KFMC Health Improvement Partners (KFMC)

Reviewer Application

KFMC use only:

Date received: ______________

Format HC/E copy

Choose one:

☐ New application – date submitted: ____________________________

☐ Re-verification – date submitted: ____________________________________

License Number: ____ Expiration Date: ___________

SS#: __________ - ________ - ___________ Date of Birth:_________________

Please print name & credentials:

____

Last First Middle Credentials (MD, DO, etc.)

Alternate Name(s): ____

____

Mailing Address:____

If you are part of a group practice, please list the **Name of the group and note the City and State**

____

<u>Provide phone #, fax #, and your email</u>: Mark the box, indicating the best way to contact you.

☐ Home Phone: _________________________ ☐ Work Phone/Extension: _______________

☐ Cell Phone: ____________________ Fax # and contact: _____________________________

☐ Email: ____

<u>Affiliated Hospitals</u>

Please list the **name, city and state** of facilities which you are affiliated with:

____

____

If you have no hospital privileges, indicate 'NONE'

Applicant Initials: ___________

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Certification(s) and Subspecialty(ies)

Current Board Certifications:
(Certifications only. Board eligible or Board qualified status is not recognized by URAC as a certification.)

A list of board certifications and subspecialties recognized by the American Board of Medical Specialties follows. Please check a box in **list A** reflecting your board, **list B** for your certification, and **list C** for your subspecialty.

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
☐ Allergy & Immunology	☐ Allergy & Immunology	
☐ Anesthesiology	☐ Anesthesiology	☐ Critical Care Medicine ☐ Hospice and Palliative Medicine ☐ Pain Medicine ☐ Pediatric Anesthesiology ☐ Sleep Medicine
☐ Colon and Rectal Surgery	☐ Colon and Rectal Surgery	
☐ Dermatology	☐ Dermatology	☐ Dermatopathology ☐ Pediatric Dermatology
☐ Emergency Medicine	☐ Emergency Medicine	☐ Anesthesiology Critical Care Medicine ☐ Emergency Medical Services ☐ Hospital and Palliative Medicine ☐ Internal Medicine-Critical Care Medicine ☐ Medical Toxicology ☐ Pain Medicine ☐ Pediatric Emergency Medicine ☐ Sports Medicine ☐ Undersea and Hyperbaric Medicine
☐ Family Medicine	☐ Family Practice	☐ Adolescent Medicine ☐ Geriatric Medicine ☐ Hospice and Palliative Medicine ☐ Pain Medicine ☐ Sleep Medicine ☐ Sports Medicine
☐ Internal Medicine	☐ Internal Medicine	☐ Adolescent Medicine ☐ Adult Congenital Heart Disease ☐ Advanced Heart Failure & Transplant Cardiology ☐ Cardiovascular Disease ☐ Clinical Cardiac Electrophysiology ☐ Critical Care Medicine ☐ Endocrinology, Diabetes & Metabolism ☐ Gastroenterology ☐ Geriatric Medicine ☐ Hematology ☐ Hospice and Palliative Medicine ☐ Infectious Disease ☐ Interventional Cardiology ☐ Medical Oncology ☐ Nephrology ☐ Pulmonary Disease ☐ Rheumatology ☐ Sleep Medicine ☐ Sports Medicine ☐ Transplant Hepatology
☐ Medical Genetics and Genomics	☐ Clinic Biochemical Genetics ☐ Clinical Cytogenetics ☐ Clinical Genetics (M.D.) ☐ Medical Molecular Genetics	☐ Medical Biochemical Genetics ☐ Molecular Genetic Pathology

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
☐ Neurological Surgery	☐ Neurological Surgery	
☐ Nuclear Medicine	☐ Nuclear Medicine	
☐ Obstetrics & Gynecology	☐ Obstetrics & Gynecology	☐ Critical Care Medicine ☐ Female Pelvic Medicine & Reconstructive Surgery ☐ Gynecologic Oncology ☐ Hospital and Palliative Medicine ☐ Maternal & Fetal Medicine ☐ Reproductive Endocrinology/Infertility
☐ Ophthalmology	☐ Ophthalmology	
☐ Orthopedic Surgery	☐ Orthopedic Surgery	☐ Orthopaedic Sports Medicine ☐ Surgery of the Hand
☐ Otolaryngology	☐ Otolaryngology	☐ Neurotology ☐ Complex Pediatric Otolaryngology* ☐ Plastic Surgery within the Head and Neck* ☐ Sleep Medicine
☐ Pathology	☐ Pathology-Anatomic/Pathology-Clinical ☐ Pathology-Anatomic ☐ Pathology-Clinical	☐ Blood Banking/Transfusion Medicine ☐ Clinical Informatics ☐ Cytopathology ☐ Dermatopathology ☐ Neuropathology ☐ Pathology-Chemical ☐ Pathology -Forensic ☐ Pathology- Hematology ☐ Pathology-Medical Microbiology ☐ Pathology – Molecular Genetic ☐ Pathology Pediatric
☐ Pediatrics	☐ Pediatrics	☐ Adolescent Medicine ☐ Child Abuse Pediatrics ☐ Developmental-Behavioral Pediatrics ☐ Hospice and Palliative Medicine ☐ Medical Toxicology ☐ Neonatal-Perinatal Medicine ☐ Pediatric Cardiology ☐ Pediatric Critical Care Medicine ☐ Pediatric Emergency Medicine ☐ Pediatric Endocrinology ☐ Pediatric Gastroenterology ☐ Pediatric Hematology-Oncology ☐ Pediatric – Hospital Medicine* ☐ Pediatric Infectious Disease ☐ Pediatric Nephrology ☐ Pediatric Pulmonology ☐ Pediatric Rheumatology ☐ Pediatric Transplant Hepatology ☐ Sleep Medicine ☐ Sports Medicine
☐ Physical Medicine and Rehabilitation	☐ Physical Medicine and Rehabilitation	☐ Brain Injury Medicine ☐ Hospice and Palliative Medicine ☐ Neuromuscular Medicine ☐ Pain Management ☐ Pediatric Rehabilitation Medicine ☐ Spinal Cord Injury Medicine ☐ Sports Medicine
☐ Plastic Surgery	☐ Plastic Surgery	☐ Plastic Surgery Within the Head and Neck* ☐ Surgery of Hand
☐ Preventive Medicine	☐ Aerospace Medicine ☐ Occupational Medicine ☐ Public Health and General Preventive Medicine	☐ Addiction Medicine ☐ Clinical Informatics ☐ Medical Toxicology ☐ Undersea and Hyperbaric Medicine

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APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	**LIST B** General Certificates	**LIST C** Sub-specialty Certificates
☐ Psychiatry & Neurology	☐ Psychiatry ☐ Neurology ☐ Neurology with Special Qualifications in Child Neurology	☐ Addiction Psychiatry ☐ Brain Injury Medicine ☐ Child & Adolescent Psychiatry ☐ Clinical Neurophysiology ☐ Epilepsy ☐ Forensic Psychiatry ☐ Geriatric Psychiatry ☐ Hospice and Palliative Medicine ☐ Neurodevelopmental Disabilities ☐ Neuromuscular Medicine ☐ Pain Medicine ☐ Sleep Medicine ☐ Vascular Neurology
☐ Radiology	☐ Diagnostic Medical Physics ☐ Diagnostic Radiology ☐ Interventional Radiology & Diagnostic Radiology ☐ Nuclear Medical Physics ☐ Radiation Oncology ☐ Medical Physics	☐ Hospice and Palliative Medicine ☐ Neuroradiology ☐ Nuclear Radiology ☐ Pain Medicine ☐ Pediatric Radiology
☐ Surgery	☐ Surgery ☐ Vascular Surgery	☐ Complex General Surgical Oncology ☐ Hospice and Palliative Medicine ☐ Pediatric Surgery ☐ Surgery of the Hand ☐ Surgical Critical Carey
☐ Thoracic Surgery	☐ Thoracic and Cardiac Surgery	☐ Congenital Cardiac Surgery
☐ Urology	☐ Urology	☐ Female Pelvic Medicine & Reconstructive Surgery ☐ Pediatric Urology

*Subspecialties that have been approved, but not yet issued.

If your certification is NOT on the list, please document the specialty certification and the name of certifying board below.

Certification ______________________________________ Board ________________________

Are you a hospitalist? Yes ☐ No ☐ Are you certified as a hospitalist or in hospital medicine? Yes ☐ No ☐

If your hospitalist certification is through an organization other than the American Board of Medical Specialties, please document the name of the certifying board in the area above.

If your specialty certification is Family Practice, do you deliver babies? Yes ☐ No ☐

Do you participate in your specialty Maintenance of Certification (MOC) program? Yes ☐ No ☐

Additional Required Information

Length of time providing direct patient care and dates: (IR-RCQ 1-2(a.iv)), IR-RCQ 1-4(b))

Document the dates reflecting when you have provided direct patient care on a full-time basis (37.5 or more hours a week). The years do not have to be consecutive, however if not consecutive, you must document the Month/year to Month/year of each occurrence of full time direct patient care.

Month/year: ______________________________ to month/year (or to present): _____________________

Month/year: ______________________________ to month/year (or to present): _____________________

Month/year: ______________________________ to month/year (or to present): _____________________

Month/year: ______________________________ to month/year (or to present): _____________________

Month/year: ______________________________ to month/year (or to present): _____________________

Have you provided direct clinical care to patients within the past three (3) calendar years. **(IR-RCQ 1-6(b))**

Yes ☐ No ☐

Applicant Signature: ____ Date of Application: _________________

Check the box beside any document you are enclosing and return with your application.

Required enclosures:

- ☐ Application
- ☐ KFMC PR Attestations
- ☐ Curriculum Vitae
- ☐ Confidentiality of Information form
- ☐ Organizational Conflict of Interest and Disclosure of Affiliations
- ☐ W-9