MATERNAL HEALTH PROGRAM
Attn: License application
P.O. Box 25307
Albuquerque, NM 87125
Account XXXXXX7789

Contacts at the Program:
Email: amber.montoya@state.nm.us
phone: 505-476-8907
OR catherine.avery@state.nm.us
phone: 505-476-8866

APPLICATION FOR MIDWIFERY STUDENT PERMIT RENEWAL

INSTRUCTIONS:

1. Enclose a non-refundable check or money order for $50.00 made out to Public Health Division.
2. Enclose a completed Student/Instructor Relationship form for any midwifery instructor(s) you have not already registered.

Full Name_____

Date of Birth_____ SSN_____

Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Email Address _____

List states/countries you been licensed as a health care provider_____

_____

Have you had any revocation, suspension or other disciplinary actions against a health care license in any state or country? Yes☐ No☐ If Yes, explain on a separate sheet which state or country, type of license, type of disciplinary action, dates, and circumstances. (If you have given this information in a previous application, you need only write any update information.)

Signature _____ Date_____

HSC/LA Credentials
PO Box 92200
Albuquerque, NM 87199-2200
1-866-908-0070 (Toll-free)
505-346-0288 (Facsimile)
cvs@nmhsc.com

Credentialing Itemized Request Form

Customer Name: New Mexico Department of Health/Public Health Division

Requested By: MCH Program Request Date (by MCH): _____

✓ I agree to pay the itemized fee per the current contract, plus additional verification fees incurred. *Verification fees will be passed though at cost.*

Please place a check mark next to the verification service you are requesting:

NPDB/HIPDB Query ✓

In the section below in LEGIBLE type, please provide as much information on the practitioner this request relates to. For NPDB/HIPDB queries, this will ensure a more accurate and detailed report on the practitioner:

Practitioner's Name: _____
Last *First* *MI* *Title, e.g. M.D.*

Gender: _____ Social Security Number: _____

Date of Birth: _____ DEA Number: _____

Office Address: _____
Street Address

_____
City *State* *Zip Code*

License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____
License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____
License Number: _____ License Type (e.g. RN, CNM): _____ License State: _____

Board Specialty (if applicable): _____

Midwifery School Program: _____ Graduation Date _____

*Itemized verifications are typically completed within 1-2 business days of receipt of the **completed** form and signed release.*

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")

Authority to Release: I have applied to participate as a provider for _____

New Mexico Department of Health/Public Health Division

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date (do not type)

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations ("MCO's"), Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.