



MARRIAGE AND FAMILY THERAPIST

MEDICAL STAFF CREDENTIAL VERIFICATION

The purpose of this questionnaire is to verify that your credentials are in good standing with the appropriate licensing board, National Practitioner Data Bank, and other associations before an authorized approval and hiring determination is made.

Signature of Hiring Authority	Date
Name of Institution	

Please Check One

- Civil Service
 Contractor / Registry
 2-Year Reappointment
 Lateral Transfer from: _____
 Other: _____

Application for the position of: Marriage and Family Therapist

Applicant's Name (Last)	(First)	(Middle)	Social Security Number
Home Address	E-Mail Address		Contact Number(s)
City	State	Zip Code	(Date of Birth)
Other Names Used			(Gender) <input type="checkbox"/> Male <input type="checkbox"/> Female

Professional School(s):

Name of School	Degree	Year Graduated

Professional License(s)/Certification(s)/Registration(s):

License number: _____ State: _____ License number: _____ State: _____

*Please attach additional license information on a separate page if needed.

NPI Number: _____

Unlicensed Hours accrued toward licensing: _____

*Applicants applying unlicensed must submit official transcripts to: California Department of Corrections & Rehabilitation
 Plata Support Division
 P. O. Box 4038, Suite: 315
 Sacramento, CA 95812-4038
 Attn: C&PU Transcripts

**ANY AFFIRMATIVE ANSWER TO QUESTIONS ONE THROUGH 14 & 16
REQUIRES ADDITIONAL INFORMATION ON A SEPARATE PIECE OF PAPER, ELABORATING
UPON THE RESPONSE AND DESCRIBING THE CIRCUMSTANCES INVOLVED.**

- 1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? Yes No
- 2. Has your license to practice in any state ever been relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily? Yes No
- 3. Have you ever been asked to surrender your license? Yes No
 Additional information is attached for the above section (questions ____, ____, ____, ____)

- 4. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, CHAMPUS, or Medicaid)? Yes No
- 5. Have you ever 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? Yes No
 Additional information is attached for the above section (questions ____, ____, ____, ____)

- 6. Have you ever been named as a defendant in any criminal proceedings? Yes No
- 7. Has your employment, Medical Staff appointment, or clinical privileges ever been suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily? Yes No
- 8. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before the hospital or health facility's Board made a decision? Yes No
- 9. Have you ever been the subject of focused individual monitoring at any hospital or health care facility? Yes No
 Additional information is attached for the above section (questions ____, ____, ____, ____)

- 10. Have any profession liability claims or suits ever been filed against you or are any presently pending? Yes No
- 11. Have any judgments or settlements been made against you in professional liability cases? Yes No
- 12. Had your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? Yes No
- 13. Has any information pertaining to, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank? Yes No
 Additional information is attached for the above section (questions ____, ____, ____, ____)

- 14. Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment, or supply house or other business to which patients from the CDCR might be referred or recommended?
 Yes No
- 15. Are you able to perform all the services required by your agreement with, or the professional bylaws of, the CDCR to which you are applying, with or without reasonable accommodation, according to the accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes No *If no please explain in separate piece of paper.*
- 16. Does your curriculum vitae show any gaps in training or practice greater than 3 months in duration? Yes No
 Additional information is attached for the above section (questions ____, ____, ____, ____)



APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this application is true and complete. Any misrepresentation, misstatement, or omission from this Medical Staff Credential Verification, whether intentional or not, may constitute sufficient cause for rejection of this verification resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

Signature of Applicant

Date