New Mexico Department of Health

# COVID-19 Credentialed Provider Registration (?Nurses?)

Pursuant to direction by Michelle Lujan Grisham, Governor of the State of New Mexico, the New Mexico Department of Health (NMDOH) provides this registration form for healthcare providers licensed and in good standing with the appropriate New Mexico professional boards to be credentialed as a COVID-19 Credentialed Provider.

The provider, or designee, must complete the following demographic information for the provider.

Please type or print in black ink when completing this form. If you need more space, attach additional sheets and reference the question being answered.

| GENERAL INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| LAST NAME | SUFFIX | FIRST | MIDDLE | | | |
| | | | | | | |
| DATE OF BIRTH (MM/DD/YYYY) | | GENDER | | | | |
| | | □ MALE | □ FEMALE | □ OTHER | | |
| DEGREE: | □ MD □ DO □ DPM □ DC □ DDS □ DMD<br>□ CNP □ CNMW □ PA □ EMT □ OTHER: | | | | | |
| Any other name under which you have been known? (AKA) LIST | | | | | | |
| HOME STREET ADDRESS | CITY | STATE | ZIP CODE | | | |
| | | | | | | |
| HOME PHONE NUMBER | PAGER/ANSWERING SERVICE | HOME E-MAIL ADDRESS | | | | |
| | | | | | | |
| SOCIAL SECURITY NUMBER | STATE LICENSE NUMBER | NPI – INDIVIDUAL | | | | |
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| **MAIN PRACTICE LOCATION** | | | | | | |
| INSTITUTION/GROUP/CLINIC NAME (if applicable) | OFFICE MANAGER | | | | | |
| | | | | | | |
| STREET ADDRESS | CITY | STATE | ZIP CODE | | | |
| | | | | | | |
| PHONE NUMBER | FAX NUMBER | | | | | |
| | | | | | | |
| TYPE OF PRACTICE: | □ SOLO | □ MULTI-SPECIALITY GROUP | □ SINGLE SPECIALTY GROUP | □ HOSPITAL-BASED | | |
| STREET ADDRESS | CITY | STATE | ZIP CODE | | | |
| | | | | | | |
| Business Phone | Business Phone | Fax | | | | |
| **MAIN SCOPE OF PRACTICE** | | | | | | |
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| PROPOSED PRACTIVE LOCATION(S) | | | | |
|---|---|---|---|---|
| INSTITUTION/GROUP/CLINIC NAME (if applicable) | | | OFFICE MANAGER | |
| | | | | |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| PHONE NUMBER | | FAX NUMBER | | |
| | | | | |
| TYPE OF PRACTICE: | □ SOLO | □ MULTI-SPECIALITY GROUP | □ SINGLE SPECIALTY GROUP | □ HOSPITAL-BASED |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| BUSINESS PHONE | BUSINESS PHONE | | FAX | |
| | | | | |
| PROPOSED COVID-19 CLINICAL SERVICES | | | | |
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| | | | | |
| INSTITUTION/GROUP/CLINIC NAME (IF APPLICABLE) | | | OFFICE MANAGER | |
| | | | | |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| PHONE NUMBER | | FAX NUMBER | | |
| | | | | |
| TYPE OF PRACTICE: | □ SOLO | □ MULTI-SPECIALITY GROUP | □ SINGLE SPECIALTY GROUP | □ HOSPITAL-BASED |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| BUSINESS PHONE | BUSINESS PHONE | | FAX | |
| | | | | |
| PROPOSED COVID-19 CLINICAL SERVICES | | | | |
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| | | | | |
| | | | | |
| INSTITUTION/GROUP/CLINIC NAME (IF APPLICABLE) | | | OFFICE MANAGER | |
| | | | | |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| PHONE NUMBER | | FAX NUMBER | | |
| | | | | |
| TYPE OF PRACTICE: | □ SOLO | □ MULTI-SPECIALITY GROUP | □ SINGLE SPECIALTY GROUP | □ HOSPITAL-BASED |
| STREET ADDRESS | CITY | | STATE | ZIP CODE |
| | | | | |
| BUSINESS PHONE | BUSINESS PHONE | | FAX | |

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PROPOSED COVID-19 CLINICAL SERVICES

**REQUEST FOR DESIGNATION**

CHECK ONE:

- o AS A PHYSICIAN (MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHIC MEDICINE), I REQUEST BEING DESIGNATED BY THE SECRETARY OF HEALTH AS A "COVID-19 CREDENTIALED PHYSICIAN."

**OR**

- o AS AN ADVANCED PRACTICE CLINICIAN (CERTIFIED NURSE PRACTITIONER, CERTIFIED REGISTERED NURSE ANESTHETIST, CLINICAL NURSE SPECIALIST, CERTIFIED NURSE-MIDWIFE), I REQUEST BEING DESIGNATED BY THE SECRETARY OF HEALTH AS A "COVID-19 CREDENTIALED ADVANCED PRACTICE CLINICIAN."

**CERTIFICATION**

IN ORDER TO SUPPORT THE STATE'S COVID-19 RESPONSE, I CERTIFY THAT:

| INITIALS | |
|---|---|
| | I WILL BE PROVIDING CARE TO A PERSON INFECTED WITH THE COVID-19 VIRUS OR TO PERSONS THAT ARE REASONABLY BELIEVED MAY BE INFECTED WITH COVID-19 VIRUS. |
| | THE CLINICAL SERVICES WILL MATERIALLY FURTHER THE STATE INTEREST IN PUBLIC HEALTH AND WELFARE IN RESPONDING TO THE COVID-19 VIRUS. |
| | I WILL PROVIDE CARE RELATED WITHIN MY SKILLS AND BACKGROUND THAT IS DURING NECESSARY TO PROVIDE CARE DURING THE PENDENCY OF THE EXISTING HEALTH EMERGENCY. THE SECRETARY MAY WEIGH AND CONSIDER ANY ADDITIONAL FACTORS THE SECRETARY DEEMS APPROPRIATE GIVEN THE OPERATIVE FACTS AND CIRCUMSTANCES. |

**PROVIDER STATEMENT**

ALL INFORMATION AND DOCUMENTATION SUBMITTED BY ME IN THIS APPLICATION IS CORRECT AND COMPLETE TO MY BEST KNOWLEDGE AND BELIEF.

I ACKNOWLEDGE THAT ANY MATERIAL MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION MAY CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION.

I CONSENT TO THE RELEASE OF ALL INFORMATION THAT MAY BE RELEVANT TO AN EVALUATION OF MY CREDENTIALS, INCLUDING INFORMATION ABOUT DISCIPLINARY ACTIONS OR OTHER CONFIDENTIAL OR PRIVILEGED INFORMATION. I UNDERSTAND AND AGREE THAT THIS CONSENT IS IRREVOCABLE FOR ANY PERIOD IN WHICH I AM A PROVIDER. I RELEASE NMDOH FROM ANY AN ALL LIABILITY FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN OBTAINING INFORMATION AND EVALUATING MY CREDENTIALS.

| NAME (PLEASE PRINT) | SIGNATURE | ORIGINAL ATTESTATION DATE |
|---|---|---|
| | | |

**SECRETARY DECISION**

IN CONSIDERATION OF THE ABOVE, I, SECRETARY OF HEALTH, DR. TRACIE C. COLLINS, RECOGNIZE THE ABOVE-NAMED AS A "COVID-19 CREDENTIALED PHYSICIAN" OR "COVID-19 CREDENTIALED ADVANCED PRACTICE CLINICIAN." THIS INDIVIDUAL SHALL BE CONSIDERED A PUBLIC EMPLOYEE FOR PURPOSES OF THE TORT CLAIMS ACT WHEN

PERFORMING THE COVID-19-RELATED DUTIES FOR WHICH THEY RECEIVED THAT CREDENTIAL. THIS DESIGNATION WILL BE IN EFFECT FOR ONE YEAR FROM THE BELOW DATE, UNTIL REVOKED FOR CAUSE, OR UNTIL THE END OF THE DECLARED STATE OF EMERGENCY

**OR**

**THE ABOVE NAMED IS UNABLE TO BE RECOGNIZED AS A** "COVID-19 CREDENTIALED PHYSICIAN" OR "COVID-19 CREDENTIALED ADVANCED PRACTICE CLINICIAN" UNDER THE NMDOH DUE TO THE FOLLOWING:

THE INDIVIDUAL MAY SUBMIT A NEW REQUEST FOR CONSIDERATION IF IT ADDRESSES THE ABOVE ISSUES.

| TRACIE C. COLLINS, MD | | |
|---|---|---|
| NAME (PLEASE PRINT) | SIGNATURE | DATE OF APPROVAL |