Sanford Health Multi-Facility, Sanford Health Plan and CVO-Contracted Entities
Initial Application

Applicant's Name:

Check all that apply:

☐ Applying for appointment/clinical privileges at a Sanford Medical Center-*Refer to page 2 for full listing*

☐ Applying as Solutions by Sanford contractor

☐ Applying as a Sanford Clinic Employee

- ☐ Sanford Clinic North (Fargo Region)
- ☐ Sanford Clinic of Northern Minnesota (Bemidji Region)
- ☐ Sanford Clinic West (Bismarck Region)
- ☐ Sanford Clinic South (Sioux Falls Region)

☐ Applying as a Locum/Independent contractor Company:_____

☐ Applying for Sanford Health Plan - *Refer to page 3*

☐ Applying for a CVO-Contracted Entity - *Refer to page 3 for full listing*

If you have a credentialing contact at your current practice or your locum company we may contact regarding questions on this application, please complete below.			
Name:			Phone:
Address:			Fax:
City:	State:	Zip:	Email:

Have you ever previously applied to a Sanford facility? ☐ Yes ☐ No

If Yes, which facility?_____

Approximate date:_____

SANFORD HEALTH MULTI-FACILITY AND HEALTH PLAN APPLICATION

You may complete one application if applying to multiple Sanford facilities/entities. In order to process your application for all Sanford facilities it is important to identify all facilities for which you are applying on this page. Please check those facilities which apply. If unsure, please contact your clinic manager for assistance.

NOTE: <u>All sites requested will be contacted for authorization of credentialing/privileging.</u>

Facility Appointment	City	State	Requesting at this Site	Facility Appointment	City	State	Requesting at this Site
Sanford Aberdeen Medical Center	Aberdeen	SD	☐	Sanford Luverne Medical Center	Luverne	MN	☐
Sanford Bagley Medical Center	Bagley	MN	☐	Sanford Mayville Medical Center	Mayville	ND	☐
Sanford Bemidji Medical Center	Bemidji	MN	☐	Sanford Sheldon Medical Center	Sheldon	IA	☐
Sanford Bismarck Medical Center	Bismarck	ND	☐	Sanford Sioux Falls USD Medical Center	Sioux Falls	SD	☐
Sanford Canby Medical Center	Canby	MN	☐	Sanford Thief River Falls Medical Center	Thief River Falls	MN	☐
Sanford Canton-Inwood Medical Center	Canton	SD	☐	Sanford Tracy Medical Center	Tracy	MN	☐
Sanford Chamberlain Medical Center	Chamberlain	SD	☐	Sanford Vermillion Medical Center	Vermillion	SD	☐
Sanford Clear Lake Medical Center	Clear Lake	SD	☐	Sanford Webster Medical Center	Webster	SD	☐
Sanford Dickinson Ambulatory Surgery Center	Dickinson	ND	☐	Sanford Westbrook Medical Center	Westbrook	MN	☐
Sanford Fargo Medical Center	Fargo	ND	☐	Sanford Wheaton Medical Center	Wheaton	MN	☐
Sanford Hillsboro Medical Center	Hillsboro	ND	☐	Sanford Worthington Medical Center	Worthington	MN	☐
Sanford Jackson Medical Center	Jackson	MN	☐	Watertown Ambulatory Surgical Center	Watertown	SD	☐

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

SANFORD HEALTH PLAN

Applying with Sanford Health Plan & not employed by Sanford Clinic ☐

Complete primary practice location information below if applying for Sanford Health Plan & not employed by Sanford Clinic

Name:			Phone:	Fax:
Address:			Email:	
City:	State:	Zip:	Federal Tax ID:	Type II NPI:

SANFORD MANAGED FACILITIES AND SANFORD CENTRAL VERIFICATION OFFICE CONTRACTED ENTITIES

Certain non-Sanford Facilities that are managed by or contracted with Sanford CVO have chosen to accept Sanford's uniform application. In order to process your application for these facilities it is important to identify all facilities for which you are applying on this page. Please check those facilities which apply. If unsure, please contact your clinic manager for assistance.

NOTE: All sites requested will be contacted for authorization of credentialing/privileging.

Entity Name	City	State	Requesting at this site
Bethesda Nursing Home	Beresford	SD	☐
Community Memorial Hospital	Burke	SD	☐
Coteau Des Prairies	Sisseton	SD	☐
Endoscopy Center	Rapid City	SD	☐
LifeScape	Sioux Falls	SD	☐
Mahnomen Health Center	Mahnomen	MN	☐
McKenzie County Hospital	Watford City	ND	☐
MN Veterans Home – Luverne	Luverne	MN	☐
Orange City Area Health System	Orange City	IA	☐
Ortonville Area Health Services	Ortonville	MN	☐
Perham Health	Perham	MN	☐
Pioneer Memorial Hospital & Health Services	Viborg	SD	☐
Sanford Home Medical Equipment	Sioux Falls	SD	☐
TLC Advantage, LLC	Sioux Falls	SD	☐
Windom Area Hospital	Windom	MN	☐
Winner Regional Healthcare Center	Winner	SD	☐

PERSONAL INFORMATION

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

Name:

Last First Middle Professional Title/Degree

All Name(s) or aliases(s) which you have been identified under:

Last First MI

Marital Status: **Spouse Name:**

Date of Birth: **Place of Birth:**

City State Country

Social Security Number: **Gender:** Male ☐ Female ☐

Citizenship: If Not American Citizen, Status and Visa numbers:

Do you speak a language other than English, including American Sign Language, with sufficient fluency to speak to patients in that language without an interpreter? ☐ Yes ☐ No

If yes, what language?

Do you plan to speak in that language with your patient population without an interpreter? ☐ Yes ☐ No

If yes, have you ever taken a medical language assessment exam for this language? ☐ Yes ☐ No
If yes, provide a copy of the certificate of completion. If no please refer to page 29 for FAQ.

National Provider Identification Number (NPI):

Driver's License Number: **Issuing State:**

Current Home Address:

Street City State Zip

Future Home Address:

(If different from above) Street City State Zip

Home Number: **Cell Number:**

E-Mail Address:

***Do you perform Telemedicine Services from your home?** ☐ Yes ☐ No

***Clinic/Location of preferred billing/mailing address:**

***Address:**	***City:**	***State:**	***Zip:**

***Denotes required fields for Sanford Health Plan**

MEDICAL EDUCATION/PROFESSIONAL EDUCATION

Institution Name:_____
Address:_____ City:_____State:_____ Zip: _____

Phone:_____ Fax:_____
Degree Received:_____

From:_____ To:_____
Month/Year Month/Year

POSTGRADUATE TRAINING

Provide the following information for each training program attended. **List All (Completed or Not)**

1. Institution Name:_____

Address:_____ City:_____State:_____Zip:_____

Phone:_____Fax:_____

Program Director:_____ E-mail:_____

Type or Degree:_____

Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

Specialty:_____

From:_____ To:_____ Successfully Completed: ☐ Yes ☐ No ☐ In Progress
Month/Year Month/Year

If not successfully completed, explain:_____

2. Institution Name:_____

Address:_____ City:_____ State:_____Zip:_____

Phone:_____ Fax:_____

Program Director:_____ E-mail:_____

Type or Degree:_____

Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

Specialty:_____

From:_____ To:_____ Successfully Completed: ☐ Yes ☐ No ☐ In Progress
Month/Year Month/Year

If not successfully completed, explain:_____

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3. Institution Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Program Director: _____ E-mail: _____

Type or Degree: _____

Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

Specialty: _____

From: _____ To: _____ Successfully Completed: ◯ Yes ◯ No ◯ In Progress
Month/Year Month/Year

If not successfully completed, explain: _____

4. Institution Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Program Director: _____ E-mail: _____

Type or Degree: _____

Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

Specialty: _____

From: _____ To: _____ Successfully Completed: ◯ Yes ◯ No ◯ In Progress
Month/Year Month/Year

If not successfully completed, explain: _____

ECFMG-APPLICABLE TO INTERNATIONAL MEDICAL GRDUATES

ECFMG Number: _____ Date Issued: _____ Valid Through: _____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

BOARD CERTIFICATION

Please give the following information for each certification you have completed, or are eligible to complete.

Specialty: _____ Board Status: _____

Board Name/Issued By: _____

Date Issued: _____ Date Recertified: _____ Expiration Date:

Are you participating in MOC? Yes No N/A If No, Explain: _____ Certification Number: _____

If Yes, do you intend on continuing MOC? Yes No If No, Explain:

If you are not certified, are you qualified to sit for the exam? Yes ☐ No ☐

Are you scheduled to take the exam? Yes ☐ No ☐ If yes, attach Confirmation letter.

Date Scheduled: Oral: _____ Written: _____

Have you ever failed a board certification exam? Yes ☐ No ☐ If yes, provide explanation _____

_____

SUB-SPECIALTY: _____ Board Certified Yes No

Specialty: _____ Board Status: _____

Board Name/Issued By: _____

Date Issued: _____ Date Recertified: _____ Expiration Date: _____

Are you participating in MOC? Yes No N/A If No, Explain: _____

If Yes, Do you intend on continuing MOC? Yes No If No, Explain: _____

SUB-SPECIALTY: _____ Board Certified Yes ☐ No ☐

Specialty: _____ Board Status: _____

Board Name/Issued By: _____

Date Issued: _____ Date Recertified: _____ Expiration Date: _____

Are you participating in MOC? Yes No N/A If No, Explain: _____

If Yes, Do you intend on continuing MOC? Yes No If No, Explain: _____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

PROFESSIONAL LIABILITY INSURANCE CARRIERS FOR APPOINTMENT

Enclose a copy of **ALL** professional liability insurance coverage (e.g. face sheet/verification of self-insurance) for all policies from the **LAST 5 YEARS**, **CURRENT** and **FUTURE** practice locations. Copy must include effective dates, insurance carrier, expiration date, coverage limits and name of each provider covered. Complete requested information below and enclose copy of Certificate of Insurance for each. If additional space is required, attach a separate sheet.

Current/Most Recent Policy **Insurance Carrier Name:** _____

Coverage Dates: Address: _____

City State Zip

From: _____ Verification Contact: _____ Phone: _____ Fax: _____

To: _____ Facility in which policy issued: _____

Policy Number: _____ Expiration Date: _____

Amount of Coverage: (per occurrence/aggregate): _____

☐ Check if will be covered under Sanford Health Policy. If no, complete below.

Pending Policy **Insurance Carrier Name:** _____

Coverage Dates: Address: _____

City State Zip

From: _____ Verification Contact: _____ Phone: _____ Fax: _____

To: _____ Facility in which policy issued: _____

Policy Number: _____ Expiration Date: _____

Amount of Coverage: (per occurrence/aggregate): _____

EMERGENCY CARE TRAINING CERTIFICATIONS

Check classification(s) and *attach copy of certificate(s):*

☐ Basic Life Support (BLS) Expiration Date: _____

☐ Advanced Cardiac Life Support (ACLS) Expiration Date: _____

☐ Advanced Trauma Life Support (ATLS) Expiration Date: _____

☐ Neonatal Advanced Life Support (NALS) Expiration Date: _____

☐ Pediatric Advanced Life Support (PALS) Expiration Date: _____

☐ Neonatal Resuscitation (NRP) Expiration Date: _____

Other: _____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

LICENSURE

List all CURRENT, PAST and PENDING Professional/Training (Residency, Fellowship) License(s).
*If restricted/limited, please check box in last column and attach an explanation on a separate sheet.
Duplicate Section if need additional space.

State	License Number	Type	Date Issued	Date Expired	License Status	Restricted*
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

FEDERAL DEA/STATE CONTROLLED SUBSTANCE REGISTRATION

NOTE: Address on DEA certificate must be in the state where you will be practicing as applicable to this application.

Do you hold a current FEDERAL DEA? Yes ☐ No ☐ Not applicable to practice ☐

DEA certificate pending; date application submitted to DEA:_____
(Attach copy of application)

If you do not maintain a DEA certificate, please explain:

Other: _____

List all CURRENT, PAST and PENDING Federal DEA and State Controlled Substance Registrations.

State	Registration Type	License Number	Date Issued	Date Expired	Status

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

PROFESSIONAL EXPERIENCE

Employment:

List all activities in chronological order since completion of training**.** (do not include affiliations, internships, residencies or training).

If you worked for a physician-staffing group or did locum tenens, list the company in which employed including dates. Facilities in which you worked will be listed in the affiliations section.

Affiliations:

List **ALL** hospital/health system/clinical practice affiliations or locations where you have privileges or had been privileged, contracted, associated, practiced, etc. since completion of training (do not include employment, internships, residencies or training).

If you worked for a physician-staffing group or did locum tenens, list all facilities in which you worked in that capacity.

Gaps:

Explain all gaps in employment and/or clinical practice that are 60 days or greater since completion of training.

EMPLOYMENT

List all employment chronologically starting with the employment location pertinent to this application.
(month & year are required)

Employment Location:

Start Date:	Position:			
	Address:	City:	State:	Zip:
	Phone:		Fax:	
	Contact Name:		Email:	
☐ Employment ☐ Academic/Faculty ☐ Additional Location ☐ Military			Other:	

Will this be your primary location? ◯ Yes ◯ No

Will you provide services for additional/outreach locations for this practice? ◯ Yes ◯ No
If yes please list on Appendix B, Additional Practice Locations.

Provide the following information if you will be enrolling this practice with Sanford Health Plan.
(Disregard if Sanford Clinic Employed.)

Federal Tax ID Number:_____ Type II NPI Number:_____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

EMPLOYMENT CONTINUED
DUPLICATE THIS SECTION AS NEEDED

Employment Location (past or present):

Start Date:	Address:	City:	State:	Zip:
End Date:	Phone:	Fax:		
Reason for leaving:	Contact Name:	Email:		

☐ Employment ☐ Academic/Faculty ☐ Additional Location ☐ Military Other:

Will you provide services for additional/outreach locations for this practice? ☐ Yes ☐ No
If yes please list on Appendix B, Additional Practice Locations.

Provide the following information if you will be enrolling this practice with Sanford Health Plan.
(Disregard if Sanford Clinic Employed.)

Federal Tax ID Number: _____ Type II NPI Number: _____

Employment Location (past or present):

Start Date:	Address:	City:	State:	Zip:
End Date:	Phone:	Fax:		
Reason for leaving:	Contact Name:	Email:		

☐ Employment ☐ Academic/Faculty ☐ Additional Location ☐ Military Other:

Will you provide services for additional/outreach locations for this practice? ☐ Yes ☐ No
If yes please list on Appendix B, Additional Practice Locations.

Employment Location (past or present):

Start Date:	Address:	City:	State:	Zip:
End Date:	Phone:	Fax:		
Reason for leaving:	Contact Name:	Email:		

☐ Employment ☐ Academic/Faculty ☐ Additional Location ☐ Military Other:

Will you provide services for additional/outreach locations for this practice? ☐ Yes ☐ No
If yes please list on Appendix B, Additional Practice Locations.

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

AFFILIATIONS

Do you currently or will you have Hospital Privileges? ☐ **Yes** ☐ **No** **If yes complete below.**

If you do not plan to have admitting privileges, describe method/coverage for continuity of care. Please provide covering physician's name, if applicable.

List **ALL** affiliations chronologically starting with the location pertinent to this application. List hospital/health system/clinical practice affiliations or locations where you have privileges or had been privileged, contracted, associated, practiced, etc.

(do not include employment, internship, residency or training).

Hospital/Affiliation:				
Start Date: *(month & year required)*	Department Chairperson/Chief of Staff Name:			
	Address:	City:	State:	Zip:
	Phone:	Fax:		
	Email:			
Admitting Privileges: ☐ Yes ☐ No	☐ Active ☐ Consulting ☐ Telemedicine Only ☐ Temporary ☐ Pending			
	Other:			
Hospital/Affiliation:				
Start Date: *(month & year required)*	Department Chairperson/Chief of Staff Name:			
End Date: *(month & year required)*	Address:	City:	State:	Zip:
	Phone:	Fax:		
	Email:			
Admitting Privileges: ☐ Yes ☐ No	☐ Active ☐ Consulting ☐ Telemedicine Only ☐ Temporary ☐ Pending			
	Other:			

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

AFFILIATIONS CONTINUED
DUPLICATE THIS SECTION AS NEEDED

Hospital/Affiliation:

Start Date:	Department Chairperson/Chief of Staff Name:			
End Date:	Address:	City:	State:	Zip:
	Phone:		Fax:	
	Email:			

Admitting Privileges ☐ Yes ☐ No ☐ Active ☐ Consulting ☐ Telemedicine Only ☐ Temporary ☐ Pending

Other:

Hospital/Affiliation:

Start Date:	Department Chairperson/Chief of Staff Name:			
End Date:	Address:	City:	State:	Zip:
	Phone:		Fax:	
	Email:			

Admitting Privileges ☐ Yes ☐ No ☐ Active ☐ Consulting ☐ Telemedicine Only ☐ Temporary ☐ Pending

Other:

Hospital/Affiliation:

Start Date:	Department Chairperson/Chief of Staff Name:			
End Date:	Address:	City:	State:	Zip:
	Phone:		Fax:	
	Email:			

Admitting Privileges ☐ Yes ☐ No ☐ Active ☐ Consulting ☐ Telemedicine Only ☐ Temporary ☐ Pending

Other:

NOTE: A CV OR "SEE CV" MAY NOT BE USED ***in lieu of completing any answers on this application***

GAPS

Explain all gaps in employment and/or clinical practice that are 60 days or greater since completion of training.

From: _____ Explain: _____

To: _____

From: _____ Explain: _____

To: _____

From: _____ Explain: _____

To: _____

From: _____ Explain: _____

To: _____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

PEER REFERENCES FOR APPOINTMENT

Please list three (3) professional peers who have personal knowledge of your **current (within the past 12 months)** clinical skills, abilities, judgment, professional performance and clinical competence or have been responsible for professional observation of your work. A peer is defined as an individual in the same professional discipline with essentially equal qualifications (MD and DO are considered equivalent; DDS/DMD for DDS/DMD.)

In selecting your references:

- Include at least one (1) current practicing partner.
- At least one reference should be in your specialty (and if possible from the same subspecialty).
- **Do not include your residency/fellowship director, relatives, or pending partners.**
- **Allied Health, Professional Health or non-physician applicants include past or current supervising/collaborating physician or an MD/DO aware of clinical competency.**
- **If Physician, include Professional Health Practitioner that they supervise or hold a collaboration agreement.**

Provide current and complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

1.

Name:_____ Title:_____

Mailing Address: _____

Email: _____

Phone:_____ Fax:_____

Relationship to Applicant: _____ Specialty: _____

2.

Name: _____ Title:_____

Mailing Address: _____

Email: _____

Phone: _____ Fax:_____

Relationship to Applicant:_____ Specialty: _____

3.

Name: _____ Title:_____

Mailing Address: _____

Email: _____

Phone: _____ Fax:_____

Relationship to Applicant: _____ Specialty: _____

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REQUIRED DISCLOSURE QUESTIONS

All questions must be answered. A complete explanation, to include resolution of issues, must be provided if any of the questions are answered in the affirmative. An additional sheet or attachments may be added if needed.

1. Yes ☐ No ☐ Has your professional license or registration been terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, voluntarily relinquished, withdrawn, or not renewed by any licensing or disciplinary board, agency or committee, any health-related entity, or any governmental agency or organization, or is there a review pending?

2. Yes ☐ No ☐ Has your professional license or registration been subject to proceedings or investigations by a licensing or disciplinary board, agency or committee, health-related entity or governmental agency or organization to terminate, stipulated, restrict, limit, withdraw, condition, reprimand, suspend, revoke, refuse, deny, relinquish, or not renew your professional license and, if so, what were the results?

3. Yes ☐ No ☐ Has your DEA registration been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?

4. Yes ☐ No ☐ Has your membership or fellowship in any professional organization or your specialty board certification been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?

5. Yes ☐ No ☐ Have you appeared or been requested to appear before any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization concerning any violation by you of any law, rule or regulation of any state, district, territory or province of the United States, Canada or other country?

6. Yes ☐ No ☐ Have you ever withdrawn your application for appointment, reappointment or clinical privileges at any hospital or health care facility, or for participating provider status in a managed care organization, or resigned before a decision was made by a governing board of such entities?

7. Yes ☐ No ☐ Have you voluntarily relinquished your membership, participation, clinical privileges or request for privileges, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?

8. Yes ☐ No ☐ Have you involuntarily relinquished your membership, participation, clinical privileges or request for privileges, professional license or registration?

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9. Yes ☐ No ☐ Have you ever resigned employment with any employer in lieu of impending investigation, complaint, disciplinary action or termination?

10. Yes ☐ No ☐ Have you ever been terminated or involuntarily separated from employment?

11. Yes ☐ No ☐ Have you ever been subject to a focused review or peer review investigation at any hospital, health care facility or managed care organization (except for focused professional practice evaluation for initial/provisional status)?

12. Yes ☐ No ☐ Have any conditions ever been imposed on your appointment and clinical privileges at any hospital or health care facility, including but not limited to, any performance improvement plan, general consultation requirements, proctoring, additional training requirements, probation, or conditions pertaining to clinical practice or behavior/professional conduct?

13. Yes ☐ No ☐ Have you been subject to proceedings or investigations (for any reason) by any medical facility or professional society, group or organization to terminate, stipulate, restrict, limit, condition, reprimand, suspend, revoke, refuse, deny, relinquish, withdraw or not renew membership?

14. Yes ☐ No ☐ Have you been notified of a complaint by a medical facility or professional society, group or organization, or any licensing or disciplinary board, agency or committee, health-related entity, or governmental agency or organization?

15. Yes ☐ No ☐ Have you had your membership, participation, clinical privileges, request for privileges or employment terminated, stipulated, restricted, limited, conditioned, reprimanded, suspended, revoked, refused, denied, withdrawn or relinquished to, or not renewed by any peer review committee or organization, third party payer, clinic hospital, medical staff, or any health-related agency or organization, or is there a review pending?

16. Yes ☐ No ☐ Have you been reprimanded, censured or otherwise disciplined by, or been subject to a corrective action agreement/plan with any licensing or disciplinary board, agency or committee, health-related entity, governmental agency or organization, peer review organization, professional assistance program, third party payer, clinic, hospital or medical staff?

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17. Yes ☐ No ☐ Have you ever been sanctioned by, terminated from, excluded from, or refused/denied participation in any state, federal or private health benefit or health insurance program, plan, policy or payer, including but not limited to the Medicare and Medicaid programs?

18. Yes ☐ No ☐ Are you currently under any sanction which precludes you from enrolling as a participating provider with the Medicare, Medicaid or any other federal or state benefit program or is any investigation or proceeding with respect to any such action presently underway? (If yes, include in full explanation nature and extent of any such sanction.)

19. Yes ☐ No ☐ Have you ever been reported to the NPDB (National Practitioners Data Bank) for any reason?

20. Yes ☐ No ☐ Have you been dishonorably discharged from a branch of the United States military or National Guard?

21. Yes ☐ No ☐ Have you been charged or have pending charges, by complaint, information, indictment, arrested or otherwise, of any felony misdemeanor, other than a minor traffic violation?

22. Yes ☐ No ☐ Have you ever been party to any civil litigation relating to the practice of your profession, other health care-related matters, third-party reimbursement, or ethical issues?

23. Yes ☐ No ☐ Have you ever been convicted of, plead guilty to, or plead no contest to, or received a suspended imposition of sentence or suspended sentence of any kind to any felony or misdemeanor, other than motor vehicle speeding violations? (If yes, please include in the full explanation the dates, initial charges and resolution of charges.)

24. Yes ☐ No ☐ Have you ever been accused of or been disciplined, found liable, guilty or responsible for sexual impropriety, sexual misconduct, sexual harassment, disruptive or discriminatory behavior?

25. Yes ☐ No ☐ Have you been convicted of or pleaded no contest to a drug or alcohol related offense?

26. Yes ☐ No ☐ Are you currently using any illegal drugs or any other substance in an illegal manner that would impair your ability to practice safely? ("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 medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 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.) _____

If you answer no to question number 27 below, please provide full explanation.

27. Yes ☐ No * ☐ Are you able to safely and competently provide appropriate care to patients and otherwise perform the duties and responsibilities in your area of practice including, but not limited, to exercise the clinical privileges requested, provide emergency service coverage and other professional services of appointment or membership?

_____

~Malpractice Questions~ Answer ALL Malpractice Claim History Questions.
If questions 30-34 are answered IN THE AFFIRMATIVE, please COMPLETE, SIGN AND DATE the "Professional Liability Addendum" section in its entirety.

28. Yes ☐ No ☐ Have you practiced within your profession without professional liability insurance? (If yes, provide additional information below.)

_____

29. Yes ☐ No ☐ Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?

_____

If you answer yes to any of the questions below, please provide full explanation on the following Professional Liability Addendum.

30. Yes* ☐ No ☐ Have you had any judgments entered against you in a professional liability case?

31. Yes* ☐ No ☐ Have you ever had any final judgments, settlements, or malpractice claims paid by you or on your behalf by another entity?

32. Yes* ☐ No ☐ Have there been, or are there currently pending, any malpractice claims, suits, demands, settlements or arbitration proceedings involving your professional practice?

33. Yes* ☐ No ☐ Have you ever been denied professional liability insurance, has your coverage ever been canceled or have you ever been rated at a higher rate than average risk class for your specialty?

34. Yes* ☐ No ☐ Has any insurance company ever imposed a surcharge or additional premium because of your claims history?

I hereby certify that all the information on this application form is complete, true and accurate.

Printed Name _____

Signature_____ **Date**_____

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

PROFESSIONAL LIABILITY ADDENDUM
CONFIDENTIAL INFORMATION

If you answered, **"YES"** to questions regarding **"Malpractice Claim History, Professional Complaints and/or Actions"**, you *must* complete the following questions in full and attach a copy of the complaint including your response to the complaint and level of participation. ***It is your responsibility to provide external verification*** (i.e. statement from an attorney, court records, etc.) ***of your response***. You may choose to have your attorney complete this form. ***Please make additional copies of this form if needed.***

Month/ Year of Incident_____/_____ Reported to the National Practitioner Databank (NPDB) ☐ **YES** ☐ **NO**
Where Incident Occurred: Facility Name_____
City State Zip

Name(s) of Plaintiff(s) or Complaint(s):_____

Describe the nature of the incident (Complaint, Allegation):

_____
_____
_____

Provide a narrative description of your participation/level of care:

_____
_____
_____

Outcome of Incident:

☐ Pending ☐ Dropped/Settled/Closed–no payment ☐ Date Closed___/___/___ ☐ Verdict for you–no payment

☐ Dropped/Settled/Closed with payment, amount:_____ ☐ Dismissed with prejudice

☐ Verdict for plaintiff, amount:_____ ☐ Dismissed without prejudice

Represented by Legal Counsel for this claim/malpractice lawsuit? ☐ YES ☐ NO
If yes*, give the **Name and Address of Counsel:

Name: _____

Address: _____
Street City State Zip

Phone **N**umber:_____ **F**ax **N**umber: _____

Insurance Company that provided coverage for this Claim:

Name: _____

Address: _____
Street City State Zip

Policy **N**umber: _____

PRINTED NAME_____

_____ _____
SIGNATURE **DATE**

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

ALL Applicants must SIGN and DATE the Waiver of Liability & Consent for Release of Information.

I understand and acknowledge that, as an applicant for appointment, membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at such facilities I am applying (hereafter each referred to as Entity), it is my responsibility to ensure that the information provided in or attached to this application is accurate and complete to the best of my knowledge and belief. I understand and agree that any material misrepresentation, misstatement in or omission from the Application may constitute grounds for immediate cessation of processing the application or automatic relinquishment of Participation.

I understand that as an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications to include professional competence, character, ethics, the ability to work cooperatively with others, the ability to safely perform the duties and responsibilities of Participation, and any other criteria adopted by the Entity's credentialing policy and/or Bylaws. I also bear the responsibility of resolving doubts about such qualifications, of providing up-dated information regarding all questions on the application form as such information becomes available, and providing additional information as may be requested by any Entity. Failure to produce any requested information will prevent my application from being processed. I agree to appear for interviews concerning my application or reapplication for Participation if requested.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated Central Verification Service (CVS), Credentialing Verification Organization (CVO), and Medical Staff Services/Office of Professional Practice , collectively referred to as "Agents", will investigate the information in this Application. I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care. By submitting this Application, I agree to such investigation the sharing of related information within Entity's organization or with Entity's representatives and/or Agents, and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. Authorization of Investigation and Release of Information Concerning Application for Participation. I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.

2. Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any health-care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me, without limitation, to the Entity and/or its Agents, and as otherwise may be required by law. I hereby further authorize Entity and/or Agents to release Disciplinary Information about any disciplinary action taken against me to entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I had knowledge that such formal charges were contemplated and/or were in preparation.

3. Release from Liability. To the fullest extent permitted by law, I extend absolute immunity to, release from any and all liability, and agree not to sue those the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurancecarrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization in connection with the gathering andrelease and exchange of information as consented to above. This release shall be in addition to any other applicable peer review or other immunities provided bylaw.

I acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation. I understand that Entity Bylaws do not constitute a contract between the medical staff and the physician and acknowledge that they can be changed by the Board of Directors at any time. I agree to adhere to the Corporate Compliance Policy of Entity and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program or activities at Entity and report any known or suspected violation of the same by myself or by any officer, director, employee or other participant to the appropriate Entity leader or Compliance Officer.

I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation. I agree that the hearing and appeal procedures set forth in the Entity's bylaws and credentialing policy shall be my sole and exclusive remedy with respect to any professional review action taken at the Entity. If, notwithstanding the provisions in this Section, I institute legal action and do not prevail, I agree to reimburse the Entity and agent and any member of the medical staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorneys' fees.

I understand and agree that the Entity or its Agents may communicate with me via e-mail over the Internet regarding my application for Participation. I understand that unencrypted, unauthorized Internet e-mail is inherently insecure. I further understand that Internet messages may be corrupted or incomplete, or may incorrectly identify the sender.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

My signature acknowledges that all of the information provided in or attached to this application is accurate and complete. I understand that any misrepresentation, misstatement, or omission from this application, whether intentional or not, shall constitute cause for the immediate cessation of the processing of the application and no further processing shall occur. In the event that Participation has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute automatic relinquishment of my Participation. In either situation, I am not entitled to any hearing or appeal rights. I agree to inform the Entity or its Agents of: any change or proposed changes in the status of my professional license or permit to practice; state or federal controlled substances registrations; professional liability insurance coverage; membership/employment/faculty status or clinical privileges in other institutions/facilities/ organizations; the existence of any disciplinary proceedings, as defined in the application; and, on the status of current or initiation of new malpractice claims.

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**.**

Printed Name: _____

Signature _____ **Date** _____

*** Signature will be saved and maintained for Pharmacy use for all practitioners who prescribe**

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

APPENDIX A

ACCESSIBILITY QUESTIONS

1. Are you currently accepting new patients into your practice?	☐ **Yes** ☐ **No**
2. Are you willing, in the future, to accept new patients?	☐ **Yes** ☐ **No**
3. Does the office have wheelchair or handicapped access?	☐ **Yes** ☐ **No**

Your practice must provide 24-hour coverage; attach an additonal sheet if necessary. List name, specialty and phone number of physicians covering your practice in your absence: _____

Ethnicity Question:

In an effort to fulfill a NCQA requirement, we are requesting the race/ethnicity of the practitioners in our network. This data will be collected and analyzed to determine if we are meeting the cultural needs of our member population. Please check your race/ethnicity below.

☐	**African American**	☐	**Native American or Alaska Native**
☐	**Asian or Asian Indian**	☐	**Native Hawaiian/Pacific Islander**
☐	**Caucasian or European**	☐	**Declined**
☐	**Hispanic or Latino**	☐	**Other**
☐	**Middle Eastern**		

Military Questions:

Are you an active member of the Reserves?	**Yes** ☐	**No** ☐	**Branch**
Are you an active member of the National Guard?	**Yes** ☐	**No** ☐	**Branch**

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

APPENDIX B

ADDITIONAL PRACTICE LOCATIONS

List all additional practice locations in which you provide services. Duplicate Section if additional space needed.
(Please also include any outreach locations) List all dates with Month/Year

*If addition/outreach location listed will be enrolled with Sanford Health Plan Please complete Federal Tax ID & Type II NPI number for each location. (Disregard if Sanford Clinic employed)

1.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

2.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

3.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

APPENDIX B CONT.

ADDITIONAL PRACTICE LOCATIONS

List all additional practice locations in which you provide services. Duplicate Section if additional space needed.
(Please also include any outreach locations) List all dates with Month/Year

*If addition/outreach location listed will be enrolled with Sanford Health Plan Please complete Federal Tax ID & Type II NPI number for each location.(Disregard if Sanford Clinic employed)

4.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

5.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

6.

Additional Location Name: _____

From Date: _____ Position: _____

Address: _____

To Date: _____ Phone: _____ Fax: _____

Contact Name: _____ Email: _____

*Federal Tax ID Number: _____ *Type II NPI Number: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

Medicare/Medicaid, Tricare and Other Government Reimbursement Programs Penalty Statement:

"NOTICE TO ALL PRACTITIONERS RECEIVING MEDICARE/MEDICAID AND OTHER GOVERNMENT REIMBURSEMENT PROGRAM PAYMENTS"

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Signature:	**Date:**

Name:

STATEMENT OF
Continuing Medical Education (CME) Hours

I hereby certify I meet the continuing medical education (CME) requirements within my state and for my appropriate licensure(s) and renewal of such licensure.

I recognize that random auditing may be conducted and if audited, I will be able to provide documentation of continuing education. I recognize that failure to produce documentation upon request may affect membership on the medical staff.

Signature:	**Date:**
Provider Name:	

HIPAA
ACKNOWLEDGMENT OF
ORGANIZED HEALTHCARE ARRANGEMENT

The undersigned agrees that, with respect to activities at the Hospital, the undersigned shall be considered as part of an Organized Health Care Arrangement (OHCA) with the Hospital as that term is defined at 45 C.F.R. §164.501. The undersigned shall comply with all Hospital policies and federal and state laws and regulations relating to the use and disclosure of individually identifiable health information, and shall adopt such procedures and comply with such policies as may be required from time to time.

The Hospital will provide all patients presenting at their facilities with a Notice of Privacy Practices that includes a notification of the OHCA between the Hospital and its medical staff. The undersigned agrees to inform their patients seen outside the hospital setting of their participation in the OHCA, as a supplement to their own Notice of Privacy Practices.

Signature:	**Date:**

Provider Name:

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

APRN COLLABORATION AGREEMENT

Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Certified Registered Nurse Anesthetists, must have the following collaboration agreement completed if required by state law, entity employment policy or hospital bylaws.

I,_____have an agreement
(**Printed Name of Applicant)**

with a licensed physician or a Medical Group to serve as a collaborative physician for questions that arise about diagnosis and treatment of my patients.

Physician Name or Medical Group	Address, City, State and Zip Code
Phone Number	Fax Number
Signature of Collaborating Physician	**Date**
Printed Name of Collaborating Physician	

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

PHYSICIAN ASSISTANT SUPERVISING PHYSICAN STATEMENT

The following must be completed for all Physician Assistants.

I,_____have an agreement
(**Printed Name of Applicant)**

with a licensed physician or a Medical Group to serve as a supervising physician.

Physician Name or Medical Group	Address, City, State and Zip Code
Phone Number	Fax Number
Signature of Supervising Physician	**Date**
Printed Name of Supervising Physician	

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

DEPENDENT PROVIDER SUPERVISING PHYSICIAN STATEMENT

The following must be completed for all dependent providers including all Allied Health Professionals who are **NOT** Licensed Independent Practitioners or Advanced Practice Providers, if required by state law, entity, employment policy or hospital bylaws. Dependent providers may include but are not limited to the following:

- ☐ Audiologists
- ☐ Certified Dental Assistants
- ☐ Chemical Dependency Counselors
- ☐ Dental Hygienists
- ☐ Genetic Counselors
- ☐ Licensed Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Marriage and Family Therapists
- ☐ Medical Physicists
- ☐ Music Therapists
- ☐ Nuclear Physicists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Registered Nurses
- ☐ Social Workers
- ☐ Surgical Technicians

I,_____have an agreement
(**Printed Name of Applicant)**

with a licensed physician or a Medical Group to serve as a supervising physician for questions that arise about diagnosis and treatment of my patients.

Physician Name or Medical Group	Address, City, State and Zip Code
Phone Number	Fax Number
Signature of Supervising Physician	**Date**
Printed Name of Supervising Physician	

NOTE: A CV OR "SEE CV" MAY NOT BE USED *in lieu of completing any answers on this application*

Bilingual Employees & Physicians
Applicable for Sanford Employees and Sanford Entities only

All employees and physicians who plan to use a language other than English in clinical conversations with patients must complete the Medical Language Assessment. Below are FAQs and the process by which you can complete the assessment.

Frequently Asked Questions

Q: "Why should I take the medical language assessment when I have a college degree in another language or I speak another language fluently?"
A: "The certification shows that you are competent to speak to patients regarding their medical care. This reduces your medical liability. A third part vendor attests to your skills and knowledge base. This allows Sanford to provide the certificate to any outside authority that may question your competence or any patient that may come back at a later time and state that we didn't provide an interpreter or that they didn't understand what you were saying to them."

Q: Who can take the test and speak another language while caring for patients?"
A: Any Sanford employee that would speak to patients about their medical care and have clinical conversations with them for their job. *Examples include but not limited to: Physicians, Nurse Practitioners, Physician Assistants, Nurses, Therapists and some Technicians.* Job that are **excluded but not limited to**: nurse aides, phlebotomy, receptionists, patient care technicians, medical assistants.

Q: "Can I interpret for any patient, anytime, anywhere if I have the certification?"
A: "No, you can only interpret for the patients that you are directly taking care of. Your colleagues should use another interpreter source for their patients."

Q: "Will I get paid additional money if I become certified and interpret for my patients?"
A: "No."

Q: "How do I take the test?"
A: "Contact **Cindy Baldwin, Enterprise Risk Management (Cindy.Baldwin@sanfordhealth.org or 605-312-7638)**. She will get you the link to register for the phone assessment thru Language Line®. The test is approximately 40 minutes. At the end of the assessment, a certificate will be available."

Q: "What do I do with the certificate?"
A: "Keep a copy for yourself and forward a copy to Enterprise Risk Management. They will connect with HR or the Medical Staff office to make sure your employee file is updated and you are reminded when recertification is due."

Q: "How much does the test cost?"
A: "It is free for Sanford employees."

Q: "How often do I have to be certified?"
A: "Every three years."

SANFORD HEALTH

DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND INVESTIGATION FOR MEDICAL AND PROFESSIONAL CREDENTIALING & PRIVILEGING PURPOSES

Disclosure

Sanford Health or its affiliate may request from a consumer reporting agency for credentialing related purposes, a "consumer report(s)" (commonly known as "background reports") containing background information about you in connection with your application for appointment and clinical privileges (including independent contractor or similar assignments, as applicable).

Our vendor, ***Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), a consumer reporting agency located at 1 State Street, New York NY 10004, (877) 424-2457, www.sterlingtalentsolutions.com***

The background report(s) may contain information concerning your character, general reputation, personal characteristics, and professional history. The types of background information that may be obtained include, but are not limited to: criminal history; litigation history; motor vehicle record and accident history; social security number verification; address and alias history; verification of your education and employment; professional licensing, credential and certification checks; drug/alcohol testing results and history; military service; and other information.

A summary of your rights under the Fair Credit Reporting Act is hyperlinked here and can also be found on-line at https://www.ftc.gov/tips-advice/business-center/privacy-and-security/credit-reporting. Should any adverse action be taken as a result of this report, a copy this document will be provided to you separately

Authorization

I hereby authorize Company to obtain the consumer reports described above about me.

Applicant Name (Printed) _____

Applicant Signature_____Date _____

ACKNOWLEDGMENTS & AUTHORIZATIONS

REGARDING BACKGROUND INVESTIGATION

FOR

PROFESSIONAL CREDENTIALING & PRIVILEGING PURPOSES

Investigative Consumer Report:
Sanford Health or its affiliate (the "Company") may request an investigative consumer report about you from Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), a consumer reporting agency, in connection with the credentialing and privileging purposes, or engagement for services (including independent contractor or similar assignments, as applicable).

Ongoing Authorization:
If the Company approves your credentialing and privileging, the Company may obtain additional consumer reports about you without asking for your authorization again, throughout your relationship with Company and as allowed by law.

Additional Legal and Policy Notices Which May Apply to Some Applicants:
Please see the "Additional State Law Notices" for California, Massachusetts, Minnesota, New Jersey, New York, and Washington that are provided below, as applicable. A California disclosure and summary of your rights under California Civil Code Section 1786.22, and a copy of New York Article 23-A, are also included. A summary of your rights under the Fair Credit Reporting Act is hyperlinked here and can also be found on-line at https://www.ftc.gov/enforcement/rules/rulemaking-regulatory-reform-proceedings/fair-credit-reporting-act. Should any adverse action be taken as a result of this report, a copy this document will be provided to you separately. A copy of the San Francisco Fair Chance Ordinance Official Notice is hyperlinked here and can also be found on-line at http://sfgov.org/olse/fair-chance-ordinance-fco.

Acknowledgments & Authorization
I acknowledge that I have received and carefully read and understand the separate "Disclosure and Authorization Regarding Background Investigation for Professional Credentialing & Privileging Purposes"; and the separate "Summary of Rights under the Fair Credit Reporting Act" that have been provided to me by the Company. I also acknowledge receipt of and that I have carefully read and understand (if applicable), the separate California Disclosure and Summary of Rights under California Civil Code Section 1786.22; the separate New York Article 23-A.

By my signature below, I authorize the preparation of background reports about me, including background reports that are "consumer reports" by Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), and to the furnishing of such background reports to the Company and its designated representatives and agents, for the purpose of assisting the Company in making a determination as to my eligibility for credentialing and privileging (including independent contractor or similar assignments, as applicable), or for other lawful purposes.

I understand that information contained in my credentialing and privileging materials, or otherwise disclosed by me before or during my relationship with Company, if any, may be used for the purpose of obtaining and evaluating background reports on me. I also understand that nothing herein shall be construed as an offer of employment or contract for services.

I understand that the information included in the background reports may be obtained from private and public record sources, including without limitation and as appropriate: government agencies and courthouses; educational institutions; and employers. Accordingly, I hereby authorize all of the following, to disclose information about me to the consumer reporting agency and its agents: law enforcement and all other federal, state and local government agencies and courts; educational institutions (public or private); testing agencies; information service bureaus; and other consumer reporting agencies; other public and private record/data repositories; motor vehicle records agencies; my employers; the military; and all other individuals and sources with any information about or concerning me. The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my: employment and earnings history; education, motor vehicle and accident history; drug/alcohol testing results and history; criminal history; litigation history; military service; professional licenses, credentials and certifications; social security number verification; address and alias history; and other information.

By my signature below, I also promise that the personal information I provide with this form or otherwise in connection with my background investigation is true, accurate and complete, and I understand that dishonesty or material omission may disqualify me from consideration for employment. I agree that a copy of this document in faxed, photocopied or electronic (including electronically signed) form will be valid like the signed original. I further acknowledge that I have received additional state law notices that I have reviewed and read.

□ **California, Minnesota or Oklahoma consumers:** Please check this box if you would like to receive (whenever you have such right under the applicable state law) a free copy of your background report if one is obtained on you by the Company.

Applicant Name (Printed) _____

Applicant Signature_____Date _____

Not required for Sanford Health Plan-Only Applicants.

Additional State Law Notices

CALIFORNIA: Pursuant to section 1786.22 of the California Civil Code, you may view the file maintained on you by the consumer reporting agency during normal business hours. You may also obtain a copy of this file, upon submitting proper identification and paying the actual copying costs, by appearing at the consumer reporting agency's offices in person, during normal business hours and on reasonable notice, or by certified mail. You may also receive a summary of the file by telephone, upon submitting proper identification and written request. The consumer reporting agency has trained personnel available to explain your file to you, including any coded information, and will provide a written explanation of any coded information contained in your file. If you appear in person, you may be accompanied by one other person, provided that person furnishes proper identification. "Proper identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. If you cannot identify yourself with such information, the consumer reporting agency may require additional information concerning your employment and personal or family history to verify your identity.

Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), a consumer reporting agency located at 1 State Street, New York NY 10004, (877) 424-2457, www.sterlingtalentsolutions.com. If you have any questions regarding privacy, please read our privacy policy at https://www.sterlingcheck.com/about/privacy-clients/.

MASSACHUSETTS: Upon request to the Company, you have the right to know whether the Company requested an investigative consumer report about you and, upon written request to the Company, you have the right to receive a copy of any such report. You also have the right to ask the consumer reporting agency (e.g., Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), for a copy of any such report.

MINNESOTA: You have the right in most circumstances to submit a written request to the consumer reporting agency (e.g., Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"),) for a complete and accurate disclosure of the nature and scope of any consumer report the Company ordered about you. The consumer reporting agency must provide you with this disclosure within 5 days after (i) its receipt of your request or (ii) the date the report was requested by the Company, whichever date is later.

NEW JERSEY: You have the right to submit a request to the consumer reporting agency (e.g., Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), for a copy of any investigative consumer report the Company requested about you.

NEW YORK: You have the right, upon written request to the Company, to be informed of whether or not the Company requested a consumer report or an investigative consumer report about you. Shown above is the address and telephone number for Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), the consumer reporting agency used by the Company. You may inspect and receive a copy of any such report by contacting that consumer reporting agency. A copy of Article 23-A of the New York Correction Law is also provided below.

WASHINGTON STATE: If the Company requests an investigative consumer report, you have the right, upon written request made to the Company within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation requested by the Company. You are entitled to this disclosure within 5 days after the date your request is received or the Company ordered the report, whichever is later. You also have the right to request a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

CALIFORNIA APPLICANTS ONLY

CALIFORNIA DISCLOSURE

The Company may order a consumer report on you in connection with your professional credentialing and privileging application, and if you are approved, the Company may order additional such reports on you for background review purposes. Such reports may contain information about your character, general reputation, personal characteristics, and mode of living. The consumer reporting agency, Sterling Infosystems, Inc. ("STERLING TALENT SOLUTIONS"), a consumer reporting agency located at 1 State Street, New York NY 10004, (877) 424-2457, www.sterlingtalentsolutions.com. If you have any questions regarding privacy, please read our privacy policy at https://www.sterlingcheck.com/about/privacy-clients/.

A SUMMARY OF YOUR RIGHTS UNDER CALIFORNIA CIVIL CODE SECTION 1786.22

(a) An investigative consumer reporting agency shall supply files and information required under Section 1786.10 during normal business hours and on reasonable notice.

(b) Files maintained on a consumer shall be made available for the consumer's visual inspection, as follows:

(1) In person, if he appears in person and furnishes proper identification. A copy of his file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided.

(2) By certified mail, if he makes a written request, with proper identification, for copies to be sent to a specified addressee. Investigative consumer reporting agencies complying with requests for certified mailings under this section shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the investigative consumer reporting agencies.

(3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.

(c) The term "proper identification" as used in subdivision (b) shall mean that information generally deemed sufficient to identify a person. Such information includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if the consumer is unable to reasonably identify himself with the information described above, may an investigative consumer reporting agency require additional information concerning the consumer's employment and personal or family history in order to verify his identity.

(d) The investigative consumer reporting agency shall provide trained personnel to explain to the consumer any information furnished him pursuant to Section 1786.10.

(e) The investigative consumer reporting agency shall provide a written explanation of any coded information contained in files maintained on a consumer. This written explanation shall be distributed whenever a file is provided to a consumer for visual inspection as required under Section 1786.22.

(f) The consumer shall be permitted to be accompanied by one other person of his choosing, who shall furnish reasonable identification. An investigative consumer reporting agency may require the consumer to furnish a written statement granting permission to the consumer reporting agency to discuss the consumer's file in such person's presence.

NEW YORK APPLICANTS ONLY

NEW YORK CORRECTION LAW ARTICLE 23-A
LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

§750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.
(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.
(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.
(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.
(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.
(b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.
(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.
(d) The time which has elapsed since the occurrence of the criminal offense or offenses.
(e) The age of the person at the time of occurrence of the criminal offense or offenses.
(f) The seriousness of the offense or offenses.
(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.
(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights