PERMANENTE DENTAL ASSOCIATES
EMPLOYMENT AND CREDENTIALING APPLICATION

PERSONAL INFORMATION

First Name	Middle Name	Last Name/Degree
Other names you have been known by (birth name)		
Home Address: Street, City, State, Zip Code		
Home Phone	Work Phone	Email
Social Security #	National Provider Identifier #	Date Available For Work

LICENSES, EXAMINATIONS, REGISTRATIONS

❒ General Dentist ❒ Specialist_____ (specify specialty)	Washington License # Permits Expiration Date	Oregon License # Permits Expiration Date
DEA Registration # Expiration Date	Other State/License # Permits Expiration Date	Other State/License # Permits Expiration Date
Licensing Exams		CPR Certification(s) and Expiration Date(s)

DENTAL EDUCATION

Dental School	Dates Attended
Graduation Date	Class Standing (percentile)

POSTGRADUATE EDUCATION/TRAINING

Please list any postgraduate education/training (e.g., specialty or general practice residencies, fellowships) completed, currently enrolled in, or in the process of applying for. Attach additional sheets if necessary. ❒ **N/A**

Program	Program Director	
Mailing address	Telephone	
Type of Training (e.g. residency, etc.)	Specialty	Dates of Training
Did you successfully complete the program? Yes ☐ No ☐ If you answered "No" please provide details on a separate sheet of paper.		
Program	Program Director	
Mailing address	Telephone	
Type of Training (e.g. residency, etc.)	Specialty	Dates of Training
Did you successfully complete the program? Yes ☐ No ☐ If you answered "No" please provide details on a separate sheet of paper.		

BOARD CERTIFICATIONS

Please provide the following information regarding any and all board certifications/eligibility. ❒ **N/A**

Name of Specialty Board Certification/Eligibility (circle)	Effective Date Expiration Date

WORK HISTORY

Please list in reverse chronological order, beginning with the most current, all employment affiliations since completion of dental school (use separate sheets if necessary). On a separate sheet, explain any gaps in work history.

Name of Current/Past Practice/Title	From (MO/YR) To (MO/YR) City/State
Name of Current/Past Practice/Title	From (MO/YR) To (MO/YR) City/State
Name of Current/Past Practice/Title	From (MO/YR) To (MO/YR) City/State

OTHER AFFILIATIONS, HOSPITALS

Please list **ALL** other health care organizations and hospitals where you are **currently affiliated, employed, or have applied to** (including any university, independent practice association, or preferred provider organization). ❒ **N/A**

Name of Organization	Affiliation Dates City, State		
Type of Affiliation	Department	Telephone	Fax
Name of Organization	Affiliation Dates City, State		
Type of Affiliation	Department	Telephone	Fax

MILITARY SERVICE

Branch	Rank	Dates of Service	Are you in the reserves?

Discharge Status: ☐ Honorable ☐ Dishonorable ☐ Other (please specify)

PROFESSIONAL LIABILITY CARRIER(s) AND HISTORY

Please list any insurance carrier(s) during the last ten years **(attach a copy of your current certificate of insurance.)** ❒ **N/A**

Insurance Carrier _____ Policy #_____

Occurrences_____Claims Made_____ Coverage Limits_____Dates of Coverage_____

Address _____ City _____ State_____Telephone _____

Insurance Carrier _____ Policy #_____

Occurrences_____Claims Made_____ Coverage Limits_____Dates of Coverage_____

Address _____ City _____ State_____Telephone _____

PROFESSIONAL REFERENCES

List the names of three practitioners (outside of Permanente Dental Associates) who have supervised your clinical practice or have worked with you professionally and have knowledge of your current clinical competence, character, conduct and relationships with patients, staff and colleagues within the last two years.

1) Reference Name, Degree, Title	Affiliation or Practice Name
Address, City, State, Zip	Telephone Fax
Nature Of Your Professional Association With Reference ❒ Training Program Director ❒ Employer ❒ Associate In Practice ❒ Other	Time Period Of The Association From _____ (MO/YR) To _____(MO/YR)
2) Reference Name, Degree, Title	Affiliation or Practice Name
Address, City, State, Zip	Telephone Fax
Nature Of Your Professional Association With Reference ❒ Training Program Director ❒ Employer ❒ Associate In Practice ❒ Other	Time Period Of The Association From _____ (MO/YR) To _____(MO/YR)
3) Reference Name, Degree, Title	Affiliation or Practice Name
Address, City, State, Zip	Telephone Fax
Nature Of Your Professional Association With Reference ❒ Training Program Director ❒ Employer ❒ Associate In Practice ❒ Other	Time Period Of The Association From _____ (MO/YR) To _____(MO/YR)

HEALTH STATUS

If the answer to any of the following questions is "yes," please provide full details on a separate sheet of paper. Each case will be judged on its own merits with respect to its effect on your professional qualifications and competence.

		YES	NO
A.	Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations?	☐	☐
B.	Within the last two years, have you been dependent upon alcohol or drugs?	☐	☐
C.	Within the last two years, have you been in treatment for alcohol or drug abuse or dependency?	☐	☐
D.	Within the last two years, has your membership, participation, affiliation, or privileges with any health care organization been terminated, suspended, or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	☐	☐

PROFESSIONAL HISTORY

If you answer "yes" to any of the following questions, please give details on a separate sheet of paper. Each case will be judged on its own merits with respect to its effect on your professional qualifications and competence.

		YES	NO
A.	Have you, your license, registration, certification, permit, Drug Enforcement Agency registration, other controlled substance, or authorization to practice your profession or occupation or to provide health care services of any nature (either as a student, intern, resident, or in any other capacity) been denied, restricted, suspended, not renewed, revoked, voluntarily or involuntarily relinquished, or been subject to investigation, review, reprimand, warning or any disciplinary action or probationary condition, or has any such action been initiated or pending?	☐	☐
B.	Have your clinical privileges, membership, participation and/or employment in any health care organization been denied, investigated, restricted, suspended, terminated, revoked, not renewed, or subject to a warning or any disciplinary action or probationary condition, or are any such actions pending, or have actions been recommended by a health care organization?	☐	☐
C.	Have you voluntarily, involuntarily, or under the threat of an investigation relinquished or withdrawn your request for clinical privileges, membership, participation, contractual affiliation, or employment with any hospital or health care organization?	☐	☐
D.	Have you been notified that a report, complaint, or other filing regarding your practice, including a malpractice payment made on your behalf, has been made to the National Practitioner Data Bank or any state licensing board?	☐	☐
E.	Have you been convicted of, or pleaded guilty to, a criminal offense (i.e., a felony or misdemeanor), and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense, or are any such charges pending?	☐	☐
F.	Have you, your fees, quality of care or other practices been subject to investigation or action, including fraud or abuse proceedings, by a government agency or third party payer, including but not limited to suspension, sanction or other restriction by any private, federal or state health payment program?	☐	☐

If the answer to any of the following questions is "yes," please complete the enclosed Claim Form. Each case will be judged on its own merits with respect to its effect on your professional qualifications and competence.
The following questions apply to the preceding two year period.

		YES	NO
A.	Have you been named as a defendant, involved, and/or have you been alleged to have been negligent, in a professional liability case in the past 2 years or have any settlements been made on your behalf, or are any such cases pending? **If so, use the Claim Form to describe each case and its current status or disposition.**	☐	☐
B.	Has the care which you provided been the subject of any claim of negligence or other action for damages?	☐	☐
C.	Have you been denied professional liability coverage or insurance?	☐	☐
D.	Has your professional liability coverage or insurance policy been revoked, canceled or relinquished (whether voluntary or involuntary) under a threat of cancellation?	☐	☐
E.	Have you practiced without professional liability coverage when you were required to have it? If so, please state the reason(s) why.	☐	☐

APPLICANT RELEASE/ AGREEMENT/ ATTESTATION

I fully understand that any significant misstatement in, or omission from, this application constitutes cause for denial of employment and/or appointment, or cause for summary dismissal.

All information submitted by me in this application is true and complete to my best knowledge and belief.

In making this application for appointment to the Professional Staff of Permanente Dental Associates, I pledge to practice ethically, to provide for continuous care for patients, and to be bound by Bylaws and Rules and Regulations of Professional Staff and such amendments thereto as may be adopted from time to time, and by Dental Group policies affecting practice therein.

By submitting this application, I consent to the exchange of information and documents between any and all institutions, individuals, licensing agencies, and federal and state governmental bodies with whom I have been associated that are material to evaluating and monitoring my professional practices, qualifications, competence, morality or ethics.

I hereby release Permanente Dental Associates and Kaiser Foundation Health Plan of the Northwest, and their representative(s) from liability for all acts performed and statements made in good faith in connection with evaluating my application and credentials and in monitoring my professional activities. I further release from liability all individuals and organizations which, in good faith, provide information to Permanente Dental Associates and Kaiser Foundation Health Plan of the Northwest, including otherwise privileged or confidential information.

I understand that Permanente Dental Associates will rely upon the information given on this application form during the processing of my application for employment and Professional Staff membership and privileges. Where appropriate, I have the right to review the information submitted in support of my application, and correct erroneous information. I will give Permanente Dental Associates 24 hours notice of my intent to review, and upon notification of inconsistent or missing information, I have the responsibility to respond immediately with the correct or complete information.

I agree that I will immediately inform Permanente Dental Associates of any change or modification to the information provided therein, so that at all times, Permanente Dental Associates will have accurate and current information.

_____ _____

Signature of Applicant Date

Permanente Dental Associates is an Equal Opportunity Employer. Facts relating to race, color, national origin, sex, or age are not requested by this application and are not considered in determining your qualifications for employment.