OKLAHOMA
State Department
of Health

123 Robert S. Kerr Ave
Oklahoma City, OK 73102
Phone 405.426-8175
Oklahoma.gov/Health/HRDS

Uniform Credentialing Application

63 O.S. 2011, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e., do not state "see CV"), unless the credentialing entity to which you are applying advises you otherwise. Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to:_____

Date:_____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION. THE COMPLETED APPLICATION MAY BE SUBMITTED TO HOSPITALS, AMBULATORY SURGERY CENTERS, MANAGED CARE ORGANIZATIONS, AND OTHER ENTITIES REQUIRING CREDENTIALS VERIFICATION.

PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH

SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix

Professional Degree _____ Gender: ☐ Male ☐ Female

Other Name by Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___-___ ___-___ ___ ___ ___ to ___ ___-___ ___-___ ___ ___ ___

Other Name by Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___-___ ___-___ ___ ___ ___ to ___ ___-___ ___-___ ___ ___ ___

Social Security Number ___ ___ ___-___ ___-___ ___ ___ ___ NPID (formerly UPIN)_____

Date of Birth: ___ ___-___ ___-___ ___ ___ ___ _____
Place of Birth Citizenship

_____
Visa Type Visa Number (provide copy) Expiration Date

_____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address for All Credentialing Correspondence: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Contact Person for Credentialing Correspondence: _____

This Section continues on next page.

-Section 2 Continued-

Office Street Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Mailing Address: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Office Billing Address (If Different From Claims Payment Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Claims Payment Address (If Different From Office Billing Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Make Checks Payable To: _____

SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice) | Subspecialty | % Of Time

Secondary Specialty | Subspecialty | % Of Time

Do you wish to be listed as:
☐ Primary Care Provider ☐ Specialist ☐ Hospitalist ☐ On-Call ☐ Other (specify)_____
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

☐ Yes ☐ No Are you accepting new patients?
☐ Yes ☐ No Are you willing, in the future, to accept new patients?
☐ Yes ☐ No Do you admit your own patients to hospitals?
If no, please explain how your patients will be admitted, which hospital and who will provide patient care.
☐ Yes ☐ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?
☐ Yes ☐ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) Phone Number | ( ) Fax Number | ( ) Answering Service Number

Name: _____

Street Address | Suite Number

City | State | Zip Code

( ) Phone Number | ( ) Fax Number | ( ) Answering Service Number

List any restrictions on your practice (i.e., patient age and gender): _____

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____)_____

Dates Attended (mo/day/year) From: __ __-__ __-__ __ __ __ to __ __-__ __-__ __ __ __

Graduation Date __ __-__ __-__ __ __ __

(2)_____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____)_____

Dates Attended (mo/day/year) From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __

Graduation Date __ __-__ __-__ __ __ __

(3)_____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____)_____

Dates Attended (mo/day/year) From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __

Graduation Date __ __-__ __-__ __ __ __

Foreign Medical Graduates:

ECFMG #_____

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed: ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(2) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was the program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(3) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(4) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1)_____ ( )_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

(2)_____ ( )_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

(3)_____ ( )_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1)_____ ☐ Primary ☐ Secondary
Facility Name

_____
Complete Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

(2)_____ ☐ Primary ☐ Secondary
Facility Name

_____
Complete Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) _____ ☐ Primary ☐ Secondary
Facility Name

_____
Complete Mailing Address City State Zip Code Telephone Number

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e., clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1)_____
Name and Nature of Affiliation

_____
Mailing Address City State Zip Code Telephone Number

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2)_____
Name and Nature of Affiliation

_____
Mailing Address City State Zip Code Telephone Number

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3)_____
Name and Nature of Affiliation

_____
Mailing Address City State Zip Code Telephone Number

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __

_____
Location Branch of Service

From: __ __-__ __-__ __ __ __ **to** __ __-__ __-__ __ __ __

_____
Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

State	Type	Number	Original Date of Issue	Expiration Date
			__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __
			__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __
			__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __
			__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __

USMLE/ECFMG Number: __ __-__ __-__ __ __ __ Certification Date: __ __-__ __-__ __ __ __

SECTION 10:CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

State	Type	Number	Original Date of Issue	Expiration Date
		__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __	
		__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __	
		__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __	
		__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __	

BOARD CERTIFICATION

Are you Board Certified? ☐ Yes ☐ No

Name of Board: _____

Date Initially Certified	Date Most Recently Recertified	Date Certification Expires
__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __	__ __-__ __-__ __ __ __

☐ Yes ☐ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification | Name of Board

__ __-__ __-__ __ __ __ | __ __-__ __-__ __ __ __ | __ __-__ __-__ __ __ __

Date Initially Certified | Date Most Recently Recertified | Date Certification Expires

Subspecialty or Added Qualification | Name of Board

__ __-__ __-__ __ __ __ | __ __-__ __-__ __ __ __ | __ __-__ __-__ __ __ __

Date Initially Certified | Date Most Recently Recertified | Date Certification Expires

BOARD QUALIFICATIONS

☐ Yes ☐ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

☐ Yes ☐ No Are you planning to take the exam?

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

Date Scheduled:

Oral __ __-__ __-__ __ __ __

Written __ __-__ __-__ __ __ __

Other __ __-__ __-__ __ __ __

Subspecialty or Added Qualification | Name of Board

Date Qualified __ __-__ __-__ __ __ __ Date Qualification Expires __ __-__ __-__ __ __ __

Classifications:

☐ Yes ☐ No Are you certified in CPR? Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Basic Life Support (BLS) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Advanced Cardiac Life Support (ACLS) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Health Care Provider (CoreC) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Advanced Trauma Life Support (ATLS) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Neonatal Advanced Life Support (NALS) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Pediatric Advanced Life Support (PALS) Expires __ __-__ __-__ __ __ __

☐ Yes ☐ No Other_____ Expires __ __-__ __-__ __ __ __

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No Reference Lab? ☐ Yes ☐ No On Site? ☐ Yes ☐ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?

If yes, please list:_____

☐ Yes ☐ No Other:_____

Other Resources _____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

☐ Yes ☐ No Do you or your business own, operate, manage, or participate in any medical enterprise or business? If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify) _____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No | Reference Lab? ☐ Yes ☐ No | On Site? ☐ Yes ☐ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?
If yes, please list:_____
☐ Yes ☐ No Other:_____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

Name _____ Specialty _____ Telephone (_____) _____

☐ Yes ☐ No Do you or your business own, operate, manage, or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
☐	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
☐	Current Federal DEA Registration Certificate
☐	Emergency Care Training Certificates (CPR, etc., if certified)
☐	Photo Identification
☐	Curriculum Vitae
☐	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct, and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:
Practitioners are reminded that each organization will require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note the section number and question number that you are addressing.

SUPPLEMENTAL UNITED CONCORDIA® ATTESTATION QUESTIONS

An explanation for any attestation questions answered yes must be submitted with this application.
The explanation should include the dates, amounts, outcome and signature of the applicant.

		YES	NO
1.	Do you have any pending malpractice, civil, or criminal claims against you or are you currently the subject of an investigation by any licensing authority, DEA or CMS entities, hospital, education or training program, Medicare or Medicaid program or any other federal or state health programs?	☐	☐
2.	Are you currently aware of any malpractice, civil, or criminal allegations that could lead to a malpractice suit, civil suit or criminal action against you?	☐	☐
3.	Has any malpractice carrier made an out of court settlement or paid a Professional Liability claim on your behalf in the past five years or within the past ten years for the SmileNet Network only, or has any payment to resolve or avoid any allegation(s) concerning your competence, conduct or quality of care (not involving litigation, arbitration, or mediation) ever been paid by you or on your behalf?	☐	☐
4.	Has your Professional Liability Insurance ever been denied, suspended, revoked, canceled or not renewed in the past five years?	☐	☐
5.	Have you ever had a change of status in your Dental License(s), Hospital Privileges, Board Certification, or Federal or State Narcotics License(s)?	☐	☐
6.	Has a governmental agency, including a state licensing board, ever investigated you, suspended, revoked or taken any other action against either your Narcotic(s) Licenses or License(s) to practice dentistry?	☐	☐
7.	Have any Medicare/Medicaid charges ever been filed against you, or has your participation in any government programs ever been denied, suspended or revoked?	☐	☐
8.	Have you ever been the subject of an investigation, indicted for, convicted of, or pleaded “no contender” to a misdemeanor (other than a traffic violation), felony, moral or ethical crime, including fraud, an act of violence, child abuse, a sexual offense or sexual misconduct, or are you under investigation for such conduct?	☐	☐
9.	Has your status as a provider, or membership in any professional organization, ever been denied, suspended, revoked, disciplined, cancelled, sanctioned, or are you currently under investigation by any municipal, state, federal or any other governmental agency, HMO, PPO or other prepaid health plans (e.g. Medicare or Medicaid)?	☐	☐
10.	Have you ever been convicted for use, possession or sale of illegal drugs?	☐	☐
11.	Do you currently, or did you in the past two years, engage in the unlawful use of illegal drugs, including improper use of prescription drugs?	☐	☐
12.	Are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors or treats you?	☐	☐
13.	Do you have any limitations, including those which could risk the safety or the well-being of your patients, for which reasonable accommodation is necessary in order to perform the essential and/or marginal duties of your job?	☐	☐
14.	Are you employed by the United States Government?	☐	☐

SUPPLEMENTAL UNITED CONCORDIA® ATTESTATION RELEASE

I acknowledge and agree that United Concordia Companies, Inc. has a valid interest in obtaining and verifying information concerning my professional competence in determining whether to enter into an agreement with me for the provision of dental services to members of the affiliated prepaid dental care plans. Accordingly,

(i) I attest to United Concordia Companies, Inc. that the information obtained in the attached application is true and complete to the best of my knowledge. I agree to inform United Concordia Companies, Inc. promptly if any material change in such information occurs, whether before or after my entering into an agreement with United Concordia Companies, Inc. for the provision of dental services.

(ii) I hereby consent to the release to United Concordia Companies, Inc., of any information which may reasonably be considered relevant to an evaluation of my professional competency, including any information relating to any disciplinary action, suspension, or curtailment of dental privileges, and also including such elements of my character, morals, and ethics which may reasonably be considered to have an impact upon my professional competency and reputation, by any hospital, professional society, licensing authority, health maintenance organization, dental plan organization, health insurer, malpractice insurer, attorney, data bank, or any other person or entity which may possess such information.

(iii) I authorize United Concordia Companies, Inc. and their affiliates, subsidiaries, or related entities to consult with hospital administrators, the State board, malpractice carriers, and other persons to obtain and verify information. I release United Concordia Companies, Inc. and their employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluation my application.

(iv) I release from liability any and all individuals and organizations, including, but not limited to hospitals, medical staff offices, professional societies, licensing authorities, and health and dental maintenance organizations, who provide information to the credential verification organization, in good faith and without malice, information concerning my professional competence, ethics, character and other qualification for professional service.

TO BE COMPLETED BY DENTIST

Print Full Name	Date

Signature (Stamps NOT Accepted)

United Concordia dental®

United Concordia Companies, Inc. is committed to providing equal opportunity and access to its provider network. In accordance with this commitment, United Concordia Companies, Inc. will not deny an application for participation or terminate participation in its provider network on the basis of gender, race, ethnicity/national identity, national origin, language, creed, religion, age, sexual orientation, or patient's insurance coverage (e.g., Medicaid) in which a provider specializes.

Providing race, ethnicity, and/or language information as part of the credentialing process is optional. If you are willing to provide this information, please fill out the fields below, as the credentialing application you will fill out may not include all of these:

Race/Ethnicity **(Choose only one)**

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Asian Pacific American
☐ Black ☐ Black Non-Hispanic ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Native Hawaiian
☐ Pacific Islander ☐ Subcontinent Asian American ☐ White Non-Hispanic ☐ Other Race or Ethnicity

Language(s) Spoken by Provider (Other than English); **(Please only include languages spoken by provider, not office personnel)**

☐ Arabic ☐ Chinese ☐ French ☐ Hindi ☐ Korean ☐ Persian ☐ Pilipino/Tagalog
☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other:_____