



PARTICIPATING PROVIDER APPLICATION INSTRUCTIONS

Print legibly or type and answer all questions. If a question is not applicable to you or your practice, please indicate with "N/A". It is your responsibility to complete the application in full, including complete addresses, phone numbers etc. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required, shall be deemed to be withdrawn.

*****DO NOT COPY APPLICATION BACK TO BACK*****

Please attach a copy of the following documents with your application:

- All State professional License(s), with Controlled Substance Past and Current
- Current Federal Drug Enforcement Agency Certificate (if applicable)
- Current Curriculum Vitae
- Copy of Board Certification (if applicable)
- Copy of diploma from Medical School (If foreign language, provide English Translation)
- Copy of ECFMG Certificate (If applicable)
- Current malpractice insurance coverage verification
- Professional Liability Information Sheet (must sign)
- Results of TB Test or clear chest x-ray documentation
- MMR and Hepatitis B documentation
- Pharmacy Signature Registration form (if applicable)
- Privilege Delineation form (if applicable)
- Current photo identification (i.e. driver's license, passport)
- Continuing Medical Education (Please note if still in training)
- Current BLS or ACLS (if applicable)

Practitioner Rights

Practitioners are provided the opportunity to review information used in the credentialing process.

Evaluation may include information obtained from outside primary sources (e.g., malpractice insurance carriers or state licensing board.) This review does not include NPDB reports, references or recommendations or other information that is peer review protected. The MSO is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited bylaw.

In the event that credentialing information obtained from other sources varies substantially from that supplied by the practitioner, the practitioner is notified by the MSO and offered the opportunity to correct erroneous information submitted by another party. Upon request practitioners are informed of the status of their credentialing or recredentialing application by telephone, email or letter.

****Please be sure to schedule Drug Test**

MUST CALL APPROPRIATE OFFICE TO SCHEDULE PRE-EMPLOYMENT DRUG SCREENING TEST AT A MINIMUM OF 4 DAYS PRIOR TO BEGINNING CLINICAL DUTIES. RESULTS TAKE AT LEAST 48 HOURS AND WE MUST HAVE CLEARANCE BEFORE WE CAN START THE APPROVAL PROCESS. SEE BELOW:

***** All drug tests are scheduled by your hiring department.**

If you have any questions regarding completion of this application, please call 801-587-6023 or Please return the completed application and attachments to your designated Department/Division Coordinator. Applications must have Department Chair and Division Chief Approval before submission to the Medical Staff Office.

University Health Care Hospitals and Clinics
Medical Staff Office
650 Komas Drive, Suite 100
SLC, UT 84112

Revised 11/12/2009

Clinic Location:

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: () _____ Fax Number: () _____

Provider Pager No: _____

Office Manager: _____ Office Mgr. Phone: () _____

Office Manager's Email Address: _____

III. Academic/Medical Education/Training

1. Academic Education:

College/University: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

Academic Education:

College/University: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

2. Medical Education

Medical School: _____ Telephone: _____

Address: _____

City _____ State & Zip Code: _____ Country: _____

Degree: _____ Dates From: ____/____/____ To: ____/____/____

If foreign medical graduate, please indicate: Certificate No.: _____

Attach copies of: ♦ ECFMG certificate and ♦ International medical school diploma

3. Internship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ____/____/____ To: ____/____/____ Program completed? ♦ Yes ♦ No

4. Residency: Program Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ____/____/____ To: ____/____/____ Program completed? ♦ Yes ♦ No

5. Residency: Program Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

6. Fellowship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

7. Fellowship: Program/Specialty: _____

Institution: _____ Telephone: _____

Address: _____

City: _____ State & Zip Code: _____ Country: _____

Dates From: ___/___/___ To: ___/___/___ Program completed? Yes No

IV. Certification Specialty

<i>Name of Specialty Board</i>	<i>Certification Date</i>	<i>Expiration Date</i>	<i>Re-Certification Date</i>

If not certified, do you intend to apply for certification examination? Yes No

If yes, when? _____

Have you been accepted to take the certification examination? Yes No

If yes, what dates are you scheduled to take the certification examination? _____

V. Licenses/Certifications

1. List all state professional licenses, past and current (please attach a copy)

State	License No.	Date Issued	Expiration Date
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___

2. Federal DEA Certificate and Controlled Substance Certificate for all states: (Please attach a copy.)

Federal DEA
Certificate Number: _____ Expiration Date: ____/____/____

Controlled Substance Numbers (if applicable)
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____
Certificate Number: _____ Expiration Date: ____/____/____

VI. Professional History

List in reverse chronological order current and previous professional experience. During the past 10 years. **PLEASE DO NOT WRITE, "SEE CV."** PLEASE PROVIDE EXPLANATIONS OF ANY GAPS IN HISTORY ON A SEPARATE SHEET OF PAPER. Do not include educational training in this section. Please attach a Curriculum Vitae. List additional employment on a separate page.

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Current Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

Dates: From ____/____/____ To: ____/____/____ Supervisor: _____

Previous Practice/Employment: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Reason for Leaving: _____

VII. Professional Liability Insurance Information: Minimum coverage amounts are 1M per occurrence and 3M aggregate. Please attach copy of professional liability face sheets. Please list insurers for last 10 years.

Current Insurance Carrier: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy Number: _____ Phone Number: () _____
Retro Active Date: ___/___/___ Expiration Date: ___/___/___
Coverage Amounts: Per Occurrence: _____ Aggregate: _____
Length of Time with current insurer: _____

Previous Insurance Carrier: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy Number: _____ Phone Number: () _____
Retro Active Date: ___/___/___ Expiration Date: ___/___/___
Coverage Amounts: Per Occurrence: _____ Aggregate: _____
Length of Time with current insurer: _____

Previous Insurance Carrier: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy Number: _____ Phone Number: () _____
Retro Active Date: ___/___/___ Expiration Date: ___/___/___
Coverage Amounts: Per Occurrence: _____ Aggregate: _____
Length of Time with current insurer: _____

VIII. Professional Peer References: List Peers who have first hand knowledge of your clinical practice during the last two years. (MD=MD, PhD = PhD etc..)

Name: _____ Telephone No.: () _____
Professional Relationship: _____ Length of Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Name: _____ Telephone No.: () _____
Professional Relationship: _____ Length of Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Name: _____ Telephone No.: () _____
Professional Relationship: _____ Length of Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____

IX. Questionnaire

If the answer is “Yes” to any of the following questions, please provide complete details on a separate sheet of paper.

1.	Professional License: a. Have proceedings ever been instituted to have your license to practice medicine limited, suspended, revoked, denied, restricted or voluntarily withdrawn (examples probationary conditions or disciplinary proceedings)? b. Have you ever allowed a license to expire? c. Have proceedings ever been instituted to have your DEA License or other controlled substance authorization denied, revoked or suspended? d. Have you ever entered into a consent agreement or stipulation, or have you voluntarily surrendered your license pending a disciplinary action or investigation?	◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No
2.	Hospital Privileges: a. Have any of your clinical privileges ever been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished? b. Have you every voluntarily or involuntarily terminated any medical staff membership here or at another facility? c. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility?	◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No
3.	Have proceedings ever been instituted to have your specialty board certification denied, revoked or suspended?	◇ Yes ◇ No
4.	a. Have you ever been convicted or pleaded guilty or no contest for any felony? Is any such action pending? b. Have you ever been convicted or pleaded guilty or no contest for any misdemeanor related to the practice of health care, including fraud or abuse relating to a government health program, violations of law pertaining to controlled substances, insurance fraud, or abuse, physical abuse, neglect, sexual abuse, or exploitation of individuals in vulnerable populations? Is any such action pending?	◇ Yes ◇ No ◇ Yes ◇ No
5.	a. Have you ever been investigated by or suspended, sanctioned, or restricted from participating in any Private, federal or state health insurance program, HMO, PPO, provider network or regulatory agency (e.g., Medicare, Medicaid)?	◇ Yes ◇ No
6.	Professional Liability: a. Have you ever practiced medicine without malpractice insurance? b. Have you ever been denied malpractice insurance or has your policy been canceled or denied renewal? c. Has your malpractice carrier ever excluded any specific procedures from your insurance coverage? d. Have you ever received notification alleging malpractice on your part through a letter from an attorney, Notice of Intent, Notice of Claim, Summons and Complaint, or otherwise? e. Have prior malpractice claims been resolved through private settlement negotiations, mediation, arbitration, court action, or otherwise? f. Have any professional liability suits been filed against you which are presently pending?	◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No ◇ Yes ◇ No

Attestation

I hereby certify that the information in this application is true and complete and that it accurately discloses all matters requested. I understand that it is my ongoing duty to report any changes relating to information provided in this application. I understand that any omissions, misrepresentations, or false information in this application constitute cause for denial of my appointment or membership and may be cause for my summary dismissal from the staff and the summary removal of any privileges or membership granted to me.

Applicant Name: (Please Print) _____

Applicant Signature: _____
 (original signature required)

Date: _____

**RECOMMENDATION AND APPROVAL FOR MEDICAL STAFF APPOINTMENT AND
CLINICAL PRIVILEGES AT UNIVERSITY OF UTAH HOSPITALS & CLINICS / UNI**

Name of Applicant: _____

DEPARTMENT CHAIR/DIV. CHIEF RECOMMENDATION: *I have reviewed this application for appointment in regard to clinical privileges requested (attached), physical and mental fitness, and ethical and moral character, and the quality and content of Continuing Education completed.*

I recommend appointment to the Professional Staff at the University of Utah Hospitals & Clinics.

	DATE
DIVISION CHIEF _____	_____
DEPARTMENT CHAIR _____	_____
CREDENTIALS COMMITTEE MEMBER _____	_____

OFFICAL COMMITTEES	DATE
CREDENTIALS COMMITTEE	_____
MEDICAL BOARD COMMITTEE	_____
HOSPITAL BOARD	_____

For participation with the University of Utah Neuropsychiatric Institute

RECOMMENDATION: *I have reviewed this application for appointment in regard to privileges requested (attached), physical and mental fitness, ethical and moral character, and the quality and content of Continuing Education completed.*

I recommend appointment to the Professional Staff at the University of Utah Neuropsychiatric Institute.

	DATE
CREDENTIALS COMMITTEE _____	_____
MEDICAL DIRECTOR _____	_____
EXECUTIVE COMMITTEE _____	_____
GOVERNING BOARD _____	_____

UNIVERSITY OF UTAH PRACTITIONER'S AUTHORIZATION AND RELEASE OF LIABILITY

By applying for appointment or reappointment to the Medical Staff of the University of Utah Hospitals and Clinics (UUHC), including the University, University of Utah Neuropsychiatric Institute (UNI) University of Utah Medical Group (UUMG) participation and/or University of Utah Health Plans (UUHP) participation, I:

- Fully understand that any significant misstatements in or omissions from the Application constitute cause for denial of appointment, reappointment and/or participation or cause for summary dismissal from the UUHC, UNI Medical Staff and UUMG and/or UUHP participation. All information that is submitted by me in this application is true to my best knowledge and belief.
- Signify my willingness to appear for interviews in regard to my Application.
- Authorize the UUHC, UNI, UUMG, UUHP and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications; and I hereby consent to the release of such information.
- Consent to the inspection by the UUHC, UNI, UUMG, UUHP and its representatives of all records and documents (including medical records at other hospitals) that may be material to an evaluation of my professional qualifications and competence to carry out the requested clinical privileges, as well as moral and ethical qualifications for Medical Staff membership and/or UUMG participations.
- Release from any liability all UUHC, UNI, UUMG, UUHP and it's representatives for their acts performed in good faith and without malice in connection with evaluation of my Application, my credentials, and qualifications.
- Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to the UUHC, UNI, UUMG, and UUHP in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment, clinic privileges and/or UUMG and UUHP participation.
- Authorize and consent to the release of information by the UUHC, UNI, UUMD, UUHP or its Medical Staff, to other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care, with any information relevant to such matters that the UUHC and UUMG may have concerning me, and release UUHC, UUMG, UUHP and its representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.
- Where allowed by state or federal law, consent to the inspection and release of any documents produced in the course of any federal Drug Enforcement Agency, or state/local medical board investigation into my competence, professional ethics or character while practicing medicine. This includes but is not limited to voluntary stipulations, findings of fact, and any other judicial, quasi-judicial or administrative documents produced in the course of an investigation into my competence, professional ethics or character.
- Agree to immediately report to the UUHC, UNI, UUMG and/or UUHP any investigation into my competence, professional ethics or character while practicing medicine initiated by any state/local medical boards, professional certifying boards or federal agency and/or failure to retain board certification, licensure, clinical privileges or malpractice coverage.
- Agree to immediately report to the UUHC, UNI, UUMG, and/or UUHP any action on my part, whether voluntary or involuntary, to enter a substance abuse treatment program.
- Certify that I have received, read and agree to abide by the:
 - UNI Professional Staff Bylaws <http://healthcare.utah.edu/UNI/PDFs/bylaws.pdf>
 - UUHC Medical Staff Bylaws <http://uuhc.utah.edu/mso/pdfs/bylaws.pdf>
 - UUMG Medical Staff Bylaws <http://uumg.med.utah.edu/uumginfo.cfm>
 - UUMG Credentialing Policy & Procedures <http://uumg.med.utah.edu/uumginfo.cfm>

as applicable to me, the provider. I will observe and adhere to the aforementioned documents that apply and agree to be bound by the terms thereof. I also agree that when an adverse ruling is made with respect to my Medical Staff appointment, clinical privileges, and/or UUHP panel membership I will exhaust the administrative remedies afforded by the applicable documents before resorting to legal action

- Understand and agree that I, as an applicant for UUHC, UNI, UUMG and/or UUHP Panel membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.
- Am aware that the UUHC/UNI/UUMG/UUHP will query the national Practitioner Data Bank as a part of the application process.
- Fully understand all information, interviews, reports, statements, memoranda, or other data furnished in connection with my application, and any findings or conclusions resulting therefrom are privileged communications and that I am not entitled to their disclosure. The only exception to this may occur, at the discretion of the University, to the extent that these privileged materials are submitted to a hearing committee.

A photocopy of this Authorization and Release of Liability shall be as effective as the original when so presented. The above authorization to release information shall remain in full force for the duration of my affiliation.

Applicant Name (Please Print): _____

Applicant Signature: _____ Date: _____

PHARMACY SIGNATURE AND PATIENT CONTROL ANALGESIA (PCA)
REGISTRATION FORM

NAME: _____
(Please Print)

DEPARTMENT/DIVISION: _____

UTAH LICENSE NO: _____

CONTROLLED SUBSTANCE NO: _____

EXPIRATION DATE: _____

DEA CERTIFICATE NO: _____

EXPIRATION DATE: _____

I am certified to prescribe controlled substance level of prescriptions:

◇ Level I RESEARCH ONLY – (high abuse potential/non-acceptable medical use drugs, i.e., heroin)

◇ Level II-V PHYSICIAN WITH CONTROLLED SUBSTANCE LICENSES

◇ Level II-V ALLIED HEALTH PRACTITIONER (PA, APRN) WITH CONTROLLED
SUBSTANCE LICENSES

PCA Training completed? ◇ Yes ◇ No

Date Completed: _____

Applicant Signature: _____

Date: _____

UNIVERSITY OF UTAH HEALTH QUESTIONNAIRE

<p>Do you have, or have you had in the past, any physical or mental Conditions(s) that:</p> <p>a. have affected or could affect your ability to perform the mental and physical functions related to the specific privileges you are requesting?</p> <p>b. affect, affected or could affect the functions and obligations or medical staff membership as set forth in the Medical Staff Bylaws and/or applicant contract, with or without an accommodation?</p> <p>c. Are you taking any medication that may affect either your clinical judgment or motor skills?</p> <p>d. Are you under any limitation, in terms of activity or workload?</p> <p>e. Have you ever or are you now engaged in the unlawful use of drugs?</p> <p><i>If yes, please identify and describe any rehabilitation program you were enrolled in that assures your abstinence prospectively and your adherence to prevailing standards of professional performance.</i></p> <p>f. Have you ever had or do you now have an alcohol consumption problem?</p> <p><i>If yes, please identify and describe any rehabilitation program you were enrolled in that assures alcohol consumption will not interfere with your practice of medicine, patient care responsibilities, or adherence to prevailing standards of professional performance.</i></p> <p>IMMUNIZATIONS ARE ONLY REQUIRED AT INITIAL APPOINTMENT UPDATED TB IS REQUIRED EVERY TWO YEARS.</p> <p>Dates of TB: _____ MMR: _____</p> <p>Hepatitis B _____</p> <p>Copies of documentation must be attached. <i>If TB positive, attach copy of clear chest x-ray documentation.</i></p> <p>Applicant Name: _____ (Please Print)</p> <p>Applicant Signature: _____</p> <p>Date: _____</p>	<p>◇ Yes ◇ No</p> <p>◇ Yes ◇ No</p> <p>◇ Yes ◇ No</p> <p>◇ Yes ◇ No</p> <p>◇ Yes ◇ No</p> <p>◇ Yes ◇ No</p>
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**The University of Utah
Professional Liability Information and Claims History
CONFIDENTIAL**

New Applicant:	If you have EVER experienced any malpractice claims, lawsuits, settlements, proceedings or notices of intent to commence action against you arising from your medical training or your medical practice, you must complete this form FOR EACH CASE. Make copies as necessary.
	If no claims check NO CLAIMS BOX, sign and date section 10.

All information is strictly confidential. Your response must contain enough clinical detail to allow proper peer review and evaluation. Failure to provide sufficient details will prevent your application from being approved.

**THE CREDENTIALS COMMITTEE AND RISK MANAGEMENT DEPARTMENT
HAVE REQUESTED THAT THIS INFORMATION BE TYPED.**
You may attach a different document as long as it addresses all of the same information requested on this form.

<u>NO CLAIMS</u>		<input type="checkbox"/> – SIGN AND DATE SECTION 10	
1.	Date of occurrence:		
2.	Your insurance company:		
3.	What is/was your status?:	<input type="checkbox"/> Primary Defendant	<input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other? (explain)
4.	Patient name, age, gender:		
5.	Status of this case (select one):	<input type="checkbox"/> Not pursued, closed without payment <input type="checkbox"/> Notice of intent to commence malpractice action <input type="checkbox"/> Filed and pending lawsuit <input type="checkbox"/> Settled out of court	<input type="checkbox"/> Jury verdict for plaintiff <input type="checkbox"/> Jury verdict for you <input type="checkbox"/> Other (please explain)
6.	Specific allegations:		
7.	Detailed circumstances of the case: (attach separate sheet if necessary)		
8.	If the case settled, what was the total settlement amount?, AND...	\$	How much of that amount was paid by your insurance company on your behalf? \$
9.	If there was a jury verdict for the patient, what were the total damages awarded?, AND...	\$	How much of that amount was paid by your insurance company on your behalf? \$
10.	Applicant's PRINTED NAME:		
	Applicant's Signature & Date:		
		ORIGINAL SIGNATURE REQUIRED	DATE

By signing above, I certify that the information herein is true and complete. I understand that this document becomes part of my application as submitted.

University of Utah Hospitals and Clinics

Provider Performed Microscopy (PPM) Waived Test Listing

Test	CPT Code	Requested/Waived	Date Trained
Blood glucose testing – by monitoring devices cleared by the FDA specifically for home use	85013	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Fecal leukocyte examinations	87205	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Fern Test	87210, 87211	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Fecal occult blood	82270	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Hematocrit, spun (including Hematasta II, C70)	85013	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Hemoglobin, by copper sulfate method, non-automated	85018	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Hemoglobin (automated) by single analyte instruments w/ self contained or component features to perform specimen/reagent interaction providing direct measurement and readout (e.g. HemoCue)	85018	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
KOH Preps	87220	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Nasal smear for granulocytes	89050	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Nitrazine (pH) Paper for fluid pH; Gastrocult Test – Smith Kline	82273	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Ovulation tests by color comparison for human LH	84830	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Pinworm Exams	87208	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Post coital direct, qualitative microscopic examination of vaginal or cervical mucous	87210, 87211	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Qualitative semen analysis (limited to the presence or absence of sperm and detection of motility)	89300	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Sedimentation Rate (ESR), non-automated	85651	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Total cholesterol – by monitoring devices cleared by the FDA specifically for home use (Chemtrack Accumeter and Johnson & Johnson Advanced Care	82465	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Urinalysis, reagent or dipstick (bilirubin, hemoglobin, ketones, pH, nitrite, protein, specific	81002	<input type="radio"/> Requested <input type="radio"/> Waived	/ /

gravity and urobilinogen); w/out microscopy, non-automated			
Urine sediment exams	81015	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Urine pregnancy tests by visual color comparison	85018	<input type="radio"/> Requested <input type="radio"/> Waived	/ /
Wet Mount Preparations (including all direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements)	87210, 87211	<input type="radio"/> Requested <input type="radio"/> Waived	/ /

I have been trained to perform the requested tests above. I practice under CLIA certificate number: _____ and have had my name added as a trained professional.

Applicant Name (Please print): _____

Department: _____

Applicant Signature: _____ Date: _____

Notice to Providers

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.

Applicant Name: _____
(Please Print)

Applicant Signature: _____

Date: _____

NPI #: _____

UNIVERSITY OF UTAH HOSPITALS AND CLINICS
PRACTITIONER IDENTIFICATION VERIFICATION FORM

Practitioner Name: _____

Title: _____

Name of Person verifying Practitioner's Identity: _____

Title: _____

Department:

- Type of Identification: Driver's License
 Passport
 Military Identification

Signature of Practitioner: _____

Date: _____

Signature of Person obtaining the verification: _____

Date: _____

Attach copy of verification here