California Ophthalmic Laser Associates Medical Corporation
OD / MD Credentialing Application

In order for credentialing to be completed, you must include the following documents along with this completed and signed form:

- ❑ Copy of current State Department of Professional Regulation License Certificate
- ❑ Copy of the declarations page of current malpractice insurance
- ❑ Copy of current Drug Enforcement Agency (DEA) Certificate
- ❑ Copy of Board Certification.
- ❑ Copy of Curriculum Vitae

If you are a VSP credentialed doctor, it is only necessary to sign and return this top page.

Signature ___________________________________ Date__________________________

Print Name __________________________________

COLA Medical Corporation
303 W. Joaquin Ave., Suite 250
San Leandro, CA 94577

Provider Data

Professional Information

Name (Last, First, Middle): ____

Corporate Name: ____

Federal Tax I.D. #: ____________________Medicare Provider #:________________________

License #: ________________________________DEA License #: ______________________

Date of Birth: _____________________________

**Please provide a copy of each license certificate*

Primary Specialty:__________________________Sub Specialty: _______________________

Board Certification: Board Name: ________________________Date: __________________

** Please provide a copy of your board certification*

Malpractice Insurance Information

Name of Carrier: ________________________________Expiration Date: _______________

Effective Date : ______________________Carrier's Phone#:___________________________

Retroactive Date: _____________________Policy Number: ___________________________

Coverage Amount Per Occurrence: __________________Aggregate Amount: _____________

** Please provide a copy of your malpractice declarations page*

Education and Training

Degree: ______________________ Institution: ___________________Date: _____________

Internship: _________________________ Residency: ______________________________

Fellowships (Dates, Certificates, and Institutions): ___________________________________

____

____

Professional Affiliations

Hospital #1: ___________________Privileges: ____________________Date: _____________

Address: ____

Hospital #2: ___________________Privileges: ____________________Date: _____________

Address: ____

Office Data

Primary Location

Facility Name: ____

Address: Street: ____

City: ______________________ State: ______ Zip: __________ County: __________

Phone: (_____) ______________ Fax: (______) ______________

Claims Contact Person: ________________ Office Manager: ________________

Office Days and Hours of Operation: ______________________________________

Credentialing Data

1. Has your license to practice optometry in any jurisdiction ever been limited, suspended, placed on probation, revoked, or voluntarily or involuntarily surrendered for any reason? ………………………………………………………………………...	[ ] Yes	[ ] No
2. Have you ever been subjected to any sanction or disciplinary action by a hospital, Board of Medical Examiners, organized medical society, or other regulatory or oversight body? ……………………………………………………………………….	[ ] Yes	[ ] No
3. Have you ever been denied membership or renewal thereof or renewal thereof or been subject to any sanction or disciplinary action by any medical organization, Board of Medical Examiners or other regulatory or oversight body? ………………..	[ ] Yes	[ ] No
4. Have you ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid? …………………….……	[ ] Yes	[ ] No
5. Have you ever unsuccessfully defended a malpractice claim, settled out of court, or do you have any malpractice claims pending? ………………………….…………..	[ ] Yes	[ ] No
6. Have you had any malpractice claims made against you in the previous 5 years? …	[ ] Yes	[ ] No
7. Has your malpractice coverage ever been denied or cancelled? ……………………	[ ] Yes	[ ] No
8. Are you currently under indictment for any crime? …………………….…………	[ ] Yes	[ ] No
9. Have you ever been convicted or pleaded nolo contendere to a criminal offense? ...	[ ] Yes	[ ] No
10. Are you currently suffering or have you ever suffered from a disability due to mental illness that would presently impair you from the ability to practice medicine?	[ ] Yes	[ ] No
11. During the previous 10 years prior to the date of this application have you had a history of chemical dependency? …………………………………………………….	[ ] Yes	[ ] No

12. Has your license to prescribe or dispense controlled substances ever been denied, suspended, restricted, revoked or voluntarily surrendered for any reason? …………... [ ] Yes [ ] No

If you answered "yes" to any of the above questions, please provide details on a separate sheet of paper.

I warrant that the information provide herein, including the answers to the above questions, are true and correct to the best of my knowledge and belief.

Signature____ Date _________________________