

KFMC Health Improvement Partners (KFMC)
Reviewer Application

KFMC use only:

Date received: _____
Format HC/E copy

Choose one:

New application – date submitted: _____

Re-verification – date submitted: _____

License Number: _____ Expiration Date: _____

Date of birth: _____ Last 4 digits of SSN: _____

Please print name & credentials:

Last First Middle Credentials (MD, DO, etc.)

Alternate Name(s): _____

Mailing Address: _____

If you are part of a group practice, please list the **Name of the group and note the City and State**

Provide phone #, fax #, and your email: Mark the box, indicating the best way to contact you.

Home Phone: _____ Work Phone/Extension: _____

Cell Phone: _____ Fax # and contact: _____

Email: _____

Affiliated Hospitals

Please list the **name, city and state** of facilities which you are affiliated with:

If you have no hospital privileges, indicate 'NONE'

Applicant Initials: _____

Certification(s) and Subspecialty(ies)

Current Board Certifications:

(Certifications only. Board eligible or Board qualified status is not recognized by URAC as a certification.)

A list of board certifications and subspecialties recognized by the American Board of Medical Specialties follows. Please check a box in **list A** reflecting your board, **list B** for your certification, and **list C** for your subspecialty.

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	LIST B General Certificates	LIST C Sub-specialty Certificates
<input type="checkbox"/> Allergy & Immunology	<input type="checkbox"/> Allergy & Immunology	
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Critical Care Medicine <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Pediatric Anesthesiology <input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Colon and Rectal Surgery	<input type="checkbox"/> Colon and Rectal Surgery	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Dermatopathology <input type="checkbox"/> Pediatric Dermatology
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Anesthesiology Critical Care Medicine <input type="checkbox"/> Emergency Medical Services <input type="checkbox"/> Hospital and Palliative Medicine <input type="checkbox"/> Internal Medicine-Critical Care Medicine <input type="checkbox"/> Medical Toxicology <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Pediatric Emergency Medicine <input type="checkbox"/> Sports Medicine <input type="checkbox"/> Undersea and Hyperbaric Medicine
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Family Practice	<input type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Adult Congenital Heart Disease <input type="checkbox"/> Advanced Heart Failure & Transplant Cardiology <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Clinical Cardiac Electrophysiology <input type="checkbox"/> Critical Care Medicine <input type="checkbox"/> Endocrinology, Diabetes & Metabolism <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Geriatric Medicine <input type="checkbox"/> Hematology <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Interventional Cardiology <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Nephrology <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Rheumatology <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Sports Medicine <input type="checkbox"/> Transplant Hepatology
<input type="checkbox"/> Medical Genetics and Genomics	<input type="checkbox"/> Clinic Biochemical Genetics <input type="checkbox"/> Clinical Cytogenetics <input type="checkbox"/> Clinical Genetics (M.D.) <input type="checkbox"/> Medical Molecular Genetics	<input type="checkbox"/> Medical Biochemical Genetics <input type="checkbox"/> Molecular Genetic Pathology
<input type="checkbox"/> Neurological Surgery	<input type="checkbox"/> Neurological Surgery	
<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Nuclear Medicine	

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES

<p align="center">LIST A American Board of</p>	<p align="center">LIST B General Certificates</p>	<p align="center">LIST C Sub-specialty Certificates</p>
<input type="checkbox"/> Obstetrics & Gynecology	<input type="checkbox"/> Obstetrics & Gynecology	<input type="checkbox"/> Critical Care Medicine <input type="checkbox"/> Female Pelvic Medicine & Reconstructive Surgery <input type="checkbox"/> Gynecologic Oncology <input type="checkbox"/> Hospital and Palliative Medicine <input type="checkbox"/> Maternal & Fetal Medicine <input type="checkbox"/> Reproductive Endocrinology/Infertility
<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Ophthalmology	
<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Orthopaedic Sports Medicine <input type="checkbox"/> Surgery of the Hand
<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Neurotology <input type="checkbox"/> Complex Pediatric Otolaryngology* <input type="checkbox"/> Plastic Surgery within the Head and Neck* <input type="checkbox"/> Sleep Medicine
<input type="checkbox"/> Pathology	<input type="checkbox"/> Pathology-Anatomic/Pathology-Clinical <input type="checkbox"/> Pathology-Anatomic <input type="checkbox"/> Pathology-Clinical	<input type="checkbox"/> Blood Banking/Transfusion Medicine <input type="checkbox"/> Clinical Informatics <input type="checkbox"/> Cytopathology <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Neuropathology <input type="checkbox"/> Pathology-Chemical <input type="checkbox"/> Pathology-Forensic <input type="checkbox"/> Pathology-Hematology <input type="checkbox"/> Pathology-Medical Microbiology <input type="checkbox"/> Pathology-Molecular Genetic <input type="checkbox"/> Pathology-Pediatric
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Child Abuse Pediatrics <input type="checkbox"/> Developmental-Behavioral Pediatrics <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Medical Toxicology <input type="checkbox"/> Neonatal-Perinatal Medicine <input type="checkbox"/> Pediatric Cardiology <input type="checkbox"/> Pediatric Critical Care Medicine <input type="checkbox"/> Pediatric Emergency Medicine <input type="checkbox"/> Pediatric Endocrinology <input type="checkbox"/> Pediatric Gastroenterology <input type="checkbox"/> Pediatric Hematology-Oncology <input type="checkbox"/> Pediatric – Hospital Medicine* <input type="checkbox"/> Pediatric Infectious Disease <input type="checkbox"/> Pediatric Nephrology <input type="checkbox"/> Pediatric Pulmonology <input type="checkbox"/> Pediatric Rheumatology <input type="checkbox"/> Pediatric Transplant Hepatology <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Physical Medicine and Rehabilitation	<input type="checkbox"/> Physical Medicine and Rehabilitation	<input type="checkbox"/> Brain Injury Medicine <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Neuromuscular Medicine <input type="checkbox"/> Pain Management <input type="checkbox"/> Pediatric Rehabilitation Medicine <input type="checkbox"/> Spinal Cord Injury Medicine <input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Plastic Surgery Within the Head and Neck* <input type="checkbox"/> Surgery of Hand
<input type="checkbox"/> Preventive Medicine	<input type="checkbox"/> Aerospace Medicine <input type="checkbox"/> Occupational Medicine <input type="checkbox"/> Public Health and General Preventive Medicine	<input type="checkbox"/> Addiction Medicine <input type="checkbox"/> Clinical Informatics <input type="checkbox"/> Medical Toxicology <input type="checkbox"/> Undersea and Hyperbaric Medicine

APPROVED SPECIALTY BOARDS AND CERTIFICATE CATEGORIES		
LIST A American Board of	LIST B General Certificates	LIST C Sub-specialty Certificates
<input type="checkbox"/> Psychiatry & Neurology	<input type="checkbox"/> Psychiatry <input type="checkbox"/> Neurology <input type="checkbox"/> Neurology with Special Qualifications in Child Neurology	<input type="checkbox"/> Addiction Psychiatry <input type="checkbox"/> Brain Injury Medicine <input type="checkbox"/> Child & Adolescent Psychiatry <input type="checkbox"/> Clinical Neurophysiology <input type="checkbox"/> Epilepsy <input type="checkbox"/> Forensic Psychiatry <input type="checkbox"/> Geriatric Psychiatry <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Neurodevelopmental Disabilities <input type="checkbox"/> Neuromuscular Medicine <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Vascular Neurology
<input type="checkbox"/> Radiology	<input type="checkbox"/> Diagnostic Medical Physics <input type="checkbox"/> Diagnostic Radiology <input type="checkbox"/> Interventional Radiology & Diagnostic Radiology <input type="checkbox"/> Nuclear Medical Physics <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Medical Physics	<input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Neuroradiology <input type="checkbox"/> Nuclear Radiology <input type="checkbox"/> Pain Medicine <input type="checkbox"/> Pediatric Radiology
<input type="checkbox"/> Surgery	<input type="checkbox"/> Surgery <input type="checkbox"/> Vascular Surgery	<input type="checkbox"/> Complex General Surgical Oncology <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Pediatric Surgery <input type="checkbox"/> Surgery of the Hand <input type="checkbox"/> Surgical Critical Care
<input type="checkbox"/> Thoracic Surgery	<input type="checkbox"/> Thoracic and Cardiac Surgery	<input type="checkbox"/> Congenital Cardiac Surgery
<input type="checkbox"/> Urology	<input type="checkbox"/> Urology	<input type="checkbox"/> Female Pelvic Medicine & Reconstructive Surgery <input type="checkbox"/> Pediatric Urology

*Subspecialties that have been approved, but not yet issued.

If your certification is NOT on the list, please document the specialty certification and the name of certifying board below.

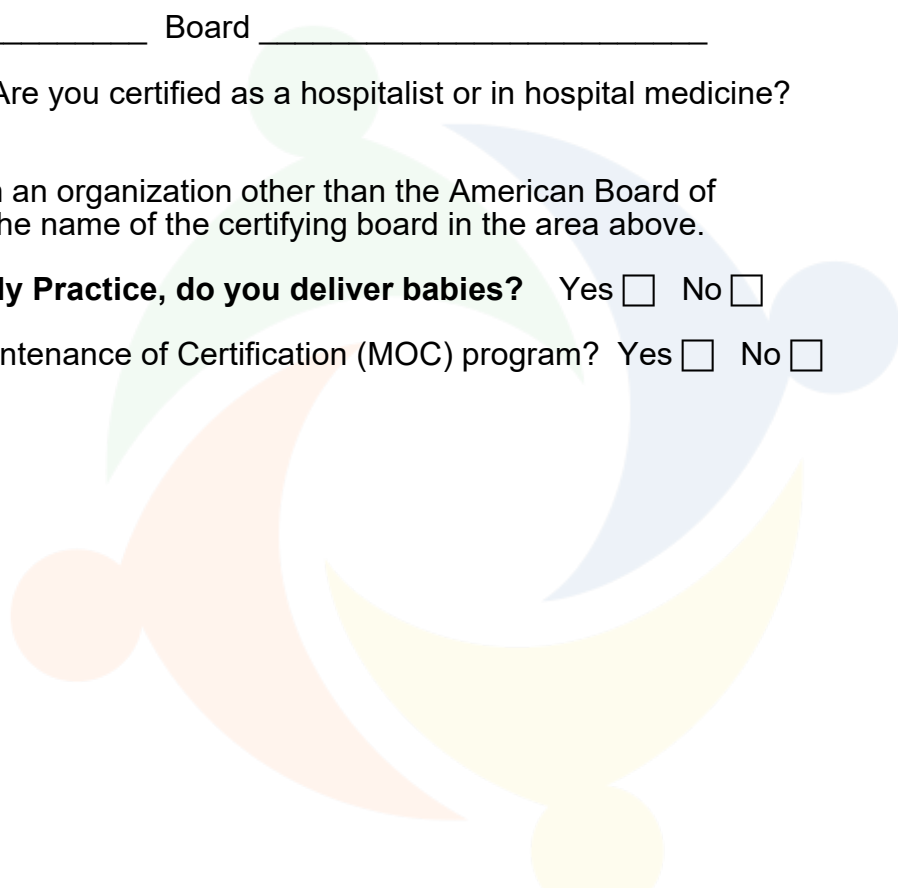
Certification _____ Board _____

Are you a hospitalist? Yes No Are you certified as a hospitalist or in hospital medicine?
Yes No

If your hospitalist certification is through an organization other than the American Board of Medical Specialties, please document the name of the certifying board in the area above.

If your specialty certification is Family Practice, do you deliver babies? Yes No

Do you participate in your specialty Maintenance of Certification (MOC) program? Yes No



Additional Required Information

Length of time providing direct patient care and dates: (IR-RCQ 1-2(a.iv)), IR-RCQ 1-4(b))

Document the dates reflecting when you have provided direct patient care on a full-time basis (37.5 or more hours a week). The years do not have to be consecutive, however if not consecutive, you must document the Month/year to Month/year of each occurrence of full time direct patient care.

Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____
Month/year: _____ to month/year (or to present): _____

Have you provided direct clinical care to patients within the past three (3) calendar years. **(IR-RCQ 1-6(b))**

Yes No

Applicant Signature: _____ **Date of Application:** _____

Check the box to verify that you've included **all** of the following **and return with your application.**

Required enclosures:

- Application
- KFMC PR Attestations
- Curriculum Vitae
- Confidentiality of Information form
- Organizational Conflict of Interest and Disclosure of Affiliations
- W-9

