. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient or are any such proceedings in progress?
☐ Yes Date: _____
☐ No

F. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or are you currently under indictment or currently have pending against you any such charges?
☐ Yes Date: _____
☐ No

G. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony or misdemeanor that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct or are you currently under indictment or currently have pending against you any such charges?
☐ Yes Date: _____
☐ No

H. In the last ten years, have you been found liable or responsible for or named in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a health care professional or that alleged fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?
☐ Yes Date: _____
☐ No

I. Have you ever been court-martialed for actions related to your duties as a health care professional?
☐ Yes Date: _____
☐ No

XIII. ATTESTATION AND SIGNATURE

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement without right of hearing.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not per se an application for employment with the Entity and that acceptance of my application by the Entity may not result in my employment by the Entity.
8. I understand and agree that I will notify all credentialing entities to which I have submitted this Uniform Application of any and all changes to the information contained in this Application

This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

~~Schedule A~~

~~COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION~~
~~AUTHORIZATION AND RELEASE OF INFORMATION FORM~~
~~Modified Releases Will Not Be Accepted~~

~~By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:~~

~~1. As an applicant for medical staff membership at the designated hospital*(s)* and/or participation status with the health care related organization*(s)* (e.g., *hospital, medical staff, medical group independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization network, medical society, professional association, medical school faculty position, other healthcare delivery entity or system, hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.~~

~~2. I also understand that I have the continuing responsibilities to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.~~

~~3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.~~

~~4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualification or matters addressed in this Application (my "Qualifications")~~

~~5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insures with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this application and my Qualifications.~~

~~6. I consent to and authorize the inspection of appropriate records and documents that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.~~

~~7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity~~

for peer review purposes). I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.

9. For Healthcare Entity membership and privileges, I acknowledge that I have been informed of or have been given the opportunity to review the medical staff bylaws, rules, regulations and policies of the entity and I hereby agree to abide by them. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession.

10. I acknowledge that any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Colorado law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluation undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

12. I understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Please print your name: _____

Signature: _____ **Date:** _____

REMEMBER TO SAVE THE COMPLETED APPLICATION

CAUTION
READ THIS INSTRUCTION CAREFULLY

Complete Supplemental A, page 25, and Supplemental B, page 26 unless instructed otherwise by credentialing entity.

200

Supplemental A

Please answer these questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.

1. Citizenship: Are you a citizen of the United States? ☐ Yes ☐ No If no, please provide appropriate documentation.

2. Date of Birth: Month ___ Day ___ Year ____ Gender: ☐ Male ☐ Female

3. Are you currently engaged in the illegal use of drugs? (Currently means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice your profession. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances and alcohol).

   ☐ Yes ☐ No

4. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

   ☐ Yes ☐ No

5. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

   ☐ Yes ☐ No

6. You must provide the following documents unless you are seeking to be employed by the credentialing entity.

   A. One recent passport size photograph of yourself or a copy of your current driver's license.

   B. Permanent Resident Card or Visa Status (if applicable).

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

Supplemental B

Health Status. ***Please answer each of the following questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.***

1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? *If the answer to this question is "YES", please give full explanation of the specific details on an Explanation Form and attach to the Application.*

   ☐ Yes ☐ No

   (Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)

2. Are you currently in a treatment or monitoring program(s) for a physical or mental condition that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this application?
   If the answer to this question is "YES", please give a full explanation of the specific details, including dates of treatment or monitoring, on an Explanation Form and attach to the Application.

   ☐ Yes ☐ No

   (Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)

3. Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? *If reasonable accommodation is required, please specify such on an attached Explanation Form.*

   ☐ Yes ☐ No

4. Please document your current TB status by checking the applicable boxes below:

   ☐ I have had a TB test within the last 12 months and the test was negative. Documentation attached. I have not experienced new risk factors for TB nor am I experiencing symptoms of active TB since my last TB test.

   ☐ I have had a history of previous infection with Mycobacterium Tuberculosis or a positive TB test but I since have had a chest x-ray which was read as normal. Documentation attached. I currently have no symptoms of active disease and have not experienced new risk factors for TB in the past year.

   ☐ I currently have active TB disease which is being adequately treated. Applicable documentation is attached.

   ☐ Other _____

5. The Colorado Board of Health requires licensed health care facilities to annually report their health care worker influenza vaccination rate and achieve a vaccination rate of at least 90%. To facilitate compliance with this rule, some health care facilities may require annual influenza vaccination of employees and staff.

☐ If this facility must comply with the Colorado Board of Health requirements, I agree to provide proof of influenza vaccination or a medical exemption before practicing at this facility.

Please print your name: _____

_____ _____

Signature Date

REMEMBER TO SAVE THE COMPLETED APPLICATION

COLORADO
Board of Health
Department of Public Health & Environment

February 16, 2022

Janel Loud-Mahany
Chair, Health Care Credentials Application Review Committee
jloud@copic.com

Dear Ms. Loud-Mahany,

Thank you for your informative presentation at the January 19, 2022 Colorado State Board of Health (Board) meeting regarding the Health Care Credentials Uniform Application Act. This Act established a health care credentials application review committee (Committee), of which you are the current Chair, to recommend to the Board a single application form for the collection of core credentials data in this State. Committee members are appointed by the Board, and changes that the Committee identifies during their yearly review of the application form are to be approved by the Board as well. During the Committee's annual meeting for review of the application in 2021, the Committee recommended that the statute should be repealed as the uniform application was no longer necessary.

While the Board still believes in the intent of the Health Care Credentials Uniform Application Act to provide a single application for credentialing of healthcare providers, it has become clear that the Act is no longer able to meet that goal. Technological advancements in the past 18 years have made the limitations of the Act clear and healthcare facilities that require credentialing have created more flexible and convenient applications, while the uniform application form exists as a pdf that needs to be printed and physically mailed to the facility. With the limitations of the uniform application, impacted facilities have created their own credentialing process, with the uniform application being redundant at this point.

Based upon the Committee's recommendations and stakeholder statements regarding the process for credentialing and the shortcomings of the current use of the uniform application form, the State Board of Health supports a statutory change to the Health Care Credentials Uniform Application Act that would result in easing the paperwork burden on health care providers seeking credentialing at healthcare facilities.

Sincerely

Patricia J. Hammon

Patricia Hammon, RN
President, Colorado Board of Health

Cc: Jill Hunsaker Ryan, Executive Director Colorado Department of Public Health and Environment
George Twigg, Director of Legislative and Intergovernmental Affairs, Colorado Department of Public Health and Environment

An Act

SENATE BILL 22-226

BY SENATOR(S) Jaquez Lewis and Rankin, Bridges, Buckner, Coleman, Donovan, Fields, Ginal, Gonzales, Hansen, Hinrichsen, Kolker, Moreno, Pettersen, Priola, Rodriguez, Simpson, Story, Fenberg;
also REPRESENTATIVE(S) Mullica, Amabile, Bacon, Bernett, Bird, Boesenecker, Caraveo, Duran, Exum, Herod, Hooton, Jodeh, Kennedy, Kipp, Lindsay, Lontine, McCluskie, McCormick, McLachlan, Michaelson Jenet, Ortiz, Ricks, Roberts, Soper, Tipper, Titone, Valdez A., Valdez D., Woodrow, Young.

CONCERNING MEASURES TO SUPPORT THE HEALTH-CARE WORKFORCE, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) All Coloradans owe a significant debt of gratitude to our health-care, public health, emergency medical services, behavioral health, and direct care workforce who displayed perseverance, dedication, resilience, and bravery through the COVID-19 pandemic;

Capital letters or bold & italic numbers indicate new material added to existing law; dashes through words or numbers indicate deletions from existing law and such material is not part of the act.

(I) Is a small rural school district or rural school district; or

(II) Is eligible to receive money under Title I, part A of the federal "Elementary and Secondary Education Act of 1965", 20 U.S.C. sec. 6301 et seq.

(9) THE GENERAL ASSEMBLY SHALL APPROPRIATE THREE MILLION DOLLARS FROM THE ECONOMIC RECOVERY AND RELIEF CASH FUND CREATED IN SECTION 24-75-228 TO THE DEPARTMENT FOR THE PROGRAM.

(10) THE DEPARTMENT AND ANY PERSON WHO RECEIVES MONEY FROM THE DEPARTMENT SHALL COMPLY WITH THE COMPLIANCE, REPORTING, RECORD-KEEPING, AND PROGRAM EVALUATION REQUIREMENTS ESTABLISHED BY THE OFFICE OF STATE PLANNING AND BUDGETING AND THE STATE CONTROLLER IN ACCORDANCE WITH SECTION 24-75-226 (5).

SECTION 10. In Colorado Revised Statutes, 25-1.5-102, **add** (1)(e) as follows:

25-1.5-102. Epidemic and communicable diseases - powers and duties of department - rules - definitions. (1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(e) FOR FISCAL YEAR 2022-23, THE GENERAL ASSEMBLY SHALL APPROPRIATE TEN MILLION DOLLARS FROM THE ECONOMIC RECOVERY AND RELIEF CASH FUND CREATED IN SECTION 24-75-228 TO THE DEPARTMENT. THE DEPARTMENT SHALL USE THIS APPROPRIATION FOR RECRUITMENT AND RE-ENGAGEMENT EFFORTS OF WORKERS IN THE HEALTH-CARE PROFESSION WITH CURRENT OR EXPIRED LICENSES AND STAFFING.

SECTION 11. In Colorado Revised Statutes, **repeal** 25-1-108.7.

SECTION 12. Appropriation. (1) For the 2022-23 state fiscal year, $35,000,000 is appropriated to the department of public health and environment. This appropriation is from the economic recovery and relief cash fund created in section 24-75-228 (2)(a), C.R.S., and is of money the state received from the coronavirus state fiscal recovery fund. To implement this act, the department may use this appropriation as follows:

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.

Steve Fenberg
PRESIDENT OF
THE SENATE

Alec Garnett
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Robin Jones
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED May 18th at 12:45 pm
(Date and Time)

Jared S. Polis
GOVERNOR OF THE STATE OF COLORADO