CREDENTIALING & PRIVILEGING APPLICATION PACKET

Licensed Independent Practitioner
Pediatric Dentist

Dear Applicant,

We appreciate your interest in becoming a part of Five Points Surgery Center. Prior to beginning your service with Five Points, you must complete our credentialing process and be approved by our credentialing committee. Our credentialing policy is compliant with AAAHC standards.

Our Privileging applies to Physicians, Dentists, CRNAs and AAs (licensed independent healthcare practitioners) who wish to provide services at Five Points Surgery Center. We have streamlined our process and will make every effort to process your application in a timely and efficient manner.

The credentialing process consists of six steps, which are as follows:

Step 1: Applicant will submit a pre-application.

Step 2: Applicant will receive the applicant packet.

Step 3: Applicant will return completed applications along with requested documents.

Step 4: Application will be reviewed and processed by our Credentialing Specialist to make sure all information is complete and accurate and verified with the appropriate third parties.

Step 5: The completed applicant packet will be forwarded to the Facility Director and reviewed by the Credentialing Committee for forwarding to the Chief Executive Officer for final approval.

Step 6. Applicant will be notified of result.

Although we will do everything to ensure there are no delays, the credentialing process may take up to 60 days after receipt of the completed APPLICATION to verify, review and obtain final approval. To expedite the process, your application should be without blanks or missing requested documents; if anything is missing, the process will be delayed.

If at any time, you have questions please contact the Facility Director or Compliance Officer at Five Points so we may resolve any problems prior to submission. Our goal is to assist you while ensuring that we are compliant with the Accreditation Association for Ambulatory Health Care (AAAHC) and other relevant guidelines.

Sincerely,
Your Credentialing Team Specialist
Five Points Surgery Center

Email all correspondence to: **credentialing@fivepointssurgerycenter.com**

FIVE POINTS
SURGERY CENTER

FIVE POINTS
SURGERY CENTER

CREDENTIALING DOCUMENTATION LIST

Applicant Name: _____

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

Supplementary documents that must be completed and/or submitted include the following:

- ☐ Application
- ☐ Attestation Form
- ☐ Medicare Attestation Form
- ☐ Consent to Release Form
- ☐ Background Check Form
- ☐ Delineation of Privileges
- ☐ Internet Acceptable Usage Policy
- ☐ Confidentiality Form
- ☐ MIS Form
- ☐ Copy of Government-Issued Picture Identification
- ☐ Curriculum Vitae (CV) in Proper Format (mm/yyyy) with gaps over 30 days explained
- ☐ Copies of Diplomas (Undergrad, Post-Graduate, Medical School, Residency, F ellowship, Specialty)
- ☐ Copy of Current Licensure(s)
  - ○ Indiana License to Practice
  - ○ Indiana Drug Control License (if applicable)
  - ○ Indiana Controlled Substance (if applicable)_____
  - ○ Indiana Board Acknowledgement & Certificate(s)
  - ○ Specialty Board Acknowledgement
- ☐ Current Drug Enforcement Administration (DEA) Registration
- ☐ National Provider Identification (NPI) Notification with number (on application)
- ☐ BLS for Healthcare Providers with AED Education
- ☐ ACLS for Healthcare Providers (if applicable)
- ☐ PALS for Healthcare Providers (if applicable)
- ☐ Two (2) Peer Reference Forms
  - ○ Peer Reference One
  - ○ Peer Reference Two
- ☐ Current Sedation Permit (if applicable)
- ☐ Proof of Prior Professional Liability Insurance (minimum 1million/3million) (policy declarations page or letter from insurer)
- ☐ Copy of Most Recent Hep B vaccination or proof of immunity by positive titer
- ☐ Copy of Most Recent MMR vaccination
- ☐ Copy of Current TB – PPD Results (within 12 months of submitting application)
- ☐ Copy of Varicella vaccination or proof of immunity by positive titer
- ☐ Copy of Influenza vaccination during each Flu season (November 10th – March 31st)
- ☐ Copy of Covid-19 vaccination
- ☐ NPDB (Internal)
- ☐ Background Check Results (Internal)

STANDARD PRACTITIONER APPLICATION

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
5. SIGN AND DATE: RELEASE OF INFORMATION
6. SUBMIT REFERENCES TO BE COMPLETED AND RETURNED.
7. COMPLETE, SIGN AND DATE: DELINEATION OF PRIVILEGES
8. RETURN COMPLETED PACKET AND SUPPORTING DOCUMENTS TO FACILITY DIRECTOR OR CREDENTIALING TEAM TO BEGIN THE CREDENTIALING AND PRIVILEGING PROCESS.

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
17. NPI number _____ Medicare number _____ Medicaid number _____

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

☐ ENT ☐ Plastic Surgeon ☐ General Surgeon
☐ Pediatric Dentist ☐ Oral Surgeon ☐ Ophthalmologist
☐ Anesthesiologist ☐ CRNA ☐ General Dentist
☐ Anesthesiologist Assistant ☐ **Other** (Specify Specialty): _____

II A. MEDICAL / DENTAL/ PROFESSIONAL SCHOOL

List all Medical / Dental / Professional Schools attended. Enclose copies of your diplomas and certificates. **For CRNA/AA's - please list undergraduate and post-graduate training.**

1. _____ Medical/Dental/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy)

_____ Address _____ City _____ State _____ Zip

2. _____ Medical/Dental/Professional School _____ Degree Awarded _____ Date of Graduation (mm/yy)

_____ Address _____ City _____ State _____ Zip

Name of Applicant: _____

II B. POST-GRADUATE TRAINING

List all training attended. Enclose copies of your certificates.

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. | Fax No.

2. RESIDENCY 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. | Fax No.

3. FELLOWSHIP 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. | Fax No.

Directions for Sections III and IV: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges**.**

III. HOSPITAL / FACILITY HISTORY

1. **CURRENT Primary Admitting Facility** | Dates From (mm/yyyy) | Dates To (mm/yyyy)

Address | City | State | Zip | Department/ Specialty

Staff Category | Chairperson | Telephone No. | Fax No.

2. **Admitting Facility** | Dates From (mm/yyyy) | Dates To (mm/yyyy)

Address | City | State | Zip | Department/ Specialty

Staff Category | Chairperson | Telephone No. | Fax No.

IV. WORK HISTORY [add additional sheets if needed]

Chronologically list all work history activities since completion of postgraduate training.

NAME OF APPLICANT:

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

_____ _____ _____ _____ _____ _____
Address City State Zip Telephone No. Fax No.

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

_____ _____ _____ _____ _____ _____
Address City State Zip Telephone No. Fax No.

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

_____ _____ _____ _____ _____ _____
Address City State Zip Telephone No. Fax No.

V. PROFESSIONAL LICENSURE

1. _____ _____ _____
Indiana State Medical / Dental / Professional License No. Date First Issued Expiration Date

2. _____ _____
Drug Enforcement Administration Certification No. (DEA) Expiration Date

3. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:

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

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

4. _____
Medicare ID No.

5. _____ 6. _____
UPIN (Unique Physician Identification Number) NPI (National Provider Identifier)

VI. BOARD CERTIFICATION/CERTIFYING ENTITY N/A ☐

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				
If Eligible but not certified Please list below				

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 medical board examination? ☐ Yes ☐ No If yes, will you re-take? ☐ Yes ☐ No

Name of Applicant: _____

VII. PROFESSIONAL PEER REFERENCES

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference should be from the Chief of the department or service where the applicant last furnished professional services.

1. _____ _____ (___) ___-____
Name Title/Relationship Telephone No.

_____ (___) ___-____
Address City State Zip Fax No

Email Address: _____ Years Known: _____

2. _____ _____ (___) ___-____
Name Title/Relationship Telephone No.

_____ (___) ___-____
Address City State Zip Fax No

Email Address: _____ Years Known: _____

3. _____ _____ (___) ___-____
Name Title/Relationship Telephone No.

_____ (___) ___-____
Address City State Zip Fax No

Email Address: _____ Years Known: _____

VIII. PROFESSIONAL LIABILITY CARRIER INFORMATION

Does your current professional liability insurance cover you in all of your practice locations? ☐ Yes ☐ No

Provide 10 years of Malpractice coverage
Use additional sheet if needed

1. _____ _____
Current Insurance Carrier Policy No.

_____ (___) ___-____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

Type of coverage ____ Claims made ____ Occurrence

2. _____ _____
Current Insurance Carrier Policy No.

_____ (___) ___-____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

Type of coverage ____ Claims made ____ Occurrence

3. _____ _____
Current Insurance Carrier Policy No.

_____ (___) ___-____
Address City State Zip Telephone No.

_____ _____ _____
Coverage Amount: (Claim/Aggregate) Type of Coverage Exclusions from Coverage

_____ _____ _____
Initial Date of Coverage Retroactive Date of Coverage Expiration Date

Type of coverage ____ Claims made ____ Occurrence

Name of Applicant: _____

IX. CLAIM / LAWSUIT HISTORY - 10 YEARS OF HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	**YES**	**NO**
Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?		
Are there any now still pending?		
Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases?		
Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?		
Have you ever been denied professional insurance, or has your policy ever been cancelled?		

X. 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 practice medicine and perform the functions of your job with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental, physical condition, or emotional impairment which in any way may impair or limit your ability to practice medicine/dentistry 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.*

XI. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being <u>denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action</u>, 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		
DEA Registration or Controlled Substance 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		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		

Name of Applicant: _____

XII. 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		
To your knowledge, have you ever been reported to the National Practitioner Date Bank or the Indiana Board of Medical Examiners? (If yes, please explain)		
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		

ATTESTATION STATEMENT

By applying for clinical privileges. I hereby signify my willingness to appear for interviews in regard to my application, and I authorize FIVE POINTS SURGERY CENTER, its staff, and their representatives to consult with member of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carrier, who may have information bearing on my professional competence, character, and ethical qualifications.

I hereby further consent to inspection by "FIVE POINTS," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership.

I hereby release from liability all representative of FIVE POINTS and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to FIVE POINTS or to the members of its medical/dental staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions FIVE POINTS may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability and hold harmless FIVE POINTS and any other third party for so doing. I understand and agree that I, as an applicant or clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at FIVE POINTS SURGERY CENTER, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of FIVE POINTS SURGERY CENTER. I agree and will abide to the rules and regulations, as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the Governing Standards as may be enacted from time to time.

In addition, I agree to notify FIVE POINTS of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no tight of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as original. By my signature on this application, I attest that I have received an annual TB test and that I am immunized against communicable diseases as recommended by the CDC guideline for health care workers.

Applicant's Signature: _____

Print Name: _____ **Date:** _____

MEDICARE ATTESTATION ACKNOWLEDGEMENT STATEMENT
NOTICE TO DENTISTS AND PHYSICIANS

Medicare payment to Five Points Surgery Center is based on each patient's procedures performed, as attested to by the patient's attending dentist/ physician by virtue of his or her signature in the surgery center record. Anyone who misrepresents, falsifies, or conceals funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I, _____, the undersigned, acknowledge having received the above notice.

(print or type name)

_____ _____

(legal signature) (date)

(Legal signature means that which you would normally use on documents such as a will, checks, etc. Initials are not acceptable.)

Five Points Surgery Center

Standard Practitioner Application

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: _____

AUTHORIZATION FOR RELEASE OF INFORMATION FOR
MEDICAL OR DENTAL STAFF APPOINTMENT AND FACILITY PRIVILEGES

In connection with my application to Five Points Surgery Center's Medical or Dental Staff, I authorize BACKGROUND INFORMATION to be obtained by Center to procure background information about my character or reputation, including but not limited to information as to my employment, education, driving record, social security number verification, criminal record, and/or other public records history. I authorize all persons to fully disclose information relevant to this investigation. I release from liability all persons, companies, and governmental or other agencies disclosing such information. I further authorize that a photocopy of this authorization may be considered as an original.

Additionally, I give the center permission to investigate any incidents of workplace misconduct of which I have been accused or for which I am alleged to have been involved during my appointment or employment with Medical or Dental Staff(s), Allied Health Professional Staff(s), or healthcare organization(s).

I have read, understand, and authorize any person, agency or other entity contacted by the Center to furnish the above-mentioned information.

I further understand that this authorization/release is valid throughout my term of appointment.

This form will not be accepted if altered, illegible or incomplete.

_____ _____
Signature Date

_____ _____
*Type or Print Name Other Names (alias, maiden)

_____ _____
*Social Security # *Email

_____
Current Address

_____ _____ _____
City State Zip County of Resident

____/____/____ _____ _____
*Date of Birth *Gender (M or F) *Phone Number

**** Without this information, we may not be able to identify you in the course of our background check.***

FIVE POINTS SURGERY CENTER (FPSC) CONFIDENTIALITY AND INFORMATION ACCESS AGREEMENT

IMPORTANT: *Please read the entire Agreement and accompanying policy. If you have any questions, please ask them before signing. You will receive a copy of your signed agreement for your records and a copy will be retained with your credentialing packet.*

This document is confirmation to Five Points Surgery Center that I am fully aware of the implications of misuse of any confidential and proprietary information pertaining to patients, caregivers, employees and center operations.

GENERAL AGREEMENT: During my duties with FPSC, I may receive or have access to verbal, written or computer-generated information concerning patients, providers or institutionally proprietary data. I agree that, except as authorized or directed by FPSC or by legal process, I will not at any time during or after my tenure disclose any such information to any person, or permit any person to examine or make copies of any documents prepared by me, coming into my possession or control, or to which I have access unless as needed during my required activities. *I understand that unauthorized access or disclosure may result in disciplinary action and civil or criminal penalties; or both.*

I understand that all business activities of FPSC are considered confidential. I also understand that if I am exposed to FPSC business information that I am obligated not to discuss or disclose such information to persons outside FPSC unless as needed during my required activities. Additionally, within FPSC, such information will only be discussed with employees whose job requires such knowledge.

INFORMATION ACCESS AGREEMENT: I recognize and acknowledge that access to Health System information requires unique responsibilities for care and security. Therefore, I agree to the following:

- I will keep my computer access identifications and passwords confidential and not share them with anyone. Nor will I use another's identification and password.
- I understand that my computer login ID is the equivalent to my legal signature, and I will be accountable for all work done under my login ID.
- I will use my computer access solely to perform my duties with a clear need-to-know criterion.
- I will use my access to patient information (including myself, family members and friends) solely to perform my duties with a clear need-to-know criterion.
- I will not enter or attempt to enter false information into a live production environment.
- I will use designated sign-off procedures when leaving a computer workstation or terminal.
- I will not provide protected patient information (PHI) in writing, discussion or other manner to those who do not have a need to know.
- I will not remove PHI from the surgery center without authorization.
- I will discard materials containing PHI according to the surgery center policy.
- I know that patient confidentiality and privacy is a patient right and I will respect that right.

_____ _____

Signature Date

_____

Applicant's Printed Name

FIVE POINTS
SURGERY CENTER

Internet Acceptable Usage Policy Acknowledgment Form

As an employee or other authorized user of Five Points Surgery Center computer network, I have received and reviewed the VFive Points Surgery Center Internet Acceptable Usage Policy (the "Policy"). I understand that my use of the company's computer network is conditioned on my full compliance with the provisions of that Policy. I further understand that violations of the Policy may subject me to disciplinary action, up to and including termination of my relationship with Five Points Surgery Center.

I recognize and understand that I am being provided with access to the company's corporate internal network for the purpose of facilitating the internal business purposes of Five Points Surgery Center. I acknowledge that, to the extent permitted by applicable law, Five Points Surgery Center reserves and will exercise the right to monitor, review, audit, record, and publish reports and usage patterns regarding my Internet usage activities, at any time and for any purpose, with or without notice to me. I further acknowledge that I have no reasonable expectation of privacy as to my internet usage on the company's corporate internal network, including without limitation the identities and consent onetime sites visited, as well as the frequency and timing of such visits. I understand that I may not access or view internet sites containing offensive, pornographic, or otherwise objectionable or inappropriate materials. I also understand that I am responsible for my own internet activity using the company's corporate internal network and that Five Points Surgery Center cannot protect me from offensive or inaccurate information that I may access on the Internet.

By using the Five Points Surgery Center corporate internal network and accessing the internet through that network, I consent to the above terms and agree to abide by all terms of the Policy.

Signature of Employee

Date

Printed Name

FIVE POINTS
SURGERY CENTER

Medical / Allied Health Staff
Management Information System Form

Practice Name: _____

Practice Manager: _____ Office Number: _____

Legal First Name	MI	Legal Last Name

Requested Start Date: _____ ☐Permanent ☐Temporary

(Recommended 30 Days After Application Completion)

Requested End Date: _____

(Complete only if temporary privileges requested; if no date, credentials will expire in 90 days)

Email Address: _____ Contact Number: _____

Medical/Allied Health Staff Status:

☐ MD	☐ NP	☐ CDA
☐ DMD	☐ CRNA	☐ DAI
☐ DDS	☐ AA	☐ DAII
☐ PA	☐ RN	☐ OTHER _____

- ☐ Confidentiality Policy
- ☐ IT Policy

Security Questions:

1. Mother's Maiden Name:
2. City of Birth:

Temporary password will be provided during Five Points Orientation

Signature: _____

Office Use Only

Network ID: _____ Date Created: _____ Created by: _____

Medical Staff: _____ Logged Tracking Chart: _____

APPLICANT PEER REFERENCE FORM

*Please send this form to **two (2) of your peers** to complete.*

Applicant Name: _____

Specialty: _____

To Whom It May Concern: I have submitted an application for appointment/reappointment to the staff of Five Points Surgery Centers. Please complete the information below and return it directly to **credentialing@fivepointssurgerycenter.com**. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____ _____

Applicant Signature Date

Please answer to the best of your ability.	Yes	No
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?	◯	◯
Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?	◯	◯
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?	◯	◯
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?	◯	◯
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?	◯	◯
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?	◯	◯
Does the practitioner exhibit personal integrity and adherence to professional ethics?	◯	◯
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?	◯	◯
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinical privileges?	◯	◯

The above evaluation is based on: *(check all that apply)*

- ☐ Close observation of clinical performance
- ☐ General impression
- ☐ Composite information from file
- ☐ Practitioner's reputation in the community
- ☐ Co-worker

Recommendation:

- ◯ Highly recommend
- ◯ Recommend as qualified and competent
- ◯ Recommend with reservation
- ◯ Do not recommend
- ☐ Additional Comments

_____

Reference Information

Print Name: _____ Signature: _____

Title: _____ Phone: _____ Date: _____

APPLICANT PEER REFERENCE FORM

*Please send this form to **two (2) of your peers** to complete.*

Applicant Name: _____

Specialty: _____

To Whom It May Concern: I have submitted an application for appointment/reappointment to the staff of Five Points Surgery Centers. Please complete the information below and return it directly to **credentialing@fivepointssurgerycenter.com**. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____ _____

Applicant Signature Date

Please answer to the best of your ability.	Yes	No
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?	◯	◯
Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?	◯	◯
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?	◯	◯
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?	◯	◯
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?	◯	◯
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?	◯	◯
Does the practitioner exhibit personal integrity and adherence to professional ethics?	◯	◯
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?	◯	◯
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinical privileges?	◯	◯

The above evaluation is based on: *(check all that apply)*

- ☐ Close observation of clinical performance
- ☐ General impression
- ☐ Composite information from file
- ☐ Practitioner's reputation in the community
- ☐ Co-worker

Recommendation:

- ◯ Highly recommend
- ◯ Recommend as qualified and competent
- ◯ Recommend with reservation
- ◯ Do not recommend
- ☐ Additional Comments

_____

Reference Information

Print Name: _____ Signature: _____

Title: _____ Phone: _____ Date: _____

FIVE POINTS SURGERY CENTER

PRIVILEGE REQUEST FORM | Pediatric Dentist Delineation Of Privileges

I hereby request surgical privileges in the specialty of **Pediatric Dentists** as shown on this form. I understand that privileges granted are subject to review coinciding with my application for medical staff membership. I routinely perform the below procedure(s) requested and these are consistent with my abilities, training and experience.

I also understand the application for additional or new procedures can be made at any time with proper documentation.

I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have checked.

PRIVILEGES	Requested	Not Requested	Granted	Denied
Diagnostic services and oral medicine including clinical examination and caries risk assessment, oral and maxillofacial radiography, diagnosis, and management of oral and perioral lesions and anomalies	☐			
Uncomplicated biopsies and adjunctive diagnostic tests	☐			
Dental prophylaxis, dietary counseling, sealant application, fluoride therapies	☐			
Comprehensive Restorative dentistry and oral rehabilitation for the primary, mixed, and permanent dentitions	☐			
Management of the developing dentition - space maintenance/regaining, correction of dental crossbites and functional shifts	☐			
Diagnosis and treatment of trauma to the primary, mixed, and permanent dentitions e.g., repositioning, replantation, and stabilization of intruded, extruded, luxated, and avulsed teeth	☐			
Management of minor infections of the maxillofacial region by surgical or medical therapy	☐			
Periodontal procedures. Gingival curettage, scaling, root planning	☐			
Pulp capping, pulpotomy, pulpectomy and root filling of primary and permanent teeth	☐			
Extractions of erupted teeth, incision, and drainage	☐			
Assessment and documentation of oral and/or dental neglect/abuse	☐			
X-Ray	☐			
Please provide written request for any additional privileges				

Applicant Signatures

Print Name _____ Date _____

Approval Signatures

Governing Board Approval _____ Print Name _____ Date _____