Application for Appointment to Medical Staff

This application is submitted to: _____, herein, this Healthcare Organization[1]

I. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: ( ) Home Fax Number: ( )	E-Mail Address: Pager Number: ( )	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Office Street Address:	City:	
	State:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Physician Name:

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship:		
Specialty:	From (mm/yy):	To (mm/yy):

Physician Name:

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (eg. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the state medical board that issued your license.
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified**:**	Expiration Date (if any):
Have you applied for board certification other than those indicated above? ☐Yes ☐ No			
If so, list board(s) and date(s):			
If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.			

Physician Name:

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.) (Attach additional sheets if necessary. Reference This Section Number and Title)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)		
State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier (NPI):		MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held. (Attach additional sheets if necessary. Reference This Section Number and Title)		
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)			
Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	
Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.			
Please list all of your professional liability carriers within the past seven years, other than the one listed above:			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Physician Name:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Physician Name:

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Physician Name:

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending? Yes ☐ No ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes ☐ No ☐

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes ☐ No ☐

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes ☐ No ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes ☐ No ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending? Yes ☐ No ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes ☐ No ☐

I. Do you presently use any drugs illegally? Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? Yes ☐ No ☐

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? Yes ☐ No ☐

L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

Physician Name:

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state* laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et. seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the un-stayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name Here:_____

Physician's Signature:_____ Date:_____

*The intent of this release is to apply, at a minimum, protections available to those in California to any action, regardless of where such action is brought.

Physician Name:

Professional Liability Action Explanation

This Addendum is submitted to _____ herein, this Healthcare Organization [1].

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:
☐ Hospital ☐ My office ☐ Other doctor's office ☐ IDTF
☐ Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

1 As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Physician Name:

Name _____ Phone Number ( )

Name _____ Phone Number ( )

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $
- ☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization."

Print Name Here: _____

Physician Signature _____ Date: _____

(Stamped Signature Is Not Acceptable)

Physician Name:

ORIENTATION CHECKLIST

ORIENTATION ITEMS FOR REVIEW	DATE COMPLETED	ORIENTATION BY	EMPLOYEE INITIALS
1. FACILITY OVERVIEW ❑ Organization Mission Statement, Vision Statement and its goals ❑ Organizational Chart ❑ Corporate Compliance Program ❑ Introduction to Facility Personnel ❑ Tour of this facility ❑ Introduction to Work Stations ❑ Equipment Management ❑ Storage, handling and access to supplies			
2. HUMAN RESOURCE POLICIES ❑ Quality Management Plan ❑ Incident reporting (aka Adverse Event) ❑ Staff grievance and complaints policy **FORMS STAFF MEMBER COMPLETES** ❑ Employment Application ❑ Employer References ❑ Job Descriptions ❑ Competency Assessments ❑ Performance Evaluations ❑ Orientation Checklist ❑ Annual In-Service Module ❑ Confidentiality Agt/HIPAA ❑ Conflict of Interest ❑ Employment Verification ❑ Health Status Attestation ❑ Flu, HEP-B, HIV Consents **DOCUMENTS STAFF MEMBER PROVIDES** ❑ Curriculum Vitae/Resume ❑ Valid, unexpired professional licenses and other credentials for inspection & photocopy ❑ Valid, unexpired CPR certificate (ACLS/BLS) ❑ Valid, unexpired US Passport, or government-issued photo ID in conjunction with a Social Security Card, or other acceptable form of photo ID listed on page 9 of Form I-9 ❑ PPD/CXR TB Results; Immun. Record			
3. ENVIRONMENT OF CARE EMERGENCY PREPAREDNESS ❑ Life & Fire Safety ❑ Emergency Evacuation ❑ Actions in Unsafe Situations ❑ Emergency Management Plan			
4. INFECTION PREVENTION AND CONTROL PRACTICES ❑ Universal Precautions ❑ Influenza Vaccination Program ❑ OSHA Bloodborne Pathogens ❑ Sharps Injury Prevention ❑ Hand Hygiene ❑ Personal Protection Equipment (PPE) ❑ Identifying, handling, and disposing of hazardous or infectious materials.			
5. PATIENT CARE ❑ Ethical aspects of patient care. ❑ Patient care services this facility provides. ❑ Patient safety. ❑ Patient confidentiality, privacy, and HIPAA requirements. ❑ Patient rights and responsibilities. ❑ Medication Reconciliation ❑ Advance Directives. ❑ Responsibility to report patient abuse and neglect.			

The above facility policies and procedures have been reviewed with me. I understand it is my responsibility to direct any questions regarding the foregoing to my manager or to Human Resources personnel for further clarification.

Print Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor / HR Signature: _____ Date: _____

CONFIDENTIAL/PROPRIETARY

Section A	**CONFIDENTIAL QUESTIONS -- HEALTH HISTORY**		
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	☐ YES	☐ NO
2.	Are you a certified Worker's Compensation provider? **If yes, please attach a copy of your certificate.**	☐ YES	☐ NO
3.	Are you a reservist? If yes, what branch of the military? _____ Anticipated date of separation from reserve duty? _____	☐ YES	☐ NO
4.	Medicaid/Medi-Cal #: _____		

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

_____ _____

Provider Name **Date**

_____

Signature

Physician Name**:**

ADDENDUM TO APPLICATION FOR MEDICAL STAFF PRIVILGES

NOTICE TO PRACTITIONERS OF CREDENTIALING RIGHTS/RESPONSIBILITIES

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to CalOptima by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, CalOptima will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter, fax, or phone. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second re-verification of primary source information will be performed by the Credentialing Department.

Print Name: _____ Date: _____

_____ _____

Signature (Stamped signature is Not Acceptable) (Date)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations, (i.e., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations [HMOs], preferred provider organizations [PPOs], other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies [with respect to certification of coverage and claims history], licensing authorities and businesses and individuals acting as their agents collectively "Healthcare Organizations") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment ethics and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization and/any persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to _____ Business and Professions Code Section _____, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such times as this applications is being processed. I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately, in writing, of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in _____; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than 14 calendar days from the occurrence of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of _____ taken or pending, including but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section _____ report with the Medical Board of _____ or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by registration of my medical staff membership or clinical privileges at this Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of criminal law (excluding minor traffic violations) or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my Curriculum Vitae, if attached, is all current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signature and current dates are required on this Information Release and the Professional Liability Explanation.

Print Name: _____

Physician Signature: _____ Date: _____