# Uniform Credentialing Application
# Frequently Asked Questions

**Health Resources Development Service**
**123 Robert S. Kerr Avenue**
**Oklahoma City, OK 73102**
**Ph. (405) 426-8175**

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1. ***What is the Uniform Credentialing Application?***

   The Uniform Credentialing Application was developed by the Oklahoma State Department of Health based on rules promulgated by the Oklahoma State Board of Health. The application form and the rules are required by Title 63 of the Oklahoma Statutes, Section 1-106.2, which reads as follows:

   > *A. By January 1, 1999, the State Board of Health shall promulgate rules necessary to develop a uniform application which shall be used in the credentialing process of health care providers. The State Department of Health shall develop such application form for:*
   >
   > > *1. Initial privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification; and*
   > >
   > > *2. Recredentialing or reappointment in a hospital, managed care organization, or other entity requiring credentials verification.*
   >
   > *B. Any entity requiring credentials verification may require supplemental information. [63 O.S. Section 1-106.2]*

2. ***Does this form apply only to physicians?***

   No. This form is designed for use by all health care providers who request privileges or membership in an entity that requires credentials verification. The application is intended be used by health care providers to request privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification.

3. ***Where do I submit the completed form?***

   This application may be submitted to hospitals, ambulatory surgery centers, managed care organizations, and other entities requiring credentials verification. **PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH.**

4. ***Will I be asked to submit any additional information?***

   Credentialing entities may require supplemental information. You may wish to contact the entity to which you plan to apply to determine whether supplemental information may be required.

5. ***Does the form have to be filled out completely?***

   We encourage applicants to fill out the application completely. Submitting incomplete forms to the credentialing entity may delay processing of the application. If you have questions about the applicability of certain items for an application or renewal with a credentialing entity, you may wish to contact that entity. Filling out the application completely and updating it periodically enables the provider to submit just one form to multiple credentialing entities.

6. ***What do I enter if an item is not applicable?***

   If an item is not applicable, please state "NA".

7. ***May I hand-write my responses on the form?***

   We recommend printing legibly or typing.

8. ***Do I need to sign and date the application?***

   Please sign and date the application in the appropriate section.

9. ***What if I run out of space?***

   You may attach additional sheets as needed.

10. ***Is a credentialing entity allowed to ask for more information than is requested on the uniform credentialing application?***

    Yes. The law authorizes credentialing entities to require supplemental information.

11. ***I am applying for recredentialing or reappointment with an entity that has previously approved me for privileges or membership. My information has not changed since I filed my last application with the entity. Am I required to complete and resubmit the entire form?***

    The answer will vary depending on the entity to which you are applying. Some hospitals, managed care organizations, or other credentialing entities may require the entire form, while others may require only supplemental information. You should contact the entity to which you are applying to determine if they require resubmittal of the entire uniform credentialing application, only supplemental information, or some combination of the uniform application and supplemental information.

12. ***Where can I obtain the form?***

    Adobe Acrobat and Word versions of the form are available on the Oklahoma State Department of Health website at:

    www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Uniform_Credentialing_Application/index.html

13. ***What if I have other questions about the application?***

    If you have questions pertaining to the standards or requirements of the credentialing entity, you should contact that entity. If you have questions about the law, rule, or the form you may contact the Managed Care Systems within the Health Resources Development Service of the Oklahoma State Department of Health by telephone at (405) 426-8175, or via email at this address: HealthResources@health.ok.gov

OKLAHOMA State Department of Health

123 Robert S. Kerr Ave
Oklahoma City, OK 73102
Phone 405.426-8175
Oklahoma.gov/Health/HRDS

# Uniform Credentialing Application

**63 O.S. 2011, Section 1-106.2**

**This form must be completed in full and typed or printed legibly (i.e., do not state "see CV"), unless the credentialing entity to which you are applying advises you otherwise. Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.**

**Name of facility/organization this application will be submitted to:**_____

**Date:**_____

**SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION. THE COMPLETED APPLICATION MAY BE SUBMITTED TO HOSPITALS, AMBULATORY SURGERY CENTERS, MANAGED CARE ORGANIZATIONS, AND OTHER ENTITIES REQUIRING CREDENTIALS VERIFICATION.**

PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH

# SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix

Professional Degree _____ Gender: ☐ Male ☐ Female

Other Name by Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Other Name by Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ NPID (formerly UPIN)_____

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Place of Birth Citizenship

_____
Visa Type Visa Number (provide copy) Expiration Date

_____
Your Personal Medicare Number Your Personal Medicaid Number

# SECTION 2: DIRECTORY INFORMATION

**Mailing Address for All Credentialing Correspondence**: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Contact Person for Credentialing Correspondence: _____

**This Section continues on next page.**

## -Section 2 Continued-

**Office Street Address:** _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

**Office Mailing Address**: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

**Office Billing Address** (If Different From Claims Payment Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

**Claims Payment Address** (If Different From Office Billing Address): _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Make Checks Payable To: _____

# SECTION 3: CURRENT PROFESSIONAL PRACTICE

Primary Specialty (or field of practice) | Subspecialty | % Of Time

Secondary Specialty | Subspecialty | % Of Time

Do you wish to be listed as:
☐ Primary Care Provider ☐ Specialist ☐ Hospitalist ☐ On-Call ☐ Other (specify)_____
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

☐ Yes ☐ No Are you accepting new patients?
☐ Yes ☐ No Are you willing, in the future, to accept new patients?
☐ Yes ☐ No Do you admit your own patients to hospitals?
If no, please explain how your patients will be admitted, which hospital and who will provide patient care.
☐ Yes ☐ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?
☐ Yes ☐ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

Street Address | Suite Number

City | State | Zip Code

(_____) Phone Number | (_____) Fax Number | (_____) Answering Service Number

Name: _____

Street Address | Suite Number

City | State | Zip Code

(_____) Phone Number | (_____) Fax Number | (_____) Answering Service Number

List any restrictions on your practice (i.e., patient age and gender): _____

# SECTION 4: EDUCATION

## Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(2) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(3) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

## Foreign Medical Graduates:

ECFMG #_____

# SECTION 5: TRAINING
## Internship/Residency/Fellowship/Preceptorship/Other

**List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.**

(1) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed: ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(2) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was the program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(3) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(4) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____

Was program successfully completed? ___ Yes ___ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

## SECTION 6: ACADEMIC APPOINTMENTS

**List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.**

(1)_____ (___)_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

(2)_____ (___)_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

(3)_____ (___)_____
Institution and Address City State Zip Code Phone Number

_____From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __
Position/Rank Inclusive Dates (mo/day/year)

## SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1)_____ ☐ Primary ☐ Secondary
Facility Name

Complete Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

Reason for Discontinuance Department or Service

(2)_____ ☐ Primary ☐ Secondary
Facility Name

Complete Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

Reason for Discontinuance Department or Service

**This section continues on next page.**

## -Section 7 Continued-

(3) _____ ☐ Primary ☐ Secondary
Facility Name

Complete Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

Reason for Discontinuance Department or Service

## SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e., clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1)_____
Name and Nature of Affiliation

Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2)_____
Name and Nature of Affiliation

Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3)_____
Name and Nature of Affiliation

Mailing Address City State Zip Code Telephone Number

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

### US Military/Public Health Service

List all medical and surgical locations and dates.

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

Location Branch of Service

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

Location Branch of Service

## SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

Oklahoma _____ __ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

__ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

__ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

__ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

__ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
USMLE/ECFMG Number Certification Date

## SECTION 10:CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

DEA _____ __ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

DEA _____ __ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

Oklahoma BNDD _____ __ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

CDS _____ __ __-__ __-__ __ __ __ __ __ __-__ __-__ __ __ __
State Type Number Original Date of Issue Expiration Date

**BOARD CERTIFICATION**

Are you Board Certified? ☐ Yes ☐ No _____
Name of Board

__ __-__ __-__ __ __ __ __ __-__ __-__ __ __ __ __ __-__ __-__ __ __ __
Date Initially Certified Date Most Recently Recertified Date Certification Expires

☐ Yes ☐ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

**This section continues on next page.**

## -Section 10 Continued-

### SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification _____ Name of Board _____

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

Subspecialty or Added Qualification _____ Name of Board _____

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

### BOARD QUALIFICATIONS

☐ Yes ☐ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

☐ Yes ☐ No Are you planning to take the exam?

☐ Yes ☐ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral __ __ - __ __ - __ __ __ __

Written __ __ - __ __ - __ __ __ __

Other __ __ - __ __ - __ __ __ __

Subspecialty or Added Qualification _____ Name of Board _____

Date Qualified __ __ - __ __ - __ __ __ __ Date Qualification Expires __ __ - __ __ - __ __ __ __

Classifications:

☐ Yes ☐ No Are you certified in CPR? Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Basic Life Support (BLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Advanced Cardiac Life Support (ACLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Health Care Provider (CoreC) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Advanced Trauma Life Support (ATLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Neonatal Advanced Life Support (NALS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Pediatric Advanced Life Support (PALS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Other_____ Expires __ __ - __ __ - __ __ __ __

# SECTION 11: OFFICE INFORMATION
## Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No Reference Lab? ☐ Yes ☐ No On Site? ☐ Yes ☐ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?

If yes, please list:_____

☐ Yes ☐ No Other:_____

Other Resources _____

List all independent licensed non-physicians working in this office.

| Name | Provider Type | License Number |
|---|---|---|
| | | |
| | | |
| | | |

Fluent Languages:

You _____

Your Staff _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| From: | | | | | | | |
| To: | | | | | | | |

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

Name _____ Specialty _____ Telephone (____) _____

☐ Yes ☐ No Do you or your business own, operate, manage, or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

# SECTION 11: OFFICE INFORMATION
## Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify) _____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No Reference Lab? ☐ Yes ☐ No On Site? ☐ Yes ☐ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?

If yes, please list: _____

☐ Yes ☐ No Other: _____

Other Resources _____

List all independent licensed non-physicians working in this office.

| Name | Provider Type | License Number |
|---|---|---|
| | | |
| | | |
| | | |

Fluent Languages:

You _____

Your Staff _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| From: | | | | | | | |
| To: | | | | | | | |

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.

**Note: These practitioners must be affiliated with the organization to which you are applying.**

Name _____ Specialty _____ Telephone (  ) _____

Name _____ Specialty _____ Telephone (  ) _____

Name _____ Specialty _____ Telephone (  ) _____

Name _____ Specialty _____ Telephone (  ) _____

☐ Yes ☐ No Do you or your business own, operate, manage, or participate in any medical enterprise or business? If yes, explain on a separate attachment.

## SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

| Attached | Item |
|---|---|
| _____ | Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD) |
| _____ | Current Federal DEA Registration Certificate |
| _____ | Emergency Care Training Certificates (CPR, etc., if certified) |
| _____ | Photo Identification |
| _____ | Curriculum Vitae |
| _____ | Tax Identification Information Form W-9 |

## SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct, and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

**NOTE:**
**Practitioners are reminded that each organization will require submission of additional information.**

## SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note the section number and question number that you are addressing.