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| **Figure 3.7** | **Initial Application** |
| **Individual information**  Type of professional: Title (MD, DO, CRNA, PA, etc.): Primary specialty: Secondary specialty:  Name (first, middle, last):  Other names used: Years associated with other name: SSN: DOB: Citizenship: Place of birth: NPI: ECFMG: Does not apply: Gender: Female Male  Are you a participating Medicare provider? Yes No Provider number: Are you a participating Medicaid provider? Yes No Provider number:  **If not a U.S. citizen:**  Indicate visa status, type, number: Expiration: (attach copy)  Are you eligible to practice in the United States? Yes No  Other languages spoken with sufficient fluency to treat patients who speak only that language:  Current home address: (street, city, state, ZIP):  Current home phone: Mobile phone: Email:  Current office address: (street, city, state, ZIP): Current office phone: Office email: Current office fax:  Send all correspondence to: Home Office Office email Do you plan to practice at this location? Yes No  If no, please indicate the last date of employment/work: | |

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| **Figure 3.7** | **Initial Application (cont.)** |
| Anticipated home address: (street, city, state, ZIP): Anticipated office address: (street, city, state, ZIP): Anticipated start date at new office location: Office manager: Applications in process at other facilities (please specify):  **Affiliation type**  Independent  Contract (Hospital contact name: )  Employed (Hospital contact name: )  Supervising physician name: Not applicable  **Military service**  Have you been on active or reserve military duty? Yes No  Dates of service to Branch: Last location:  **Clinical experience**  If you have completed residency/training in the past 5 years, attach all residency/training logs. If not, attach a list of clinical activities from the past 12 months including approximate number and type of patients treated and CME from the past 24 months.  **Undergraduate 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: | |

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| **Figure 3.7** | **Initial Application (cont.)** |
| 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:  IF NO DEGREE WAS AWARDED, ATTACH A WRITTEN EXPLANATION.  **Postgraduate education**  Internship Residency Fellowship Teaching appointment  Other graduate-level education: Specialty: Start/End dates: / Successfully completed? Yes No If no, attach a written explanation.  Facility name:  Address (street, city, state, ZIP): Program director name: Phone: Email address: Fax: Current program director (if known): | |

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| **Figure 3.7** | **Initial Application (cont.)** |
| Internship Residency Fellowship Teaching appointment  Other graduate-level education: Specialty: Start/End dates: / Successfully completed? Yes No If no, attach a written explanation.  Facility name:  Address (street, city, state, ZIP): Program director name: Phone: Email address: Fax: Current program director (if known):  Internship Residency Fellowship Teaching appointment  Other graduate-level education: Specialty: Start/End dates: / Successfully completed? Yes No If no, attach a written explanation.  Facility name:  Address (street, city, state, ZIP): Program director name: Phone: Email address: Fax: Current program director (if known): | |

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| **Figure 3.7** | **Initial Application (cont.)** |
| **Staff category requested**  PHYSICIANS:  Active  Associate  Community  Privileges only/No membership  Resident  ALLIED HEALTH:  Certified nurse-midwife  Certified nurse specialist  Certified registered nurse anesthetist  Clinical psychologist  Nurse practitioner  Physician assistant  **Clinical privileges requested**  Complete and sign the privilege delineation form(s) and attach documentation demonstrating that privileging criteria have been met. | |

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| **Figure 3.7** | **Initial Application (cont.)** |
| **Affiliations**  List all current and previous hospitals or healthcare entities/employers at which you have held appointment and/or clinical privileges in the past 10 years, beginning with the most recent. This may be supplemented but not replaced by your CV. Attach additional pages if necessary.  Current Past  Hospital, healthcare entity/employer name: Address (street, city, state, ZIP): Phone: Fax:  Status: Dates of staff: Type of privileges:  Full, unrestricted Temporary Conditional Provisional Other  If current: What percentage of your total hospital admissions in the past year were to this hospital? % If past: Reason for discontinuance:  Current Past  Hospital, healthcare entity/employer name: Address (street, city, state, ZIP): Phone: Fax:  Status: Dates of staff: Type of privileges:  Full, unrestricted Temporary Conditional Provisional Other  If current: What percentage of your total hospital admissions in the past year were to this hospital? % If past: Reason for discontinuance: | |

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| **Figure 3.7** | **Initial Application (cont.)** | | | |
| **Certification**  Board: Date initially certified: Expires: Date(s) recertified: Number of times exam taken: Passed: Failed:  If not certified, provide current status: Admissible to take exam? Yes No If no, do you intend to apply for the exam? Yes No  If yes, when does admissibility expire?  If you have been accepted to take a certification exam, lease indicate the specialty board and the dates on which you are scheduled to take the exam.  Board: Exam date: Board: Exam date:  **License and other identification numbers**  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 |  |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |

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| **Figure 3.7** | **Initial Application (cont.)** |
| If not currently licensed in [State], please provide dates of application for the following:  [State] Medical/Professional license: DEA (with [State] license): [State] Board of Pharmacy:  **Professional references**  List at least 3 professional references with firsthand knowledge of your clinical ability. At least one reference must be in the same area of professional practice and must have firsthand information about your clinical practice within the past 12 months. Exclusions: Training program directors, partners, and relatives.  Name/title:  Address (street, city, state, ZIP): Phone: Fax: Email: Specialty: Years known:  Name/title:  Address (street, city, state, ZIP): Phone: Fax: Email: Specialty: Years known:  Name/title:  Address (street, city, state, ZIP): Phone: Fax: Email: Specialty: Years known:  **Disclosure information:**  Attach a written explanation for each “Yes” answer.  Have any of the following at any time been—or are any currently in the process of being—denied, sanctioned, relinquished, reduced, denied renewal, not completed, suspended, diminished, challenged, withdrawn, ter- minated, revoked, limited, restricted, placed on probation, placed under disciplinary or investigative action, or revoked either voluntarily or involuntarily in any jurisdiction or county? | |

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| **Figure 3.7** | **Initial Application (cont.)** | | |
| 1. Medical or professional license, certification, or registration | | Yes | No |
| 2. Clinical privileges | | Yes | No |
| 3. Application/membership or other rights at any healthcare facility | | Yes | No |
| 4. Employment by any hospital, any institution, or the military | | Yes | No |
| 5. DEA registration or controlled substance registration | | Yes | No |
| 6. Medicare, Medicaid, FDA, governmental, or regulatory agency or public  program | | Yes | No |
| 7. Participation in any federal, state, or private insurance program | | Yes | No |
| 8. Participation in any HMO, PPO, or other managed care organization | | Yes | No |
| 9. Have you ever been convicted of a crime (felony or misdemeanor)? | | Yes | No |
| 10. Have you had any unresolved peer review or hospital quality issues? | | Yes | No |
| 11. Are any sanctions pending? | | Yes | No |
| 12. Have you ever voluntarily or involuntarily relinquished privileges or member-  ship at any healthcare facility in lieu of disciplinary action? | | Yes | No |
| 13. Do you have any rehabilitation or other stipulations on your current license? | | Yes | No |
| 14. Are you presently the subject of any formal disciplinary proceedings at any healthcare facility, physician organization, or professional society or  organization? | | Yes | No |
| 15. Have you ever interrupted your education, training, or practice for a period  of three months or more? | | Yes | No |
| 16. Are you now, or have you ever been, subject to physician health or well-  ness intervention? | | Yes | No |
| 17. Have you ever been sanctioned by any organization with responsibility for overseeing the quality, ethics, appropriateness, or professional conduct of  the medical profession? | | Yes | No |
| 18. Have you ever been arrested for, charged, or convicted of any crime? | | Yes | No |
| 19. Have you ever withdrawn your application for appointment/reappointment or clinical privileges at any hospital/healthcare facility/military agency before  an adverse board decision was made? | | Yes | No |
| 20. Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship,  preceptorship, or other clinical education program? | | Yes | No |
| 21. Have you ever, while under investigation, voluntarily withdrawn or prema- turely terminated your status as a student or employee in any internship,  residency, fellowship, preceptorship, or other clinical education program? | | Yes | No |
| 22. Have any of your board certifications or eligibility ever been revoked? | | Yes | No |

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| **Figure 3.7** | **Initial Application (cont.)** | | |
| 23. Have you ever chosen not to recertify or voluntarily surrendered your board  certification while under investigation? | | Yes | No |
| 24. Has a patient, employee, or colleague ever accused you of sexual harass- ment or other illegal misconduct that resulted in an investigation, sanction,  or other formal action? | | Yes | No |
| 25. Have you ever been investigated, sanctioned, reprimanded, or cautioned by any hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military  agency? | | Yes | No |
| **Professional liability insurance**  Present carrier:  Carrier address (street, city, state, ZIP):  Coverage amounts: Expiration date: Policy number: Agent name: Agent phone number:  Type of coverage: Individual Shared Self-insured | | | |
| 1. Have you ever had any malpractice actions (pending, settled, dropped,  dismissed, arbitrated, mediated, or litigated)? | | Yes | No |
| 2. Do you have any currently pending professional claims or suits? | | Yes | No |
| 3. Have any judgments or settlements been made against you in professional  liability cases? | | Yes | No |
| 4. Has your professional liability coverage ever been terminated, denied, or  limited by any insurance company? | | Yes | No |
| 5. Have you ever been rated higher-than-average risk level due to claims  experience? | | Yes | No |
| 6. Are there any exclusions in your malpractice coverage? | | Yes | No |
| 7. Has any insurance company ever imposed a surcharge or additional  premium because of your claims history? | | Yes | No |

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| **Figure 3.7** | **Initial Application (cont.)** | |
| For each “Yes” answer, attach the following information, including final settlements. Please include suits against a professional corporation of which you are a member, shareholder, or employee in any matter in which you were involved in the patient’s care.  » Name of insurance carrier and policy number  » 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 | | |
| **Call coverage**  List the name(s) of colleagues providing coverage at [Hospital] and their specialties: | | |
| Name: | | Specialty: |
| Name: | | Specialty: |
| Name: | | Specialty: |
| Name: | | Specialty: |
| Name: | | Specialty: |
| **Practice location information**  Solo primary care Solo specialty care  Group primary care Group specialty care  Group multispecialty care  Practice limitations: Female only Male only Other Practice accepts: All new patients New patients with referral  Practice location primary address: City: State: ZIP: Phone: Fax: Email:  Applicant signature: | | |