**Section 965.APPENDIX C Uniform Updating Form**

**STATE OF ILLINOIS**

**Uniform Updating Form**

**The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans that desire to recredential the professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.**

**INSTRUCTIONS**

**This form is for updating only. Other forms are required for credentialing and for recredentialing.**

**The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and recredentialing and internal business purposes.**

**AFFIRMATION OF INFORMATION**

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information will be grounds for rejection or termination, in addition to penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Uniform Updating Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Applicant's Signature (or electronic signature) |  | Type or Print Name |  | Date |

**\*\*PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION.**

**NOTIFICATION OF CHANGES**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider's Name: | |  | | | | | | | | |
|  | | | Last | | | First | | MI | | Degree |
| Date Completed: | |  | | | | |  | | | |
|  | | (mm/yy) | | | | |  | | | |
| Date of Birth: |  | | | | | |  | | | |
|  | (mm/yy) | | | | | |  | |  | |
| Illinois Professional License Number: | | | | |  | | | | | |
| Social Security Number: | | | |  | | | | | | |

**The following sections of the Uniform Health Care and Hospital Recredentials Form contain updated information and are attached (check as appropriate).**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | **ATTACHMENTS** | | | |
|  |  | | Section | A. | General Information |
|  |  | | Section | B. | Professional Information |
|  |  | | Section | C. | Hospital Membership – Current & Pending |
|  |  | | Section | D. | Ambulatory Surgical Treatment Center Practice |
|  |  | | Section | E. | Work History |
|  |  | | Section | F. | Medical Education/Clinical Training Update |
|  |  | | Section | G. | Professional History: Confidential |
|  |  | | Section | H. | Primary Site Information |
|  |  | | Section | I. | Additional Site Information |

**The updated sections are attached and the particular items updated in those sections are highlighted.**

(Source: Amended at 48 Ill. Reg. \_\_\_\_\_\_, effective \_\_\_\_\_\_\_\_\_\_\_\_)