Credentialing & Privileging Application Packet

Applicant

Clinical Support Staff

(Other Licensed or Certified

Health Care Practitioner)

PACKET OUTLINE

- Credentialing Documentation List
- Application for Appointment to Clinical Staff
- Consent to Release Information Form
- Applicant Peer Reference Form
- Job Description

CREDENTIALING DOCUMENTATION LIST

Please type or print responses legibly and in ink. Please complete all subsequent forms in their entirety and attach all supplementary documentation (*see list below*). Incomplete applications will be returned to you and may result in a delay in the credentialing/privileging process. Submit to: credentialing@fivepointssurgerycenter.com

Personal Documents:

☐ Resume in proper format (*mm/yyyy*) with gaps over 30 days explained

☐ Copies of diplomas (e.g. High School/GED, associate or highest college degree)

☐ Government-issued picture identification

☐ Social Security Card and/or Birth Certificate or Passport

☐ Voided Check for Payroll

Human Resources:

☐ Background Check Verified Date: _____

☐ Drug screen completed Date: _____

☐ FPSC Letter of Acceptance

OSHA Requirements

☐ Copy of most recent Hepatitis B vaccination, MMR, Varicella and tuberculosis PPD test, or titers

☐ Tuberculosis PPD test (within 1yr) Date: _____

☐ DRC Login

☐ OSHA walk through (Schedule with team lead 1st week of employment)

☐ FPSC Letter of Acceptance

☐ Two (2) Peer Reference Forms

☐ Curriculum vitae (CV) in proper format (*mm/yyyy*) with gaps over 30 days explained

☐ Current CPR certificate with AED education

☐ Other certificates (e.g. BLS, ACLS, PALS), if applicable

☐ Copies of diplomas (e.g. High School/GED, associate, undergraduate, post-graduate, medical school, residency, fellowship, specialty), as applicable

☐ Copy of government-issued picture identification

☐ Copy of Current Licensure (s), as applicable

☐ Indiana Board License

☐ Indiana Acknowledgment & Certificate(s) ☐ Copy of

Associations & Memberships

PLEASE:

1. COMPLETE THIS ENTIRE APPLICATION.
2. SUBMIT A COPY AND RETAIN THE ORIGINAL FOR YOUR RECORDS.
3. CURRICULUM VITAE WILL NOT BE ACCEPTED AS REPLACEMENT FOR A PART OF THIS APPLICATION.
4. SIGN AND DATE: ATTESTATION ON PAGE 9.
5. SIGN AND DATE: RELEASE OF INFORMATION ON PAGE 10.

I A. PERSONAL INFORMATION

1. _____ Name (Last, First, Middle)
2. _____ Degree/Professional Title
3. _____ Other Names You May Have Used (Maiden, a.k.a., etc.)
4. Gender: ☐ Male ☐ Female
5. _____ Home Address/Street
6. _____ City/State/Zip
7. (_____) _____ Home Telephone No.
8. (_____) _____ Home Fax No.
9. _____ E-mail Address
10. _____ Date of Birth (Month/Day/Year)
11. _____ Citizenship/Place of Birth
12. _____ Languages fluently spoken (in addition to English)
13. _____ Languages written in addition to English
14. _____ Social Security No.
15. _____ Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? ☐ Yes ☐ No

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

☐ **Dental Support Staff:**

☐ CDA ☐ Registered Dental Hygienist ☐ OR Charge Nurse
☐ DA II ☐ Staff Nurse ☐ Surgery Control
☐ DA I ☐ Other _____

☐ **Specialist:**

☐ Specialty _____
☐ Sub-Specialty _____

2. Other medical interests in practice, research, etc: _____

_____

II A. MEDICAL /DENTAL / PROFESSIONAL SCHOOL

List all Professional Schools/Institutions attended including certificate, diploma, and undergraduate. Enclose copies of your diplomas and certificates.

1. _____ _____ _____
Professional School/Institution | Degree Awarded | Date of Graduation (mm/yy)

_____ _____ _____ _____
Address | City | State | Zip

2. _____ _____ _____
Professional School/Institution | Degree Awarded | Date of Graduation (mm/yy)

_____ _____ _____ _____
Address | City | State | Zip

II B. TRAINING ☐ N/A

List all training attended. Enclose copies of your certificates. Explain any 30-day or greater gap in your training on a separate sheet.

1. INTERNSHIP Program successfully completed? ☐ Yes ☐ No

_____ _____ _____
Institution/Hospital | Dates From (mm/yyyy) | Dates To (mm/yyyy)

_____ _____ _____ _____
Address | City | State | Zip

_____ _____ (_____) _____
Program Specialty | Program Director | Telephone No.

2. EXTERNSHIP Program successfully completed? ☐ Yes ☐ No

_____ _____ _____
Institution/Hospital | Dates From (mm/yyyy) | Dates To (mm/yyyy)

_____ _____ _____ _____
Address | City | State | Zip

_____ _____ (_____) _____
Program Specialty | Program Director | Telephone No.

4. OTHER _____

Program successfully completed? ☐ Yes ☐ No

_____ _____ _____
Institution/Hospital | Dates From (mm/yyyy) | Dates To (mm/yyyy)

_____ _____ _____ _____
Address | City | State | Zip

_____ _____ (_____) _____
Program Specialty | Program Director | Telephone No.

Directions for Sections III: List in chronological order work history, which should include self-employment. If more space is needed, attach additional sheet(s). **A curriculum vitae (CV) is sufficient as replacement for these sections.**

III A. WORK HISTORY

Chronologically list all work history activities for past 10 years. Explain any gaps of more than thirty days in *III B. Time Intervals*.

1. _____ _____ _____ _____
Current Practice Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

2. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

3. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

4. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

5. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

6. _____ _____ _____ _____
Previous Practice/Employer Contact Name Dates From (mm/yyyy) Dates To (mm/yyyy)

_____ (_____) _____
Address Suite City State Zip Telephone No.

III B. TIME INTERVALS [Explain any time intervals not accounted for in application.]

Suspended from Practice _____ From _____ To _____

Loss of License _____ From _____ To _____

Served in Military _____ From _____ To _____

Personal Leave _____ From _____ To _____

Other (Please describe) _____ From _____ To _____

IV. MEDICAL/DENTAL / PROFESSIONAL LICENSURE

☐ N/A (Section)

1. _____ _____ _____
North Carolina State Medical / Professional License No. Date First Issued Expiration Date

4. ALL OTHER STATE PROFESSIONAL LICENSES:

State: _____ License No.: _____ Expiration Date: _____

State: _____ License No.: _____ Expiration Date: _____

V. BOARD CERTIFICATION/CERTIFYING ENTITY

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes ☐ Specify timeframe: _____
No ☐ Specify reason: _____

Have you ever taken and not passed a board examination? ☐ Yes ☐ No If yes, will you re-take? ☐ Yes ☐ No

VI. REFERENCES

List three professional references, preferably from your specialty area, not including relatives, and no more than one current partner or associate. NOTE: References must be from individuals who are directly familiar with your work, either clinical observation or close working relations.

1. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

2. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

3. _____ _____ (_____) _____
Name Title/Relationship Telephone No.

_____ (_____) _____
Address City State Zip Fax No

Email Address: _____

VII. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	YES	NO
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to perform your clinical duties (outlined in your job description) with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental or physical condition, which in any way may impair or limit your ability to perform your clinical duties (outlined in your job description) with reasonable skill and safety with or without reasonable accommodation?		

Applicant must check one of the following:

1. _____ I certify that I am in good health and have no physical or mental limitations.

2. _____ I do have or have had a chronic illness, physical disability and/or medical limitations to my health, which may include alcohol or drug use, but believe that this does not significantly impair my ability to render high quality medical care.*

** If you answered #2 above, a **Full Statement of Explanation** must be attached. This must include the name and address of your physician. Your physician will only be contacted with your permission.*

VIII. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	YES	NO
Medical or professional license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Board Certification		

IX. OTHER DISCLOSURES

At any time have you ever been:	YES	NO
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	**YES**	**NO**
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
Have you ever, at any time, either voluntarily or involuntarily:	**YES**	**NO**
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		

X. ATTESTATION STATEMENT

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility, disaffiliation, or cause for dismissal from FIVE POINTS SURGERY CENTER.

I agree to report any changes in my health status that would affect my ability to provide patient care as they occur.

I agree to report any changes in my staff membership status at other medical facilities during the period of this appointment.

Applicant's Signature: _____

Print Name: _____

Date: _____

Go To Next Page To Update Attestations

FIVE POINTS SURGERY CENTER

Application for Appointment to Clinical Staff

CONSENT TO RELEASE INFORMATION FORM

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of FPSC. I further understand that FPSC is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in FPSC. I understand and agree that as an applicant for participation with FPSC, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I hereby authorize FPSC and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between FPSC and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by FPSC to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of FPSC and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the FPSC's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or FPSC to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of FPSC of any changes in my professional licensure, scope of hospital privileges, participating provider status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before FPSC for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and places.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

Updated Signature: _____ Date: _____

FIVE POINTS SURGERY CENTER
JOB DESCRIPTION

PLEASE SEE ATTACHED JOB DESCRIPTION