Please type or print the information requested. Sec. VI requires applicant's signature and date, Sec. VII the Department Chair's. If more space than provided on the original is needed, attach additional sheets and reference the question being answered.

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Date:

FACULTY CREDENTIALING APPLICATION

I. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:

Degrees:	School of Dentistry Appointing Department:	E-mail Address:
Professional License/Certification Type:	**Professional License/Certification Number:**	**DEA Number *(optional)*:**
Professional License/Certification Type:	**Professional License/Certification Number:**	**NPI Number *(optional)*:**

Specialty:	Subspecialties:

Are you board or otherwise professionally certified? ☐ **No** *(please skip to Sec. II)* ☐ **Yes** *(please provide information below)*

Issuing Board/Entity:	Specialty:	Date Certified:	Date Recertified:	Exp Date: *(if any)*

II. PRACTICE INFORMATION

Does Not Apply ☐

Name of Practice / Affiliation or Clinic Name:		
Practice Street Address:		**City:**
State:	**Zip Code:**	**Telephone Number:**
		( )
E-mail Address:		**Fax Number:**
		( )

III. CURRENT PROFESSIONAL LIABILITY COVERAGE

☐ **No** ☐ **Yes** – ***Please provide policy/certificate face sheet***

IV. CURRENT PROFESSIONAL LIABILITY CLAIMS/LAWSUITS

☐ **No** ☐ **Yes** – ***Please complete Addendum 1 (attached)***

V. PRACTITIONER ATTESTATION QUESTIONS

If your answer to any of the following questions is 'Yes," provide details as specified on a separate sheet. If you attach additional sheets, sign and date each sheet.

A. PROFESSIONAL SANCTIONS

1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a. License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b. Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c. Specialty or subspecialty board certification	YES ☐	NO ☐
	d. Membership on any hospital/clinic medical/dental staff	YES ☐	NO ☐
	e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g. Professional society membership or fellowship	YES ☐	NO ☐
	h. Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO ☐
	i. Academic Appointment	YES ☐	NO ☐
	j. Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review and/or disciplinary action, formal or informal, by an ethics committee, licensing board, dental and/or medical disciplinary board, professional association, or education/training institution?	YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	YES ☐	NO ☐

V. PRACTITIONER ATTESTATION QUESTIONS ☟ *Continued*

B. AFFIRMATION OF ABILITIES

1.	Do you have, or have you had in the last two years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. **If the answer to this question is yes,** please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.	YES ☐	NO ☐
2.	Are you unable to perform any of the services/clinical privileges required by the position, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐

C. LITIGATION AND MALPRACTICE COVERAGE HISTORY

(If you answer "Yes" to any of the questions in this section, please complete Addendum 1 of this application.)

1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?	YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?	YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐

VI. ATTESTATION AND CONSENT

I certify that all the information provided on this form and on any attached information sheets are true, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of requested appointment and clinical privileges or cause for revocation of appointment and privileges. A photocopy of this application has the same force and effect as the original.

I specifically agree and consent to the disclosure and release of information to the University of Washington that assists in the verification of my academic and professional credentials and qualifications.

Applicant's Name *(print)*: _____ Date: _____

Applicant's Signature: _____

VII. DEPARTMENT AUTHORIZATION

I support the submission of this application. In the event of an adverse response to any attestation question in the Faculty Credentialing Application, I verify that I am aware of and have reviewed all information related to the occurrence.

Proposed Faculty Position: _____ Appt. Date: _____

Proposed Date of Appointment: _____

Department: _____

Department Chair Name *(print)*: _____ Date: _____

Department Chair Signature: _____

VIII. CREDENTIALING DOCUMENTATION

☐ Dental License
☐ DDS/DMD Diploma
☐ MS/MSD/MPH ☐ PhD ☐ MD ☐ Other *(specify)* _____

☐ Certificates, Graduate, Residency
☐ Board Certification
☐ Other *(specify)* _____

IX. SCHOOL OF DENTISTRY REVIEW

Date:	Reviewer	Recommendation	Signature

Addendum 1. Professional Liability Claims and Lawsuits – Detail

Please list any current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. ***Photocopy this page as needed and submit a separate page for EACH claim/event****. A legible signed practitioner narrative that addresses all of the following details is acceptable.*

Date Suit or Claim Filed: _____

Clinical details of the incident, with preceding events:
Your role and specific responsibility in the incident:
Subsequent events, including patient's clinical outcome:
Name and address of insurance carrier that handled the claim:
Your status in the legal action (primary defendant, co-defendant, other):
Current status of suit or other action:
Date of settlement, judgment, or dismissal:
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:
$

Applicant's Signature: _____ Date: _____