

DEPARTMENT OF THE NAVY
NAVAL HEALTHCARE SUPPORT OFFICE
BOX 140
JACKSONVILLE FL 32212-0140

INPUT THE FOLLOWING DATA (PRESS TAB TO START)

RANK NAME

SSN DESIGNATOR

CORPS(DC,DT,MC,MSC,NC,WO)

This information will be used to fill fields on this form. Print out this form, follow the directions and send the package to us. Certified mail is the preferred way to return the package.

CREENTIALS CHECKLIST

You **MUST** provide copies of items marked with an "X", obtained within the last two years, below in order to begin your IPF.

- X** ALL Diplomas/Certificates.
- X** ANY AS, BS, BSN, MA, MSN, or Ph.D. Certificates.
- X** All Current State Licenses/Certifications.
- X** Any Expired or Inactive State licenses/Certificates.

Include Statement of Circumstance for each state license/certification

placed in an INACTIVE status or allowed to EXPIRE within the past 10 years.

- X** All Professional Agency Certification(s) (e.g. Emergency/Trauma Nursing, Perioperative Nursing.)
- X** **Current BCLS (advanced healthcare provider course only, copy of front and back of card required)**
 1. Per BUMEDINST 1500.15A, all Navy Medical Department healthcare personnel are required to hold a current Basic Life Support (BLS) certificate. Healthcare personnel may also be required to hold other contingency training documents (ACLS, PALS, NRP, and ATLS) dependent upon professional assignments. Therefore, BLS certificates will be required for all IPF initial and re-appointment/renewal packages.
 2. Naval Reservists must be prepared to present appropriate contingency training documents when reporting to Medical/Dental Treatment facilities for annual training, drills, active duty for training or active duty for special work.
- X** **Current ACLS/ATLS/PALS/NRP (as applicable.)**
- X** Photograph (**Recent. Need NOT BE official. May not be a xerox copy.**) **MUST** be labeled with name and SSN, date.

Please provide copies of all checked items indicated in enclosure (1) and complete the forms in their entirety as identified in the cover letter and enclosure (2).

USE ONLY BLACK INK
TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL
TO THE RIGHT OF THE LINE.
DO NOT USE CORRECTION FLUID/TAPE UNDER ANY CIRCUMSTANCE

These guidelines should assist you with the completion of the **initial** package:

PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS):

1. DEMOGRAPHICS:

Complete all information requested. Complete day/month/year time frames in the "from-to" fields. If the information is not applicable, write "N/A" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding participation in continuing education. Please complete the civilian employment/civilian facilities where you were employed since completing the respective training program (i.e. Nursing School/Dental Hygiene Program, etc.). Provide complete address, phone numbers for two peers who can attest to your clinical competency.

Should you wish to attach a curriculum vitae/resume, ensure it is current. Please initial and date on each page in the lower right corner.

2. PROFESSIONAL EDUCATION AND TRAINING:

Provide copies of diplomas for completed education/training. CCPD is required to primary source verify these documents.

3. PROFESSIONAL CERTIFICATION: Self-explanatory.

4. LICENSES OR CERTIFICATIONS BY STATE OR FEDERAL AGENCY:

Please provide copies of **all** current licenses/certificates held. CCPD is required to primary source verify all licenses/certificates held. Should you allow any to lapse/expire, please note this on the PPIS as CCPD is required to primary source verify the document at time of lapse/expiration to evaluate status.

5. MEDICAL READINESS TRAINING:

All Clinical Support Staff providers must present BCLS (course C). Other contingency training documents may be submitted (ACLS, NRP, ATLS, C4, etc.).

6. HEALTH STATUS/ABILITY TO PERFORM:

Please respond to the questions that address this area. If you answer "yes" (**except 6a**) to any of the questions, provide a brief, factual response in the spaces below the questions.

Do not send a copy of a physical examination.

7. MALPRACTICE/LICENSURE/ AND LEGAL HISTORY:

Please respond to the questions that address this area. If you answer "yes" to any of the questions, provide a brief, factual response in the spaces below the questions.

8. OTHER PROFESSIONAL DOCUMENTS:

You may submit copies of any other associated training (CEU) to your profession. This is **not** required. However, you will attest to CEU participation on the PPIS.

9. RESERVE INFORMATION:

Please complete the information regarding Naval Reserve Unit, Naval Air Reserve or Naval & Marine Corps Reserve Center, Naval Reserve Readiness Command – as applicable.

10. RESERVE TRAINING HISTORY: Self-explanatory.

11. CONTINUING EDUCATION HOURS: Self-explanatory.

12. PEER REFERENCES:

(Ensure all addresses and phone numbers are complete and accurate).

PEER - is a person who has equivalent education and training standing and has worked with you in same specialty.

PEER - is not a family member or partner.

CCPD will mail two Professional Peer Inquiry forms (NHSOJAX 6010/3) and a Supervisor/Department Head/Chief of Service Civilian Employment Inquiry form (NHSOJAX 6010/13) to the individuals that have been identified on your PPIS, for completion. In addition, a copy of your signed and dated consent and release form and a self-addressed envelope addressed to the Naval Healthcare Support Office will be included (so that the individuals can mail them **directly** upon completion).

The Centralized Credentials Review and Privileging Department (CCPD) will also send the Supervisor/Department Head/Chief of Service Civilian Employment Inquiry form (NHSOJAX 6010/13) to your designated chief of service or medical director and/or the Human Resource Office/Credentialing Department at all places of employment held since obtaining your qualifying degree.

13. PROFESSIONAL ASSIGNMENTS: Self-explanatory.

CONSENT and RELEASE/PRIVACY ACT STATEMENT

Please read, sign and date in the appropriate space.

PHOTO:

Please provide a recent photograph, preferably a professional photograph of yourself **alone & without** other family members, friends or pets. Ensure that the photograph is labeled with your name, social security number and date.

ALERT ALERT ALERT

If you have received the **INCORRECT** package if you are an **ADVANCED NURSE PRACTITIONER** with one of the below Sub-Specialty Code (SSC) assignments from the Bureau of Medicine and Surgery.

Sub-Specialty Code **1. TITLE**

- 1972 Nurse Anesthesia
- 1974 Pediatric Nurse Practitioner
- 1976 Family Nurse Practitioner
- 1980 Women’s Health Nurse Practitioner
- 1981 Nurse Mid-Wife

Please call CCPD at (800) 566-8494 x8120, or fax (904) 542-7211 as soon as possible. You may e-mail at ccpd@hsojax.med.navy.mil.

DO NOT DISCARD THIS PACKAGE UNTIL DIRECTED BY THIS DIVISION.

ALERT ALERT ALERT

NAVAL HEALTHCARE SUPPORT OFFICE
CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT
BOX 140 CODE 07
JACKSONVILLE, FLORIDA 32212-0140

PERSONAL AND PROFESSIONAL INFORMATION SHEET
INITIAL NON-PRIVILEGED PROVIDER

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and making recommendations as to practitioners' competence to treat certain conditions and perform certain medical procedures and to determine for clinical support staff provider competence.

ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or on an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon).

1.

Maiden/Alias (Last, First, MI): _____

NOBC/SSP codes: _____ Date of Birth: _____

Home Address: _____

Home Phone: (____) _____ Fax: (____) _____

Work address: _____

Work Phone: (____) _____ Email: _____

Note: (Please indicate which is the best method to be contacted.) _____

2. PROFESSIONAL EDUCATION AND TRAINING (list most recent first):

a. Basic Qualifying Degree (i.e. DIPLOMA, AS, BSN, etc.)

Institution (Name and Location)	Degree	From	To
_____	_____	_____	_____

b. Additional Training

Institution (Name and Location)	Specialty (MSN, Ph.D.)	Type	From	To
_____	_____	_____	_____	_____ / _____
_____	_____	_____	_____	_____ / _____
_____	_____	_____	_____	_____ / _____

RE:

3. PROFESSIONAL CERTIFICATIONS: (i.e. CCRN)

a. Certification or Re-certification	Issue Date	Expiration Date
1. _____		
2. _____		

4. LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY:

a. License Information			
License #	State	Status	Expires
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			

b. Certification Information			
Certification #	Agency	Status	Expires
1. _____			
2. _____			
3. _____			

5. MEDICAL READINESS TRAINING (indicate trained "T" or instructor "I"):

Training	T/I	Expiration	Training	T/I	Expiration
BLS	_____	_____	ACLS	_____	_____
ATLS	_____	_____	NRP	_____	_____
C-4	_____	_____	CTTC	_____	_____

I hereby attest that I understand the requirement that I be certified in a CPR course provided by the American Heart Association/HEALTHCARE PROVIDER or the American Red Cross/PROFESSIONAL RESCUER while I am in the Naval Reserves per BUMEDINST 1500.15A. I understand that I am responsible for providing documentation of my certificate upon request (i.e. AT, ADT, IDTT).

Signature: _____ **Date:** _____

RE:

6. HEALTH STATUS AND ABILITY TO PERFORM: (ANSWER Yes or No)

(Note: Explain all Yes answers in comments Section.)

- a. Have you met the Navy’s requirement to have a completed annual physical examination, either long or short form, within the past 12 months? **(If not, please explain)**
- b. Do you currently have any physical or mental impairments that could limit your clinical abilities?
- c. Are you currently taking any medications?
- d. Do you have a potentially communicable disease?
- e. Have you ever been hospitalized for any reason during the last 5 years?
- f. Have you ever been psychiatrically hospitalized or diagnosed with a major psychiatric disorder?
- g. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?
- h. Have you ever been arrested or detained for an alcohol or drug-related incident?
- i. Have you ever been involved in the unlawful use of controlled substances?

Comments: _____

7. MALPRACTICE, LICENSURE, AND LEGAL HISTORY: (Yes or No)

(Note: Explain ALL YES answers in Comments Sections.)

- a. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)
- b. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)
- c. Have you ever been the subject of investigation resulting in the termination of employment or a contractual arrangement?
- d. Have you ever voluntarily resigned or otherwise disassociated yourself from employment or practice after being notified of intent to start action against you?
- e. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated your staff appointment (membership)?
- f. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated, or lost your clinical privileges?
- g. Has there been previously successful or currently pending challenges, revocation, or restriction to any license, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?
- h. Are you now or have you ever been required to appear before any medical or state regulatory authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?

Comments: _____

8. OTHER INFORMATION: (Include any additional information that you wish to bring to the attention of the credentials office.)

Comments: _____

9. RESERVE INFORMATION:

- a. RESERVE UNIT and RUIC: _____
- b. READINESS or RESERVE CENTER and UIC: _____
- c. NAVAL AIR RESERVE OR RESERVE CENTER: _____
- d. READINESS COMMAND (REDCOM): _____

RE:

e. BILLET ASSIGNED: _____

10. RESERVE TRAINING HISTORY:

a. OIS/DCO (Officer Indoctrination School/Direct Commissioned Officer School)

Completion Date: _____

b. List ANNUAL TRAINING (AT), ACTIVE DUTY FOR TRAINING (ADT), and ACTIVE DUTY FOR SPECIAL WORK (ADSW).

Facility/Location (Example) NH Groton	Clinical YES/NO	From 12SEP94	To 29SEP94
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c. Do you perform clinical drills at a military treatment facility? ____

If yes, provide information listed below for the:

Facility/Location (Example) NH Jacksonville	Capacity Med/Surg Nursing	Frequency 48 drills/year
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11. CONTINUING EDUCATION HOURS:

Have you fulfilled the state licensure requirements for continuing education during the past 2 years?

___YES ___NO (If not, please explain)

Have you participated in continuing education in your area of specialization during the past 2 years?

___YES ___NO (If not, please explain)

Comments: _____

12. SUPERVISOR/DEPARTMENT HEAD/CHIEF OF SERVICE REFERENCE:

Name _____ Work Phone () _____ FAX () _____

Full Address _____

PEER REFERENCES: Please provide two peer references who can attest to your qualifications **based on current clinical experience within the past two years.**

Name _____ Work Phone () _____ FAX () _____

Address _____

Name _____ Work Phone () _____ FAX () _____

Address _____

RE:

13. PROFESSIONAL ASSIGNMENTS: Please provide all information requested for each place you have been employed since completing your respective training program (i.e. Nursing Program, Dental Hygiene Program, etc.). Indicate if direct patient care was involved. If yes, **was it in your current specialty?**
List in chronological order with the most recent first, and identify gaps in employment history.

Facility/Institution _____ PHONE () _____ FAX () _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE () _____ FAX () _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE () _____ FAX () _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE () _____ FAX () _____

Address _____

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Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

RE:

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

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Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE (____) _____ FAX (____) _____

Address _____

Direct Patient Care (Y/N) ___ if yes, how many hours per week? _____

Position/Specialty _____

Point of Contact _____

Dates of Affiliation From: _____ To: _____

RE:

**** If currently working in a non-clinical setting, or working less than 10 clinical hours a week, briefly describe your current occupation and job activities. ****

I affirm and attest to the complete and correct information I have provided. I have the responsibility to comply with all credentialing policies and procedures, and Code of Ethics/Standards of Conduct. I will keep my file current by informing the Naval Healthcare Support Office of any changes; including but not limited to: my demographic information, my state license(s)/certification(s), any change in my employment status at any facility, or any professional adverse action taken against me.

Signature: _____ Date: _____

INDIVIDUAL CREDENTIALS/PROFESSIONAL FILE
CONSENT AND RELEASE/PRIVACY ACT STATEMENT

RE:

As a clinical support staff member or by applying for medical/dental staff membership of the Naval Healthcare Support Office, Jacksonville, Florida, I hereby make the following authorizations:

REFERENCES: Authorize the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives to consult with my current and prior associates and others who may have information regarding my clinical competence and other qualifications and to verify information in my file;

INSPECTION OF RECORDS: Consent to the inspection by the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, of all records and documents, that would evaluate my competence and professional, moral, and ethical qualifications;

LIABILITY INSURANCE: Authorize release of information from current and prior liability insurance carrier(s) regarding any and all information related to coverage and claim history under their company(ies);

RELEASE FROM LIABILITY: Release from liability any and all individuals and organizations who provide information to the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, in good faith and without malice concerning my clinical competence, ethics, moral character and any other qualifications. (Peer review activities are protected under the Health Care Quality Improvement Act of 1986 (HCQIA).).

TIME FRAME FOR AUTHORIZATION: Acknowledge that this form and any copies thereof may be used as authorization for securing information for two years from the date signed.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):

10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

2. PURPOSE: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials and privileging function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

3. ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

4. DISCLOSURE IS MANDATORY: In the case of all personnel, the requested information is mandatory because of the need to document all credentialing and quality assurance (performance improvement) data. If the requested information is not furnished, further action on your ICF/IPF will not be possible. This all inclusive privacy act statement will apply to all requests for personal information made by personnel for credentials review purposes and will become a permanent part of your ICF/IPF.

Your signature acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF MEMBER

SSN OF MEMBER

DATE