HWMG
HAWAII-WESTERN MANAGEMENT GROUP, INC.

Credentialing Application for Practitioners

Instructions

1. Please accurately and legibly complete **all** sections of this Credentialing Application, and mark non-applicable fields with "**N/A**". If an entire section does not apply to you, simply check the box at the top of the section marked "**Does not apply**."
2. Complete each section in its entirety. If more space is needed, please attach additional sheets and reference the question being answered. Incomplete applications or missing documents will delay your application review.
3. Sign and date the *Authorization, Attestation and Release* on page 6 of this application.
4. Kindly retain a copy of the submitted application for your files. Because certain information you provide will need to be verified, please allow up to sixty (60) days for processing. We will notify you in writing of the outcome.
5. When you have completed and signed the Credentialing Application, please send it to:

HWMG
Credentialing Department
220 South King Street, Suite 1200
Honolulu, HI 96813

Phone (808) 791-7518
Toll-Free (800) 621-6998 ext. 306
Fax (808) 535-8314
Email Credentialing@hwmg.org

Practitioner Information

Last Name	First Name	MI	Suffix	Degree/Title

Other Name(s) Used:	Gender ☐ M ☐ F	Date of Birth	Birthplace (City/State/Country)

U.S. Citizen ☐ Yes ☐ No	Social Security Number	NPI Type 1 (Individual)	CAQH ID

Practitioner Email Address

Professional License - List **all** (past, present, and pending) professional licenses.

State	License Number	Date Issued	Valid Through

Specialty/Sub-Specialty Board Certification(s)

Primary Specialty To be listed in Provider Directory? ☐ Yes ☐ No If no, explain:	Board Certified? ☐ Yes ☐ No If no, please explain: ☐ I do not intend to take exam (explain why below) ☐ I have taken exam; results are pending ☐ I intend to take the exam (enter date below)	Certifying Board
Date Initially Certified	Date Re-Certified (if applicable)	Date Expired (if applicable)

Secondary Specialty To be listed in Provider Directory? ☐ Yes ☐ No If no, explain:	Board Certified? ☐ Yes ☐ No If no, explain: ☐ I do not intend to take exam (explain why below) ☐ I have taken exam; results are pending ☐ I intend to take the exam (enter date below)	Certifying Board
Date Initially Certified	Date Re-Certified (if applicable)	Date Expired (if applicable)

Other Specialty	Board Certified? ☐ Yes ☐ No If no, explain: ☐ I do not intend to take exam (explain why below) ☐ I have taken exam, results pending ☐ I intend to take the exam (enter date below)	Certifying Board
To be listed in Provider Directory? ☐ Yes ☐ No If no, explain:		
Date Initially Certified	Date Re-Certified (if applicable)	Date Expired (if applicable)

State Controlled Substance and Federal Drug Enforcement Administration (DEA) Certification

CSC Number	State	Valid Through

DEA Number	State	Valid Through	Approved for all Schedules? ☐ Yes ☐ No If no, explain:

If you do **not** maintain a State CSC or DEA Certificate, please indicate reason:

☐ Certification is not applicable to my practice ☐ Certificate is pending; application submitted on _____

☐ Other: _____

Professional Liability Insurance

Coverage from To	Insurance Carrier Name		
Address	City	State	Zip Code
Policyholder Name		Policy Number	
Expiration Date	Amount of Coverage per Occurrence	Aggregate	

Professional Education and Training

Includes medical/dental, graduate, post-graduate, internship, residency, fellowship and other education and training programs. If additional space is required, please attach a separate sheet.

Education/Professional School

☐ **Does Not Apply**

From To	Name of Institution
Phone Number (if known)	Location
Degree Earned	Specialty

Internship

☐ **Does Not Apply**

From To	Name of Institution
Phone Number (if known)	Location
Degree Earned	Specialty

Residency

☐ **Does Not Apply**

From To	Name of Institution
Phone Number (if known)	Location
Degree Earned	Specialty

Fellowship or Other Clinical Training Programs

☐ **Does Not Apply**

From To Name of Institution	
Phone Number (if known)	Location
Degree Earned	Specialty

Educational Commission for Foreign Medical Graduates (ECFMG)

☐ **Does Not Apply**

ECFMG Number	Date Issued	Valid Through

Clinical Employment/Practice History

In chronological order of employment/practice history **since completion of your post-graduate training**, list **all** (past, present, and pending) clinical experience including hospital and clinical affiliations. If there was a gap in service or leave of absence for more than three (3) months, please explain in detail. **Leave no gaps** in chronology. If additional space is required, please attach a separate sheet.

Clinical Employment/Practice History

☐ **Does Not Apply**

From To Name of Organization		
Phone Number (if known)	Current Affiliation ☐ Active ☐ Terminated ☐ Resigned ☐ Other:	Reason for Leaving
From To Name of Organization		
Phone Number (if known)	Current Affiliation ☐ Active ☐ Terminated ☐ Resigned ☐ Other:	Reason for Leaving
From To Name of Organization		
Phone Number (if known)	Current Affiliation ☐ Active ☐ Terminated ☐ Resigned ☐ Other:	Reason for Leaving
From To Name of Organization		
Phone Number (if known)	Current Affiliation ☐ Active ☐ Terminated ☐ Resigned ☐ Other:	Reason for Leaving
From To Name of Organization		
Phone Number (if known)	Current Affiliation ☐ Active ☐ Terminated ☐ Resigned ☐ Other:	Reason for Leaving

Gaps in Service or Leaves of Absence

☐ **Does Not Apply**

From	To	Explanation for Gap in Service/Leave of Absence

Credentialing Contact Information

Provide the credentialing contact information for each unique tax identification number that you practice under. If we do not have current information on file, there could be a delay in providing your credentialing status, network updates, and other important information to your practice. You may also provide the most recent contact information by emailing us at Credentialing@hwmg.org.

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☐ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Office Name		Tax ID # (TIN)	Preferred Method of Contact ☑ Email ☐ Phone ☐ Mail ☐ Fax
Credentialing Contact Person & Job Title	Phone Number	Fax Number	Email Address
Street Address	City	State	Zip Code

Hospital Affiliations

List **all** Hawaii hospital affiliations and the type of admitting privileges (**AT** = Attending; **AM** = Admitting; **EM** = Emeritus).
Check all that apply.

☐ **Does Not Apply**

Hospital Name	Admitting Privileges			Hospital Name	Admitting Privileges		
	AT	AM	EM		AT	AM	EM
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
Primary Hospital Admitting Patients to:							

If no hospital affiliations, please describe your methods for continuity of patient care.

_____

_____

Malpractice Litigation and Professional Complaints

1. Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?

   ☐ NO; skip this Malpractice section only. ☐ YES; answer the questions below

   If there has been more than one (1) claim or lawsuit brought against you, please make copies of this page and complete all required information for each claim or lawsuit.

   For **each** lawsuit or complaint, please furnish the following 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 (e.g., statement from an attorney or court records) of your response. You may choose to have your attorney complete this section.

2. Date Incident Occurred: _____ Location of Incident: _____

3. Name of Plaintiff(s) or Complainant(s): _____

4. Describe the Nature of the Incident (complaint, allegation): _____

   _____

   _____

5. Describe your Role/Participation and Level of Care in this Incident: _____

   _____

   _____

6. Incident Outcome: ☐ Pending ☐ Closed on _____
7. If case is CLOSED, please specify outcome:
   - Closed due to: ☐ Settlement ☐ Dropped by Either Party ☐ Dismissed with Prejudice ☐ Dismissed without Prejudice
   - Verdict in favor of: ☐ You ☐ Plaintiff/Complainant ☐ Neither Parties ☐ N/A
   - Payment awarded to: ☐ You (amount = $ _____) ☐ Plaintiff/Complainant (amount = $ _____) ☐ N/A
8. Represented by Legal Counsel for this lawsuit? ☐ Yes ☐ No
   - If YES, name and address of Legal Counsel: _____

     _____
9. Name and Address of Insurance Company that provided coverage for this claim: _____

   _____

Disclosure Questions

If you answer **Yes** to any of the Disclosure Questions below, please attach a separate sheet providing an explanation for each occurrence and include the date of incident, details (including your role in the incident), subsequent events, your status, and the current status of any action taken.

Licensure and Registration

1. Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending? ☐ Yes ☐ No
2. Has your **professional license or registration** ever been investigated or is it currently being investigated, and if so, what were the results? ☐ Yes ☐ No
3. Has your **Controlled Substance/DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your Controlled Substance/DEA registration, or is there a review pending? ☐ Yes ☐ No

Clinical Privileges and Other Affiliations

4. Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, clinical staff, or any health-related agency organization, or is there a review pending? ☐ Yes ☐ No
5. Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency? ☐ Yes ☐ No
6. Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration? ☐ Yes ☐ No
7. Has your **membership or fellowship** in any professional organization or your **specialty board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked? ☐ Yes ☐ No
8. Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a **corrective action agreement/plan** with any licensing board, peer review organization, third party payer, clinic, hospital, clinical staff, or any health-related agency or organization? ☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

9. Has your certificate or participation in any **private, federal (e.g., Medicare, Medicaid) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway? ☐ Yes ☐ No

Other Sanctions or Investigations

10. Are there any **charges pending or are you currently charged** with, or have you ever been indicted or found guilty of, a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense? ☐ Yes ☐ No
11. Have you ever been found liable, guilty of or responsible for **sexual impropriety** or misconduct or sexual harassment with a patient, coworker, or other person? ☐ Yes ☐ No

Professional Liability Insurance

12. Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty? ☐ Yes ☐ No
13. Have you ever practiced within your profession without **professional liability insurance**? ☐ Yes ☐ No

Ability to Perform Job

14. Do you have a **physical or mental condition** that would affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, what accommodations would help provide appropriate care to patients and perform other essential functions? ☐ Yes ☐ No
15. Does your use (or have you been told that your use) of **alcohol or drugs** affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions? ☐ Yes ☐ No
16. Are you currently engaged in the **illegal use of drugs**? ("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. § 812.22. CSA 21 U.S.C. § 812.22 does not pertain to "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 provisions of Federal law." The term does not include, however, the unlawful use of prescription controlled substances.) ☐ Yes ☐ No

Standard Authorization, Attestation, and Release

(PLEASE READ CAREFULLY BEFORE SIGNING)

In connection with this application for participation in the HWMG Provider Network, which is owned and operated by Hawaii-Western Management Group (HWMG), I understand and acknowledge it is my responsibility as the practitioner applicant to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by HWMG for Participation.

I further acknowledge I am responsible for knowing the contents of the applicable rules and regulations, and requirements of HWMG and its professional/clinical staff/network, and agree to be bound by them in the application process and if granted Participation. I agree to participate in the HWMG Provider Network and understand an agreement is not effective until accepted by HWMG.

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize HWMG 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 qualification for Participation and authorize such third parties to release such information to HWMG and/or 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 to HWMG and/or its Agents, and as otherwise may be required by law. I hereby further authorize HWMG to release Disciplinary information about any disciplinary action taken against me to its participating 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 organization, their administrators or their clinical 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 registration prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability HWMG and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, clinical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunity provided by law for peer review activities.

I understand and agree that HWMG may communicate with me via e-mail over the internet regarding my application for credentialing. 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 this Authorization and Release is irrevocable for any period during which I am an applicant for Participation with HWMG. I agree to execute consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide consent may be grounds for termination or discipline by HWMG in accordance with the applicable bylaws, rules and regulation, and requirements of HWMG.

I acknowledge that the investigation of information in this application and the release and exchange of Disciplinary Information by HWMG and its agents are done to achieve, maintain and improve quality patient care.

I certify that all information provided by me in this application is true, correct, and complete to the best of my knowledge and belief. If there are any changes to the information, I will notify HWMG within thirty (30) days of any changes to the information.

I understand and agree that any material misstatement in or omission from this application may result in the withdrawal of the application from consideration and constitute grounds for denial or revocation of Participation. I understand and acknowledge that HWMG shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

Name of Practitioner (print)	Signature	Date

Evidence of Credentials Checklist

A copy of the following documents (where applicable) **must be included** with your Application. All evidence must demonstrate current or active status, so please check the expiration date, if any. Expired information or those with expiration dates within 30 days of submission will not be accepted and your application will be returned, which will cause delays in your application review.

Please indicate the documents that you have included with your application. If you have elected **not** to submit a particular document, please specify the reason.

Type of Document/Evidence	Check (✓) if Included	Reason for Omission
1. State Professional License *(expiration not within 30 days of submission)*	☐	☐ Not Licensed ☐ Pending from Issuer ☐ Other: _____
2. Specialty Board Certification *(expiration not within 30 days of submission)*	☐	☐ Not Board Certified ☐ Pending from Issuer ☐ Other: _____
3. State Controlled Substance or Federal DEA Certificate *(expiration not within 30 days of submission)*	☐	☐ Not applicable to practice ☐ Pending from Issuer ☐ Other: _____
4. Proof of Liability Insurance Coverage *(expiration not within 30 days of submission)*	☐	☐ Not applicable to practice ☐ Pending from Issuer ☐ Other: _____
5. Curriculum Vitae (CV)	☐	☐ No CV to Provide ☐ Other: _____
6. Professional Education and Training Certificate(s)	☐	☐ No Certificates to Provide ☐ Pending from Issuer ☐ Other: _____
7. Educational Commission for Foreign Medical Graduates (ECFMG) *(if educated outside the U.S. or Canada; expiration not within 30 days of submission)*	☐	☐ Educated in U.S./Canada ☐ Pending from Issuer ☐ Other: _____
8. Written documents detailing history of professional liability claims history, sanctions, or disciplinary actions	☐	☐ No History, Sanctions, or Actions to Report ☐ Other: _____
9. Credentialing Application for Practitioners *(fully completed)*	☐	Please specify: _____
10. Standard Authorization, Attestation, and Release *(signed & dated)*	☐	Please specify: _____