

CENTRAL OREGON
INDEPENDENT PRACTICE ASSOCIATION

CENTRAL OREGON CREDENTIALING SYSTEM (COCS)

MEMBERSHIP REQUEST FORM

(Please complete this form in its entirety)

PERSONAL INFORMATION:

Full Legal Name (Print): _____
(First) (Middle) (Last) (Degree)

Preferred Pronouns: ☐ She/Her ☐ He/His ☐ They/Them ☐ Ze/Hir ☐ Xe/Xem ☐ Ze/Zir ☐ Other _____

COIPA Applicants: If you do not currently reside in the state of Oregon or Washington, do you plan to? ☐ Yes ☐ No

Contact Information: *It's imperative that COIPA collects personal contact information for our Members that is used for COIPA specific correspondence. Failure to provide and/or update your contact information could result in suspension or termination of membership.*

Cell Phone Number: _____ **Email Address:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Partner's Name:** _____

I speak the following languages fluently: _____ ☐ None

Have you completed Cultural Competency Training? ☐ Yes ☐ No

Veteran Status: ☐ N/A ☐ Veteran ☐ Active Military

If Active Military or Veteran, please check all that apply: ☐ Navy ☐ Army ☐ Marines ☐ Coast Guard ☐ Air Force

PRACTICE INFORMATION (please explain all "no" or "n/a"):

☐ Yes ☐ No ☐ N/A	My primary admitting facility will be: _____
☐ Yes ☐ No ☐ N/A	I plan to establish practice within a reasonable distance of my primary admitting facility to allow for continuous care of my patients.
	Will you be in private practice or group practice? ☐ Private ☐ Group ☐ N/A Hospital
	Name of practice group: _____ Number Members: _____
☐ Yes ☐ No ☐ N/A	Will you accept new patients?
☐ Yes ☐ No ☐ N/A	Will you and/or your group provide 24/7 call coverage for outpatient care?
☐ Yes ☐ No ☐ N/A	Will you agree to participate in emergency call rotation and to treat all patients referred to you regardless of ability to pay, if needed?
☐ Yes ☐ No ☐ N/A	I attest that my designated call coverage person(s) will cover all medically-privileged aspects of my practice.

MEDICARE / MEDICAID CONDITIONS OF PARTICIPATION - How do you meet Medicare / Medicaid Conditions of Participation relating to hospitals, Joint Commission standards, and conditions for reimbursement to the hospital for services that you have initiated? Please check all the boxes that apply:

- ☐ I am a M.D. or a D.O. and I meet the requirements.
- ☐ I am not applying for any hospital privileges, and therefore these requirements do not apply.
- ☐ I am not a M.D. or a D.O. but am applying for hospital privileges; I have arranged to work together with (list physician(s)) _____ M.D. / D.O. to meet the requirements for my hospitalized patients.

CENTRAL OREGON

INDEPENDENT PRACTICE ASSOCIATION

MEMBERSHIP - I hereby request membership and/or privileges in the following categories (check choices):

Central Oregon IPA (COIPA) Bend, OR	☐ membership (for managed care health plan panel participation)			
Blue Mountain Hospital (BMH) John Day, OR	☐ Active Med Staff	☐ Courtesy Med Staff	☐ Associate Staff	☐ Locum Tenens ☐ Allied Health Personnel Staff
Harney District Hospital (HDH) Burns, OR	☐ Active Med Staff	☐ Courtesy Med Staff	☐ Consulting Med Staff	☐ Locum Tenens ☐ Allied Health Personnel Staff
Pioneer Memorial Hospital (HPM) Heppner, OR	☐ Active Med Staff	☐ Courtesy Med Staff	☐ Consulting Med Staff	☐ Locum Tenens ☐ Allied Health Personnel Staff
Wallowa Memorial Hospital (WMH) Enterprise, OR	☐ Active Med Staff	☐ Courtesy Med Staff	☐ Consulting Med Staff	☐ Allied Health Staff
Lake Health District (LHD)	☐ Active Med Staff	☐ Courtesy Med Staff	☐ Consulting Med Staff	☐ Locum Tenens ☐ Allied Health Personnel Staff
Doctors Park Surgery Center (DPSC) Bend, OR	☐ Active Med Staff	☐ Courtesy Staff	☐ Allied Health Staff	
Cascade SurgiCenter (CSC) Bend, OR	☐ Active Med Staff	☐ Courtesy Staff	☐ Allied Health Staff	
Central Oregon Surgery Center (COSC)	☐ Active Med Staff	☐ Courtesy Staff	☐ Allied Health Staff	
Central Oregon Radiology Associates IR (CORA) Bend, OR	☐ Active Staff	☐ Consulting Staff	☐ Allied Health Staff	

DOCUMENTATION & ELIGIBILITY REQUIREMENTS - Please attach the following information to this request form:

- Government-issued photo ID (e.g., driver's license or passport)
- Copies of ACLS, ATLS, BLS certificates, if applicable
- Copies of your CME certificates, or provide a list of CME courses you have completed during the past five (5) years
- Verification of American board eligibility and/or certification
- A copy of your curriculum vitae/resume

If you are a Physician's Assistant, also provide:

- Verification of NCCPA certification. If you are not certified, when do you intend to take the exam? ____/____/____
- A copy of your Collaboration Agreement with either a physician or employer group

LICENSURE - You must have an active "unrestricted" license to practice in the State of Oregon and/or the State of Washington. If you provide care to patients in both states, you must have an active "unrestricted" license in both states.

MISCELLANEOUS:

☐ Yes	☐ No	Do you participate in the Medicare program?
☐ Yes	☐ No	Are you currently under governmental investigation?
☐ Yes	☐ No	Are you currently (voluntarily) opted out of the Medicare program? If yes, provide next eligibility date: ____ / ____ / ____
☐ Yes	☐ No	Have you ever been excluded (sanctioned) from Medicare? If yes, provide explanation:

CONTINUING MEDICAL EDUCATION - *If you answer "yes", please attach copies of your CME certificates or provide a list of CME courses you have completed during the past two years. If you answer "no," please give a full explanation and attach it to this application* **not applicable for COIPA only applicants

- COIPA requirement:** No CME requirement.
- HDH & HPM requirement:** No CME requirement.
- BMH & WMH & LHD requirement:** ☐ Yes ☐ No: I attest I have obtained 60 hours of Category 1 CME over the past two-years.



- **CSC & COSC & DPSC requirement:** ☐ Yes ☐ No: I attest I have obtained 40 hours of Category 1 CME over the past two-years.
 - **CORA requirement:** No CME requirement.
-



ATTESTATION/AUTHORIZATION/RELEASE STATEMENT:

I hereby request an application form, acknowledging that the application process will not become effective until such time as I may be deemed eligible for membership and, if applicable, privileges. I have been advised that as part of the credentialing process, Central Oregon Credentialing System (COCS) will be using the services of the Central Oregon Independent Practice Association (COIPA).

I shall provide information of my involvement in any professional liability action in all circumstances. I retain the right to correct any erroneous information given on the application. If you are deemed eligible for membership, during the processing of your application, Central Oregon Credentialing System (COCS) will be using a credentials verification service organization (CVO) to verify all the data that you have submitted on or with your application form. Please be aware that this service may find it necessary to contact you at some point in the process, should they encounter some difficulty with the information you have provided.

Name of CVO: Central Oregon Independent Practice Association (COIPA)
Attention: Credentialing Department, 1230 NE 3rd St Suite 200, Bend OR, 97701
Telephone: (541) 585-2590 / FAX: (541) 585-2591 / Email: credentialing@coipa.org

MEDICARE ATTESTATION STATEMENT: I acknowledge that I have received the following notice and understand its implications by signing below and dating my acknowledgment. This record will be kept in my credentials file, with a copy forwarded to the hospital medical records department of those hospitals and affiliates to which I have applied for membership.

"Notice to Providers: Medicare/Champus payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physicians by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

I certify that the information provided in this Membership Request Form is complete, current, correct, and not misleading.

Practitioner - Signature: _____ Date: _____

Practitioner - Print Name: _____