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| **Figure 3.23** | **APP-Specific Initial Application** |
| **Individual information**  Name (first, middle, last): Type of professional: Title (CRNA, NP, PA, etc.): Other names used: Years associated with other name:  SSN: DOB: Citizenship: Place of birth: UPIN #: Medicaid #: ECFMG: Does not apply:  Gender: Female Male If not a U.S. citizen:  Indicate visa status, type, number: Expiration:  (attach copy) | |
| **Affiliation type**  Affiliated group name:  Primary office address:  Street City/State/ZIP Phone Fax Home address:  Street City/State/ZIP Phone Primary clinical affiliation requested:  Anesthesiology Emergency Medicine Family Practice  Obstetrics-Gynecology Pediatrics Cardiovascular Surgery  Ophthalmology Orthopedics General Surgery  Plastic-Reconstructive Surgery Internal Medicine Pathology  Psychiatry Radiology Otolaryngology  Neurosurgery  Subspecialty: | |

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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | |
| **Language fluency** | | | |
| **Language** | **Speak** | **Read** | **Write** |
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| American Sign Language: (Y/N) | | | |
| **Education**  College/University: Address (street, city, state, ZIP):  Start/End dates: / Graduation date: Degree awarded:  College/University: Address (street, city, state, ZIP):  Start/End dates: / Graduation date: Degree awarded: | | | |
| **Professional education**  Medical/Professional school: Address (street, city, state, ZIP): Start/End dates: / Graduation date: Degree awarded:  Medical/Professional school: Address (street, city, state, ZIP): Start/End dates: / Graduation date: Degree awarded:  Were all training programs successfully completed? Yes No If no, provide explanation on a separate sheet. | | | |

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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | | |
| **Professional references**  List at least two medical or healthcare professionals (or more), not including relatives, current partners, or associates in practice. Provide current, complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.  Name/title: Relationship: Address (street, city, state, ZIP): Phone: Fax: Email:  Specialty: Years known:  Name/title: Relationship: Address (street, city, state, ZIP): Phone: Fax: Email:  Specialty: Years known:  Name/title: Relationship: Address (street, city, state, ZIP): Phone: Fax: Email:  Specialty: Years known: | | | | |
| **Licensure**  List all licenses and certifications ever held, including temporary licensure. | | | | |
| **License type** | **License number** | **State of registration** | **Currently practicing in this state?** | **Expiration date** |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |

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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | | | | | | | |
| **CONTROLLED SUBSTANCE REGISTRATION: If applicable.**  Type: (S) State (F) Federal  **Certification status** | | | | | | | | | |
| **State/agency** | **Date issued** | | **Number** | | | **Type** | | **Expiration date** | |
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| 1. Are you currently certified in any specialty? Yes No 2. Have you ever been examined by a specialty organization but failed to pass the examination?   Yes No  If not certified, indicate any of the following that apply:  I have taken examination, results pending for board. I have taken Part I and am eligible for Part II of the exam. I am intending to sit for the examination on date. I am not planning to take the certification examination. | | | | | | | | | |
| **State/field**  **certified in:** | **Certifying org.**  **name** | | **Date**  **certified** | | **Date recertified** | | **Exp.**  **date** | | **Can take**  **exam until:** |
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| **OTHER CERTIFICATIONS:** Basic Life Support (BLS) and/or other clinical certifications | | | | | | | | | |
| **Type** | | **Sponsor** | | **Date certified** | | | **Expiration date** | | |
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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | | |
| **Type** | | **Sponsor** | **Date certified** | **Expiration date** |
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| Do you hold CPR instructor certification? Yes No  **ADMINISTRATIVE POSITIONS:** Include all past and present.  List all administrative positions held at other hospitals and with other medical affiliations, corporations, military assignments, or government agencies. If more space is needed, attach an additional sheet. | | | | |
| **Institution and address** | | **Position** | **Responsibilities** | **Dates (from/to)** |
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| **PRACTICE HISTORY:** Include all professional affiliations, including private practice and status. Type: (S) Solo (P) Partnership (G) Single-specialty group (MS) Multispecialty group | | | | |
| **Type** | | **Practice name and**  **address** | **Supervisor** | **Dates (from/to)** |
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| **MANAGED CARE AFFILIATIONS:** Include all managed care affiliations held, past and present. | | | | |
| **Organization and address** | | | **Specialty** | **Dates (from/to)** |
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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | | |
| **ACADEMIC APPOINTMENTS:** Include all positions held, past and present.  **Professional liability insurance**  Present carrier: Carrier address (street, city, state, ZIP): Coverage amount: Expiration date: Policy number: Agent name: Agent phone number: Type of coverage: Individual Shared Self-insured  Include name of all carriers for the past 10 years, including address, city, state, ZIP code, policy number, and amount of coverage. | | | | |
| **Institution and address** | | **Policy number** | **Amount of coverage** | **Dates (from/to)** |
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| Have there ever been or are there currently pending any claims, settlements, or judgments against you?  Yes No  Has your professional liability insurance carrier(s) excluded any specific area of practice or terminated or denied coverage? Yes No  If the answer to any of the above questions is yes, please provide a full explanation of each matter on a sepa- rate sheet and attach. The explanation must include:  » The name of the court in which the suit was filed  » Caption and docket number of the case  » Name and address of the attorney defending you  » Name, address, and age of claimant or plaintiff  » Nature and substance of the claim  » Date and place at which claim arose  » Whether you were primary defendant or codefendant  » Amounts paid, if any  » Date, manner, and reasons for disposition, judgment, settlement, or otherwise | | | | |

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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | |
| Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee.  **Clinical performance**  Do you have any condition that could compromise your ability to perform any of the mental and physical functions related to the specific services/clinical privileges you are requesting or that could compromise your ability to fulfill the obligations that accompany affiliation with this hospital? Yes No  If yes, please provide full details on a separate sheet, including names and addresses of physicians and hospitals involved and a description of any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. Regardless of how this question is answered, the application will be processed in the usual manner.  **Disciplinary actions**  Have any of the following ever been—or are any currently in the process of being—investigated, challenged, denied, revoked, terminated, suspended, reduced, limited, relinquished, placed on probation, or not renewed, voluntarily or involuntarily? If yes, please provide full explanation here or on a separate sheet. | | | |
| Any health-related professional registration/license in any state | | Yes | No |
| Other health-related professional registration/license (e.g., federal or DEA state  controlled-substance permit) | | Yes | No |
| Academic appointment | | Yes | No |
| Affiliation with any hospital medical staff | | Yes | No |
| Authorized services/clinical privileges at any hospital | | Yes | No |
| Other institutional affiliation or status or privileges thereat | | Yes | No |
| Health-related professional society membership or fellowship/board certification | | Yes | No |
| Have you ever been convicted of or pleaded guilty or no contest to any criminal  charges (other than motor vehicle speeding violations) brought against you? | | Yes | No |
| Have you ever been convicted of or pleaded no contest to a drug- or alcohol-  related offense? | | Yes | No |

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| **Figure 3.23** | **APP-Specific Initial Application (cont.)** | | |
| Have you ever been suspended, sanctioned, or otherwise restricted from partici- pating in any private, federal, or state health insurance program (e.g., Medicare or  Medicaid), or by a federal, state, or health agency? | | Yes | No |
| Have you ever voluntarily relinquished or withdrawn or failed to proceed with an application for any of the above in order to avoid an adverse action or to preclude  an investigation or while under investigation relating to professional conduct? | | Yes | No |
| **Supervising physician statement**  I support the application of the above-named individual for the services requested and agree to all of the terms, conditions, and obligations associated with my supervising said individual as specified in the policies and rules of the hospital relevant to the individual’s practice in the hospital.    Date Supervising practitioner | | | |