ASPA Arizona State Physicians Association

We are pleased that you have expressed an interest in becoming a member of the Arizona State Physicians Association (ASPA). Enclosed are the following:

- ASPA Application
- ASPA Payor Participation Attachments
- Copy of Physician/Provider Affiliate Agreement (**see below**)
- **Please see attached Checklist on next page regarding items needed for your application.**

Please complete the application in full **(any items that pertain to you and your Specialty MUST be filled out) (See Attached, See CV, and CAQH applications will not be accepted)** return **ALL** enclosures with the documentation requested on the application. **PLEASE DO NOT SUBMIT THE APPLICATION 2 SIDED.**

Please review and sign a copy of the contract on page 10. Please **DO NOT** date the contract cover or the 2nd page of the contract. This is to be completed on the date of approval by the Board of Directors. A dated and signed copy will be returned to you for you records following application approval.

Upon receipt of the required information, your application will undergo the credentialing process. **This process takes between 90-120 days.** The contract shall be deemed executed when signed by an official representative of the Arizona State Physicians Association. At that time you will be notified regarding which plans you will be participating in through ASPA.

Additionally, a site visit and chart audit will be required on ALL OB/GYN and Primary Care provider offices as well as Nurses in those same fields. Once your application has been submitted to our credentialing department, our QA Nurse will be calling to schedule a convenient time to come out to your office. We strongly advise you allow our nurse to come out to your office as soon as possible as your application will not be finalized and sent to committee for review until this component of the initial credentialing process has been complete.

As a Member, you may or may not have access to all ASPA's current contracted plans. Your name, specialty, and location(s) will be presented to our current contract plans for consideration of participation.

DO NOT provide services to any contracted plans **UNTIL THE EFFECTIVE DATE WITH EACH OF THE PLANS HAS BEEN CONFIRMED.** Services prior to that effective date **WILL NOT BE COVERED. PLEASE NOTE** your effective date with the plans **WILL BE DETERMINED BY THE INDIVIDUAL PLAN, NOT ASPA.**

If, of course you already have a direct contract with any of the offered plans, you should continue under that contract until your ASPA contract is in effect, at which time you have a choice to either continue under your individual contract or utilize the contract available through ASPA. We suggest you evaluate your contracts to determine which contract is better for your office.

Once you have been approved as a Member you will have access to many other services offered by ASPA.

If you require further clarification or have any questions regarding the application or credentialing processes you may contact Angie at 602-265-2524 Ext. 222. For questions regarding ASPA Contracted Plans please contact Tonya at tonya@azspa.com. For other ASPA services please contact Connie at connie@azspa.com.

Sincerely,

Angie Higgins

3030 N. Central Ave. Suite 1405, Phoenix, AZ 85012 Telephone: 602.265.2524 Fax: 602.265.3289
Email:angie@azspa.com

ASPA Arizona State Physicians Association

ASPA Initial Application Checklist

Please make sure the following items are attached upon completion and return of your ASPA Application

Payment is REQUIRED before the credentialing process can be started, please see fee structure below:

- **Specialty Physicians: $525**
- **Primary Care Physicians: $425**
- **ALL NURSES: $350 (NP's, FNP's, CNM's, RN's, etc)**
- **Allied Health Member $325 (PA's, PT's, Ph.D.'s, etc)**
- **Chiropractors: $325**

This fee includes your first year annual dues and Credentialing costs. **YOUR APPLICATION WILL NOT BE PROCESSED UNTIL THIS FEE HAS BEEN RECEIVED**. This fee should be sent in with the application or paid online at http://azspa.com/pay-your-bill-online/(with a copy of the receipt attached), if a fee is not received within 30 days of ASPA receiving the application, the application will be shredded.

- **Copy of your DEA Certificate:** (if applicable) (**MUST** show **ARIZONA** address and **Current Expiration date**)
- **Documentation of Arizona State License:** (showing **current expiration date**)
- **Copy of your Current Malpractice Facesheet:** (showing **current expiration date**)(Limits no less than $1 Million/$3Million)
- **Copy of Workman's Comp Facesheet:** (showing **current expiration date**)
- **Copy of General Liability Facesheet:** (showing **current expiration date**)
- **Copy of SAMs certificate:** (Sexual Misconduct and Molestation)
- **Copy of your Curriculum Vitae:** with minimum 5 years Work History. All dates (**Education and Work History**) **MUST** be in a Month/Year Format. **(MM/YYYY)**
- **Proof of CME Hours:** (**Chiropractors & Physical Therapist ONLY**)
- **ALL NURSES** must be **Board Certified.** ASPA does not accept Nurses that are not Board Certified. **(Please note this is not the same as being licensed with the State of Arizona)**
- **A Current W9:** (**showing Billing Address that is listed on the application**.)
- **Current CLIA Certificate(s):** if applicable (please provide if you draw/test blood in your office.)

3030 N. Central Ave. Suite 1405, Phoenix, AZ 85012 Telephone: 602.265.2524
Fax: 602.265.3289 Email:angie@azspa.com

ARIZONA STATE PHYSICIANS ASSOCIATION
STANDARD APPLICATION TO PARTICIPATE

Please Type or Print Legibly. If more space is needed, use supplementary pages. Indicate "n/a" where appropriate. ("SEE ATTACHED" "SEE CV", "SEE CAQH" ARE NOT ACCEPTED)

PERSONAL INFORMATION:

Title: _____ **Last Name**: _____ **First Name:**_____

Middle Name:_____ Suffix: _____ Salutations: Professional _____ Personal _____

Degree: _____ **Date of Birth**: ____/___/_____ **Age**: _____ **Sex:** □ Male □ Female

Social Sec. # _____ **E-Mail Address:** _____

Primary Care: _____ **Specialist**: _____ **Allied Health:** _____ ASPA ID# _____

ALIAS:

Type: Maiden Name: _____Other:_____

Title: _____ Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Start Date: _____ End Date: _____

Comment: _____

HOME AND PERSONAL INFORMATION:

Address:_____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ Listed: _____ **Telephone 2:** _____ Listed: _____

Cell Phone: _____ **Beeper:**_____

Birthplace City: _____ **State:** _____ **Country:** _____

Languages: _____ **Write**:_____ **Read:** _____**Speak:** _____

Languages: _____ **Write**:_____ **Read:** _____**Speak:** _____

Citizenship: _____

If not a Citizen of the United States please indicate the status of your visa at the present time: _____

Ethnic Background: _____ **Date of Last Physical Exam:** _____

Marital Status: _____**Spouse's Name**: _____

CREDENTIALING CONTACT INFORMATION:

Contact Name: _____ **Title:** _____

Company Name: _____

Address:_____

Suite: _____ **City:** _____

State: _____ **Zip Code:** _____ **Telephone:** _____

Cell Phone: _____ **Fax#:** _____

E-Mail: _____

OFFICE INFORMATION:

Location #1 ☐ **Primary Office** ☐ **Mailing Address** ☐ **Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: ☐ **PC** ☐ **PA** ☐ **LLC** ☐ **Other** _____ Group NPI #:_____

Practice Status: ☐ **Group** ☐ **Individual** ☐ **Partnership** ☐ **Employee**

Accepting New Patients: ___Yes ____No

Site Type: Physician Office X-ray Facility OP Surgery Urgent Care Lab ER PT Facility DME Home Health Hospice MRI Facility Dialysis Center

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

_____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____	SUNDAY	_____	_____

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

#2 OTHER OFFICE LOCATION: **□ Satellite Office □ Mailing Address □ Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: □ **PC** □ **PA** □ **LLC** □ **Other** _____ Group NPI #:_____

Practice Status: □ **Group** □ **Individual** □ **Partnership** □ **Employee**

Accepting New Patients: ___Yes ____No

Site Type: Physician Office X-ray Facility OP Surgery Urgent Care Lab ER PT Facility DME Home Health Hospice MRI Facility Dialysis Center

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

_____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____	SUNDAY	_____	_____

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

 # 3 OTHER OFFICE LOCATION: ☐ **Satellite Office** ☐ **Mailing Address** ☐ **Billing Address**

Date started at this location: _____/____/ _____ **Is Office Handicap Accessible?:** Yes ___ No ___

Office Name:_____

Address:_____**Suite#:** _____**City:** _____

State: _____ **Zip:** _____ **County:** _____

Web Site: _____ **E-mail:** _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Staff Languages: _____Write:_____ Read: _____Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ **Legal Name:** _____

Legal Identity: ☐ **PC** ☐ **PA** ☐ **LLC** ☐ **Other** _____ Group NPI #:_____

Practice Status: ☐ **Group** ☐ **Individual** ☐ **Partnership** ☐ **Employee**

Accepting New Patients: ___Yes ____No

Site Type: Physician Office X-ray Facility OP Surgery Urgent Care Lab ER PT Facility DME Home Health Hospice MRI Facility Dialysis Center

List Service you provide in this office: ___EKG ___GYN Exam ___Immunizations Other: _____

_____

Days and Hours of Operation:

SUNDAY	_____	_____	THURSDAY	_____	_____
MONDAY	_____	_____	FRIDAY	_____	_____
TUESDAY	_____	_____	SATURDAY	_____	_____
WEDNESDAY	_____	_____	SUNDAY	_____	_____

Office Contact:

Name: _____ **Title:** _____ **Salutation:** _____

Primary Contact: ___ Yes ___ No Type: __ Office __ Business ___Insurance/ Billing _____Administrator _____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other):_____

E-Mail: _____

LIST ADDTIONAL ADDRESS INFORMATION ON A SEPARATE SHEET OF PAPER

SUBMIT A W-9 FORM FOR EACH TAX ID NUMBER USED

SHARE CALL

List the names of physicians with whom you share call:

NAME: _____ Title:_____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/_____/_____

Phone: _____ Fax:_____

Hospital Privileges: _____

PHYSICIAN SPECIALTIES:

My Primary Specialty: _____

Specialize or limit my Practice to: _____

Certified: YES ☐ NO **Name of Board:** _____

Cert. #: _____ **Date:** ___/____/____ **Expires:** ___/ ____/ _____ Original Cert Year _____

Re-Cert Year: _____ Not certified, are you eligible? ☐ YES ☐ NO Exam Date: _____

Sub-Specialty: _____Certified: ☐ YES ☐ NO

Cert. #: _____ **Date:** ____/___/____ **Expires:** ____/___/ _____ Original Cert Year _____

If not certified, are you eligible? ☐ YES ☐ NO Exam Date: _____

HAVE YOU EVER BEEN EXAMINED BY ANY SPECIALTY BOARD, BUT FAILED TO PASS THE EXAMINATION?
☐ YES ☐ NO IF YES, EXPLAIN: _____

HOSPITAL / SURGICAL CENTER, ETC

PLEASE LIST ARIZONA HOSPITALS WHERE YOU HOLD PRIVILEDGES INCLUDING ANY THAT ARE PENDING. IF MORE SPACE IS REQUIRED, ATTACH ADDITIONAL SHEET:

HOSPITAL & ADDRESS **DATES FROM & TO (Mo, day & Yr)** PRIMARY HOSPITAL

#1_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#2_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#3_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#4_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#5_____ _____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#6_____ ____/____/_____TO_____/___/_____ YES_____NO_____

_____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

IF YOU DO NOT HAVE HOSPITAL PRIVILEGES, PLEASE INDICATE WHO WILL BE ADMITTING FOR YOU INCLUDE NAME OF ALL HOSPITALIST GROUPS USED:

#1 Physician Name / Hospitalist Group Name: _____ Title: _____

Phone: _____ Fax: _____

Effective: ___/___/_____ Through ____/____/_____

#2 Physician Name / Hospitalist Group Name: _____ Title: _____

Phone: _____ Fax: _____

Effective: ___/___/_____ Through: ____/____/_____

IF MORE THAN TWO PHYSICIANS OR GROUPS ARE USED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH.

EDUCATIONAL BACKGROUND

UNDERGRADUATE

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____

MEDICAL/DENTAL COLLEGE

University:_____ **Phone:** _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ Specialty: _____

OTHER PROFESSIONAL TRAINING

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____ Specialty: _____

POST GRADUATE EDUCATION

University:_____ Phone: _____

Address:_____ _____City: _____State:_____

Zip code: _____ Attention: _____ Country: _____

From: _____/_____/_____ Through: ____/____/_____ Date Graduated: ____/_____/_____

Degree Earned: _____ Specialty: _____

INTERNSHIP

University:_____ **Phone:** _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ **Specialty:** _____

IF MORE THAN ONE INTERNSHIP WAS COMMENCED OR COMPLETED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH

 # 1 RESIDENCY

University:_____ **Phone:** _____

Address:_____**City:** _____**State:**_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ **Specialty:** _____

#2 RESIDENCY

University:_____ **Phone:** _____

Address:_____**City:** _____**State:**_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated**: ____/_____/_____

Degree Earned: _____ **Specialty:** _____

IF MORE THAN TWO RESIDENCIES WERE COMMENCED OR COMPLETED, PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET AND ATTACH.

FELLOWSHIP

University:_____ **Phone**: _____

Address:_____**City:** _____**State**:_____

Zip code: _____ **Attention:** _____ Country: _____

From: _____/_____/_____ **Through:** ____/____/_____ **Date Graduated:** ____/_____/_____

Degree Earned: _____ Specialty: _____

IF MORE THAN ONE FELLOWSHIP WAS COMMENCED OR COMPLETED, PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET AND ATTACH.

PLEASE LIST ANY GAPS IN TIME (EDUCATION, RESIDENCY, ETCD) FOR THREE CONSECUTIVE MONTHS OR MORE:

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

FROM: ___/____/_____ TO: ____/___/_____ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

PLEASE ATTACH COPY OF CME FOR THE PAST 12 MONTHS, INCLUDING NUMBER OF HOURS PER MEETING. CHIROPRACTORS & PHYSICAL THERAPIST ONLY

LICENSE AND PROVIDER NUMBER INFORMATION

NPI#: _____ **Group NPI#:** _____

Medicare Provider #:_____ Effective: _____ UPIN #: _____

Accept Medicare Assignment? □ YES □ NO Group Medicare # _____

Medicaid/ AHCCCS Provider #: _____ Effective Date: _____

ECFMG Certificate #: _____ Issue Date: _____

DEA#:_____ DEA Schedules: _____

DEA Effective:_____ DEA Expiration Date: _____

Other DEA #S You Use: _____ **CLIA #:** _____ **CLIA Expires:** _____

Arizona License#:_____Original Date Issued:_____Effective:_____ **Expires:** _____

Original State Licensure: State: _____ Number: _____ Original Date issued: _____

List All Other State(s) And License Number(s) In Which You Are/Or Have Been Licensed To Practice:

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

_____ License #:_____ Effective Date:____ _____ EXPIRATION DATE: _____

PLEASE ATTACH COPIES OF YOUR DEA, EACH STATE LICENSE & ECFMG CERTIFICATE

LIABILITY CARRIERS:

Current: _____ YES _____ NO

Insurance Company Name: _____

Address:_____**Suite:** _____ **City:** _____

State: _____**Zip Code**: _____**Phone:** _____

Amount of Coverage: $_____/_____ **Policy #:**_____

From:____/_____/_____ **To:**_____/_____/_____ Certificate Holder: _____YES _____ NO

Current: _____ YES _____ NO

Insurance Company Name: _____

Address:_____**Suite:** _____ **City:** _____

State: _____**Zip Code:** _____**Phone:** _____

Amount of Coverage: $_____/_____ **Policy #**:_____

From:____/_____/_____ To:_____/_____/_____ Certificate Holder: _____YES _____ NO

FOR LIABILITY CARRIERS WITHIN THE PAST 10 YEARS -- PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH. ATTACH COPIES OF YOUR CERTIFICATES FOR MALPRACTICE INSURANCE

REFERENCES

ON YOUR BEHALF, PLEASE HAVE THREE (3) LETTERS OF REFERENCE FORWARDED TO OUR OFFICE. YOUR APPLICATION **WILL NOT** BE COMPLETE UNTIL THESE LETTERS ARE RECEIVED. REFERENCES WILL BE EVALUATED ACCORDING TO THE EXTENT OF THEIR DIRECT CLINICAL OBSERVATION OF YOUR WORK AND OTHER KNOWLEDGE OF YOU. LIST BELOW THE NAMES, ADDRESSES, AND PHONE NUMBERS OF THE **PHYSICIANS OTHER THAN YOUR CURRENT ASSOCIATES** AND **FORMER ASSOCIATES** WHO WILL BE SUPPORTING YOUR MEMBERSHIP IN ASPA. REFERENCE SHOULD BE FROM A PEER OF THE SAME SPECIALTY. **REFERENCES MUST BE FROM OTHER PHYSICIANS, ALLIED HEALTH PROVIDERS(FOR NURSES, PT'S, PA'S, ETC) ONLY DRS CAN FILL OUT FOR OTHER DRS, DRS CAN FILL OUT FOR ALLIEDS, ALLIED CANNOT FILL OUT FOR DRS.**

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ **Specialty:**_____

Address: _____**Suite#:**_____ **City:** _____

State: _____ **Zip Code**: _____ Country:_____ **Phone Number**: _____

Fax Number: _____ **Email Address:** _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ **Specialty**:_____

Address: _____**Suite #**_____ **City**: _____

State: _____ **Zip Code:** _____ Country: _____ **Phone Number:** _____

Fax N umber: _____ **Email Address:** _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ **Specialty**:_____

Address: _____**Suite #**_____ **City:** _____

State: _____ **Zip Code:** _____ Country: _____ **Phone Number:** _____

Fax N umber: _____ **Email Address:** _____

SOCIETIES, COLLEGES AND ACADEMIES

List Memberships In Professional Societies, Colleges, And Academies (Local, State Or National)

ORGANIZATION:	MEMBER SINCE:	THROUGH:
_____	_____	_____

Elected or Appointed Position Held: _____

_____	_____	_____

Elected or Appointed Position Held: _____

_____	_____	_____

Elected or Appointed Position Held: _____

**********PLEASE ATTACH CURRICULUM VITAE WHICH INCLUDES YOUR WORK HISTORY**********

WORK HISTORY

Please list your work history starting with your current position. If you need more room, please attach a separate piece of paper with the following information: **("SEE CV" WILL NOT BE ACCEPTED)**

#1 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____**Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____**Title:** _____ **Contact Phone:**_____

#2 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

#3 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

#4 Name of Company **Dates From:** **To:**

_____ ___/____/_____ ____/____/_____

Address: _____**Suite** _____**City**: _____ **State:** _____

Zip Code: _____Country: _____ **Phone:**_____ **Fax:**_____

Position Held: _____ **Primary Activity:**_____

Contact Name: _____Title: _____ **Contact Phone:**_____

PLEASE LIST ANY GAPS IN TIME (EMPLOYMENT) FOR SIX MONTHS OR MORE:

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

FROM: ___/____/_____ **TO:** ____/____/_____ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

PHYSICIAN PHILOSOPHY:

1. DO YOU UNDERSTAND THE CONCEPT OF MANAGED HEALTH CARE AND ARE YOU WILLING TO WORK WITHIN THE GUIDELINES ESTABLISHED BY CONTRACTED HEALTH PLANS? □ YES □ NO

2. DO YOU RECOGNIZE AND ACCEPT THAT UTILIZATION REVIEW AND PEER REVIEW ARE FUNDAMENTAL PRINCIPLES OF THIS ORGANIZATION? □ YES □ NO

3. DO YOU AGREE THAT MEDICAL RECORDS/CHARTS WILL BE AVAILABLE FOR UTILIZATION/QUALITY ASSURANCE REVIEW? □ YES □ NO

4. ARE YOU WILLING TO ACTIVELY PARTICIPATE ON ANY COMMITTEES REPRESENTING THIS ORGANIZATION (i.e., CREDENTIALING, QA/UR, BOARD OF DIRECTORS)? □ YES □ NO

5. WOULD YOU BE AVAILABLE TO PROVIDE EDUCATIONAL PROGRAMS IN YOUR SPECIALTY FOR MEMBERS OF THIS ORGANIZATION? □ YES □ NO

FAILURE TO ANSWER THE FOLLOWING QUESTIONS TRUTHFULLY WILL RESULT IN DENIAL OF MEMBERSHIP IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE GIVE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH HERETO.	**YES**	**NO**
1. ASIDE FROM THE ROUTINE CREDENTIALS SCRUTINY (INCLUDING ROUTINE REVIEW OF A SAMPLING OF YOUR CHARTS) WHICH OCCURRED AT YOUR INITIAL APPOINTMENT OR YOUR REAPPOINTMENT TO THE MEDICAL STAFFS OF HOSPITALS AT WHICH YOU HAVE OBTAINED CLINICAL PRIVILEGES, HAVE YOU EVER BEEN THE SUBJECT OF A PEER REVIEW PROCEEDING, INQUIRY OR INVESTIGATION? THIS INCLUDES, BUT IS NOT LIMITED TO, THE COMMENCEMENT OF A PROCEEDING BEFORE A MEDICAL STAFF REQUESTING ANY FORM OF CORRECTIVE ACTION INCLUDING REPRIMAND SUSPENSION OF PRIVILEGES, OR REVOCATION OF MEDICAL STAFF MEMBERSHIP, AND COVERS ALL SUCH PROCEEDINGS REGARDLESS OF THE FINAL OUTCOME.		
2. IN THE PAST 3 YEARS, HAVE YOU RESIGNED FROM A HOSPITAL OR RELINQUISHED CLINICAL STAFF PRIVILEGES TO AVOID DISCIPLINARY ACTIONS?		
3. HAVE YOU SUBMITTED AND SUBSEQUENTLY WITHDRAWN AN APPLICATION FOR MEDICAL STAFF MEMBERSHIP WITHIN THE PAST THREE YEARS?		
4. HAVE ANY INVESTIGATIVE ACTIONS PAST OR PRESENT BEEN INITIATED OR ARE ANY PENDING AGAINST YOU BY ANY STATE LICENSURE BOARD?		
5. HAS ANY STATE LICENSURE BOARD ISSUED ANY LETTERS OF CONCERN/ADVISORY LETTERS TO YOU IN THE PAST THREE YEARS?		
6. IN THE PAST 3 YEARS HAVE YOU VOLUNTARILY SURRENDERED OR HAD YOUR LICENSE TO PRACTICE MEDICINE DENIED, REFUSED, RESTRICTED, SUSPENDED, REVOKED OR CENSURED IN THIS OR ANY OTHER JURISDICTION?		

7. IN THE PAST 3 YEARS HAVE YOU HAD YOUR MEMBERSHIP IN ANY PROFESSIONAL OR SPECIALTY ORGANIZATION, HMO, PPO, MEDICARE, AHCCCS/MEDICAID OR OTHER PREPAID HEALTH PLAN PARTICIPATION, OR HOSPITAL STAFF DENIED, REFUSED, SANCTIONED, SUSPENDED OR REVOKED?		
8. IN THE PAST 3 YEARS HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION BY ANY PRIVATE, FEDERAL, OR STATE AGENCY CONCERNING YOUR PARTICIPATION IN ANY PRIVATE, FEDERAL, OR STATE HEALTH INSURANCE PROGRAM?		
9. IN THE PAST 3 YEARS HAVE YOU HAD YOUR LICENSE TO PRESCRIBE OR DISPENSE NARCOTICS REFUSED, SUSPENDED OR REVOKED?		
10. IS YOUR NARCOTICS REGISTRATION CERTIFICATE CURRENTLY BEING CHALLENGED?		
11. IN THE PAST 3 YEARS HAVE YOU BEEN NAMED AS A DEFENDANT IN ANY CRIMINAL PROCEEDING?		
12. IN THE PAST 3 YEARS HAVE YOU BEEN CONVICTED OF A FELONY OR ANY CRIME OTHER THAN A TRAFFIC OFFENSE?		
13. HAVE YOU HAD A JUDGMENT RENDERED AGAINST YOU IN ANY COURT ON A CLAIM ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE SINCE MEDICAL SCHOOL?		
14. AT ANY TIME SINCE MEDICAL SCHOOL, HAS ANYONE ASSERTED (REGARDLESS OF OUTCOME) A CLAIM AGAINST YOU ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE?		
15. HAVE YOU ANY MENTAL ILLNESS, CHRONIC ILLNESS, OR PHYSICAL DEFECT THAT MAY ADVERSELY AFFECT YOUR ABILITY TO PRACTICE MEDICINE?		
16. HAVE YOU TESTED POSITIVE FOR ANY CONTAGIOUS HEALTH CONDITION THAT WOULD ENDANGER PATIENTS YOU ARE TREATING?		
17. DO YOU NOW OR HAVE YOU EVER HAD AN ALCOHOL OR DRUG DEPENDENCY?		
18. DO YOU CURRENTLY USE ILLEGAL DRUGS?		
19. ARE YOU CURRENTLY TAKING ANY MEDICATION THAT MAY AFFECT EITHER YOUR CLINICAL JUDGMENT OR MOTOR SKILLS?		
20. DO YOU HAVE ANY LIMITATIONS ON YOUR HEALTH, LIFE OR DISABILITY INSURANCE?		
21. N THE PAST 3 YEARS HAVE YOU BEEN DENIED HEALTH, LIFE, OR DISABILITY INSURANCE?		
22. ARE YOU CURRENTLY UNDER ANY LIMITATIONS CONCERNING YOUR ACTIVITIES OR WORKLOAD?		
23. HAS YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE BEEN TERMINATED BY ACTION OF THE INSURANCE COMPANY IN THE PAST 3 YEARS?		
24. HAVE YOU BEEN DENIED PROFESSIONAL LIABILITY INSURANCE?		
25.HAS YOUR PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER EXCLUDED ANY SPECIFIC PROCEDURES FROM YOUR COVERAGE?		

POSITIONS AND MEMBERSHIPS

FACILITY POSITIONS: (DOES NOT INCLUDE STAFF MEMBERSHIPS, I.E. HOSPITALS, MED SCHOOLS, ETC.)

NAME OF FACILITY: _____

FROM _____/_____ /_____ TO _____/_____/_____

POSITION: _____

NAME OF FACILITY: _____

FROM _____/_____ /_____ TO _____/_____/_____

POSITION: _____

IF NEEDED FOR ADDITIONAL POSITIONS, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH HERETO.

HAVE YOU SERVED OR ARE YOU CURRENTLY SERVING IN THE US MILITARY? □ YES □ NO
(PLEASE INCLUDE DISCHARGE PAPERS.)

I verify that the information contained in this application is accurate and complete to the best of my knowledge. I understand that: it is my responsibility and to produce adequate information in a timely manner; any omissions or misrepresentations may result in an automatic denial of application or termination of ASPA membership; and that this application will not be processed until application is deemed complete by ASPA, and that it is my responsibility to provide all information requested to make a complete application.

Signature: **DATE:**

PRINT NAME HERE: _____

BEHAVIORAL HEALTH PROVIDERS COMPLETE PAGES 15 THROUGH 17

PLEASE ATTACH A COPY OF YOUR CERTIFICATES

EDUCATION AND HIGHEST DEGREE:

HIGHEST DEGREE IN SOCIAL WORK/COUNSELING YOU HAVE ATTAINED (CHECK ONE):

□ ASSOCIATE OF ARTS □ BACHELOR'S DEGREE □ MASTER'S DEGREE □ DOCTORAL DEGREE

HIGHEST DEGREE EARNED IN (CHECK ONE):

□ Ph.D □ Ed.D □ Psy.D □ Other (Specify) _____

INDICATE THE SPECIFIC PROGRAM/TRACK, DEPARTMENT AND INSTITUTION GRANTING THIS DEGREE:

NAME & ADDRESS OF INSTITUTION:
_____

NAME OF DEPARTMENT/SCHOOL: _____

NAME OF SPECIFIC PROGRAM/TRACK: _____

YEAR IN WHICH DEGREE WAS CONFERRED: _____

DID YOU COMPLETE A FORMAL RESPECIALIZATION PROGRAM IN CLINICAL COUNSELING OR SCHOOL PSYCHOLOGY AFTER COMPLETION OF DOCTORAL DEGREE IN PSYCHOLOGY? □ YES □ NO

IF YES, WAS THIS RESPECIALIZATION PROGRAM OFFERED BY A DOCTORAL PROGRAM THAT WAS ACCREDITED BY APA? □ YES □ NO NAME OF PROGRAM: _____

PSYCHOLOGIST:

WAS YOUR FORMAT INTERNSHIP OR ORGANIZED HEALTH SERVICE TRAINING PROGRAM:

□ FULL-TIME BASIS □ PART-TIME BASIS

WAS THIS TRAINING AT: □ ONE SITE □ TWO OR MORE SITES

INDICATE TOTAL NUMBER OF HOURS SUPERVISED EXPERIENCED THAT YOU RECEIVED IN EACH INTERNSHIP:

SITE ONE _____ SITE TWO_____ OTHER SITES _____ TOTAL HOURS _____

INTERNSHIP SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR: _____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? □ YES □ NO

INTERNSHIP SITE TWO:
NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR:_____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? □ YES □ NO

INDICATE TOTAL NUMBER OF HOURS SUPERVISED POST-DOCTORAL EXPERIENCED THAT YOU RECEIVED IN EACH SITE:

SITE ONE _____ SITE TWO_____ OTHER SITES _____ TOTAL HOURS _____

POSTDOCTORAL SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

POSTDOCTORAL SITE TWO:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR:_____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

SOCIAL WORKER/COUNSELOR:

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR: _____

DEGREE: _____**TELEPHONE:** _____**DATES FROM/TO:** _____

□ **FULL-TIME** □ **PART-TIME** □ **HALF-TIME OR MORE**

DESCRIBE NATURE OF WORK: _____

_____

_____

_____

_____

_____

_____

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR _____

DEGREE:_____**TELEPHONE:** _____**DATES FROM/TO:** _____

□ **FULL-TIME** □ **PART-TIME** □ **HALF-TIME OR MORE**

DESCRIBE NATURE OF WORK: _____

_____

_____

_____

_____

STATEMENT OF INFORMATION RELEASE

All information in this application is true to my best knowledge and belief. I understand that any misleading statement or material omission in this application may constitute cause for denial or cancellation of membership.

By applying to, and/or continuing participation as a member in the Arizona State Physicians Association (ASPA), I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including ASPA and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of ASPA, and **all persons and entities** providing **credentialing information to such representatives of ASPA, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in ASPA, to the extent that those acts and/or communications are protected by state or federal law.**

I authorize any third parties (including, but not limited to, individuals, agencies, medical groups, corporations, companies, employers, hospitals, health plans, licensing agencies, insurance companies, medical societies, etc.) to release information concerning my qualifications, credentials, clinical competence, quality insurance data, information pertaining to character, physical or mental health condition, behavior, ethics, claims history, disciplinary action, or any other matter reasonably having a bearing on his or her qualifications. I further authorize ASPA to release my completed credentialing file to any organization where I have applied for membership or participation and ASPA is the delegated credentialing entity.

A photocopy of this waiver shall be as effective as the original when so presented and shall be considered valid for a minimum of three (3) years from the date of signing.

NAME: _____

SIGNATURE: _____ **DATE:** _____

Arizona State Physicians Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012 / 602-265-2524
REVISED 9-17-08

MEMORANDUM OF UNDERSTANDING

Arizona State Physicians Association (ASPA) is a physician initiated and controlled organization which seeks to form an economic unit to promote delivery to the public of high quality, cost effective medical care through managed care and peer review techniques. Membership rights should not be considered an investment for profit and will not be transferable. Membership is limited to licensed health care providers who reside in Arizona and practice their profession in Arizona.

The ultimate accomplishment of the goals of ASPA cannot be guaranteed and membership as a physician provider does not ensure your participation in all ASPA contracts.

An Application for Participation in ASPA is attached. With the accompanying completed application for participation, please enclose the appropriate non-refundable credentialing processing fee indicated on attached instructional letter. By signing below, you agree that this fee is reasonable and it implies no obligation by ASPA to accept you as a member in ASPA.

Upon signing and returning this memorandum, together with the non-refundable processing fee (payable to ASPA), and application, the credentialing process will begin. You will maintain the right to review all information obtained by ASPA to evaluate the credentialing application. This review excludes confidential references, recommendations, or other information that is Peer Review Protected. Your completed application and other information will be reviewed by the Central Credentialing Committee composed of members from each Operating Division, or Arizona State Physicians Associations designee. Approval must be gained from this committee or designee, the Utilization and Quality Review Committee and the Board of Directors of ASPA. Such evaluation constitutes a peer review action under the Health Care Quality Improvement Act of 1986. Accordingly, any adverse decision based upon your competence or professional conduct is required to be reported to the State Board of Medical Examiners or the State Board of Osteopathic Examiners, or other appropriate State Authorities. By execution and delivery to Arizona State Physicians Association of this application, you hereby acknowledge receipt of this notice.

Print Name: _____

_____
SIGNATURE:

_____
DATE:

Arizona State Physicians Association
3030 North Central Avenue, Suite 1405
Phoenix, AZ 85012 / 602-265-2524
REVISED 05/22/2012

Arizona State Physician's Association
License Actions Report

PHYSICIAN NAME: _____

Please supply the following information for each Open or Dismissed Investigation; Advisory Letter; Letter of Reprimand; Decree of Censure; Suspension of License; Loss of License; Loss or Restriction of DEA License; or Probation, made in the past ten (10) years to allow proper review and evaluation by the credentials committee. If more than one license action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. Attach any related correspondence, including letters of dismissal, etc. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

_____

_____

_____

_____

Condition and diagnosis at time of incident:_____

_____

Treatment and procedures provided: _____

Patient condition subsequent to treatment:_____

_____

_____

Final outcome of the action: _____

Your relationship to Patient: ___ PCP ____Surgeon ____Assistant Surgeon ____ Consultant

Other:_____

Incident Location: _____ Date: _____

TYPE of ACTION: Open Investigation ____ Dismissed Complaint ____ Advisory Letter ____

Letter of Reprimand ____ DeCree of Censure ____ Probation ____ Loss of License ____

Restricted License _____ Other _____ _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ **Date**:_____

Arizona State Physician's Association
Malpractice Claim Report

PHYSICIAN NAME: _____

Please supply the following information for each malpractice claim made or settled in the past five (5) years to allow proper review and evaluation by the credentials committee. If more than one malpractice action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

_____

_____

_____

Condition and diagnosis at time of incident:
_____

_____

Treatment and procedures provided: _____

_____

_____

Patient condition subsequent to treatment:
_____

Final outcome of the claim:_____

_____

Your relationship to Patient: ___ PCP ____Surgeon ____Assistant Surgeon ____ Consultant

Other:_____

Incident Location: _____ Date: _____ Insurance Carrier: _____

YOUR STATUS: ____ Primary Defendant ____ Co-defendant ____Other (Describe)_____

Claim Disposition: ____ Open ____ Closed by Dismissal ____ Closed Date Closed: _____

Amount of settlement / Judgment: _____ Amount paid on YOUR behalf: _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ **Date:** _____

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

_____

SIGNATURE OF RECOMMENDING PHYSICIAN

_____

DATE:

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
3030 North Central Avenue, Suite 1405, Phoenix, AZ 85012
602-265-2524/800-522-9619
Direct Fax: 602-865-7022
Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

_____

SIGNATURE OF RECOMMENDING PHYSICIAN

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Direct Fax: 602-865-7022
Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name):_____

FROM:_____ (Please Print) **TITLE**:_____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ **SPECIALTY:** _____

ADDRESS: _____

CITY, STATE ZIP:_____**PHONE**:_____**FAX:**_____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
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Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation – Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS:_____

_____

ADDITIONAL COMMENTS ARE APPRECIATED:_____

_____

_____

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SIGNATURE OF RECOMMENDING PHYSICIAN

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DATE:

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