

North Country Community Mental Health
Credentialing & Privileging Committee
APPLICATION FOR CREDENTIALING

You are granted **Provisional/Temporary Credentialing** status at hire. This status is not to exceed 150 days.

☐ **Initial Credentialing**

(To be approved by CPC within 150 days of hire)

☐ **1st Full Credentialing**

(Application considered at 1st anniversary)

☐ **Re-Credentialing**

(Application considered every 2 yrs)

For Provisional and Initial Credentialing attach: Diploma (highest level of education), resume, license and 3 professional letters of recommendation. Transcripts are also required and must be mailed directly to HR from the school.

For Full or Re-Credentialing attach: License, 2 years continuing education showing 15 Clinical CEUs per calendar year (24 for Child Providers), Competency Evaluation, Peer Reviews (up to date) and liability insurance if a contractor.

Name:	Position	Program:
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A. Have you ever been denied membership and/or privileges at another agency? Yes ☐ No ☐
If yes; where? _____

B. Has your membership status and/or clinical privileges ever been revoked, suspended, limited, not renewed or voluntarily terminated? ☐ Yes ☐ No

Have any of your licenses/certifications/ registrations been suspended, revoked or limited since last application or voluntarily relinquished? Yes ☐ No ☐

Is any action currently pending to suspend, revoke or limit any of your licenses/certifications/ registrations? Yes ☐ No ☐

If you answered yes to any of the above, please explain: _____

C. List current licenses, certifications and registrations and provide a copy with application.

Type	State/Province	Number	Expiration

D. Have you been convicted of a felony or misdemeanor? Yes ☐ No ☐

If yes, explain: _____

E. Indicate name and address of current malpractice liability insurance carrier. (Contractual staff only. Provide copy with application).

Policy No: _____ Coverage Dates: _____ Coverage Amount: _____

F. Have any malpractice claims ever been filed against you or are there claims currently pending? Yes ☐ No ☐

G. Have any malpractice allegations involving your work been settled by you or your carrier prior to the filing of a claim? Yes ☐ No ☐

If your answer to either F or G is yes, explain the circumstances of each claim or allegation, including relevant dates and how it was disposed. _____

Your signature on this application indicates your intent to be and remain credentialed in those areas in which you are currently competent, physically and emotionally able to perform the duties as outlined by the job description. You will read the Credentialing policies and abide by them. You are consenting to have any necessary external primary source verification and relevant records/documents reviewed that are pertinent to this application. You attest that you abstain from the use of illegal drugs. You agree to complete all necessary credentialing paperwork in a timely matter when due. In addition, you testify that the information you provided is accurate and complete.

Applicant Signature: _____ Date: _____

Based on applicant's peer reviews or professional references, review of clinical competency, this application, training records and my assessment of current performance, I recommend approval for initial credentialing, full credentialing or re-credentialing as requested.

Supervisor Signature: _____ Date: _____

Forward to Human Resources after Employee and Supervisor Sign

Credentialing & Privileging Committee Use Only

Type	Verified	Initials
License, Certification or Registration*	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Education* Diploma and transcripts for Initial Credentialing attached	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Training/Experience* Continuing education for re-credentialing attached. Has 15 clinical CEUs or 24 if Child Provider per calendar year.	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Current Competence* Peer Review/3 Letters of recommendation Competency Assessment	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Liability Insurance is Maintained* (Contractual Only)	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	

* Primary

Name: _____ is recommended for ☐ initial credentialing ☐ full credentialing ☐ re-credentialing in the professional discipline of _____

Name: _____ is NOT recommended for ☐ initial credentialing ☐ full credentialing ☐ re-credentialing in the professional discipline of _____

Reason for denial: _____

Initial Reviewer _____ Date _____ C&P Committee Chair _____ Date _____

☐ Approved ☐ Denied _____
Executive Director, North Country CMH _____ Date _____

Credentials are subject to review and renewal on or before: _____