SINCE YOUR LAST APPOINTMENT, ANSWER THESE QUESTIONS:

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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D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital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 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:

CONFIDENTIAL/PROPRIETARY

Professional Liability Action Explanation

PHYSICIAN NAME: ____________________

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 (2) 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 ☐ Surgery Center
☐ 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:

Physician Name:

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)

Annual In-service Module

1. INFECTION CONTROL

I have received and reviewed the following Infection Control Policies:

- ☐ Standard Precautions
- ☐ Traffic in the OR
- ☐ Hand hygiene
- ☐ Infection/incident reporting
- ☐ Hazard/Sharps safety training
- ☐ TB exposure control
- ☐ Surgical scrub attire
- ☐ Health screening
- ☐ Annual Influenza Vaccine
- ☐ Bloodborne pathogens

I understand that infection control is a vital part of patient care in the outpatient setting. I acknowledge I have received copies of this facility's infection control policies, and have subsequently familiarized myself with the information contained therein. I acknowledge I have also received training on specific safety protocols and procedures that I am to follow pursuant to Infection Control Committee directives and guidelines established by the Centers for Disease Control (CDC). I promise to participate in all safety improvement programs implemented during the course of my tenure, including observation of handwashing frequencies and scrubbing techniques (as is applicable to my job description), and will participate in annual flu vaccination directives using recommended CDC flu vaccines that protect against the latest flu virus strains.

INITIAL HERE ________

2. EMERGENCY PREPAREDNESS

I have received and reviewed the following surgery center Emergency Preparedness policies:

- ☐ Alarms (nurse call, fire, med gas, generator)
- ☐ Fire safety/emergency procedures
- ☐ Use of fire extinguishers
- ☐ Patient emergency: O^2 Fire in the O.R.
- ☐ Patient emergency: Malignant Hyperthermia
- ☐ MDV[1] vs. SDV[2] usage
- ☐ Disaster Preparedness
- ☐ Evacuation procedures, routes
- ☐ Emergency Codes (Blue, Red, etc.)
- ☐ Incapacitated Surgeon
- ☐ Incapacitated Anesthesia
- ☐ QAPI Plan and Program for the facility

I have received copies of this facility's emergency policies and have been oriented to them. I agree that I will participate in any emergency drills that may occur and will accept the responsibilities assigned to me as a physician or other staff member during these drills and in the event of any actual emergency occurrence.

INITIAL HERE ________

3. PAIN MANAGEMENT

I have received and reviewed the following Pain Management policies:

- ☐ Reporting
- ☐ Assessment
- ☐ Patient Evaluation

I understand that respecting patients' reports of pain is a vital part of the delivery of quality care. I have reviewed this facility's policies regarding pain management and agree to follow their intent while working as an employee, independent contractor or physician/medical staff member at this facility.

INITIAL HERE ________

4. ADDITIONAL POLICIES TO REVIEW

I attest that I have received training and instructional materials regarding:

- ☐ Timeout
- ☐ High Alert, Sounds/Looks-like
- ☐ Hazard Communication
- ☐ Privacy/Confidentiality
- ☐ Cultural Sensitivity
- ☐ Medical Staff Bylaws
- ☐ Discharge Policies
- ☐ HIPAA

I have reviewed the above additional policies and agree to abide by them.

INITIAL HERE ________

I, ____, attest that I have reviewed this facility's policies on Infection Control, Emergency Preparedness, Pain Management, and others listed above that address patient care, workplace safety, and regulatory compliance. I promise to review these policies annually hereafter for changes to patient care protocols and procedures that may have occurred during the previous year.

DATE HERE → ____________________

SIGN HERE → ____

[1] MDV:Multi-dose vials; [2] SDV: Single-dose vials

*All the training videos above can be viewed by going to the website @ https://www.eliteaccreditation.org/initial-orientation-training

Conflict of Interest Disclosure

A conflict of interest occurs when the leadership or staff enters into a relationship with another organization or individual(s) which, in its content or process may adversely affect or have the appearance of adversely affecting the staff's commitment to the facility and to the culture of safety and quality.

Conflicts of interest may include, but shall not be limited to, relationships, associations or business dealings with vendors, suppliers, other healthcare organizations or individuals.

A conflict of interest may take overt or covert forms, and can represent many situations. However, it is generally understood that a conflict of interest constitutes a situation when the organization as a whole or individual representatives of the organization, has competing professional or personal obligations or personal or financial interests that would make it difficult for the organization or the individual(s) to fairly fulfill the mission, vision, values and goals of the institution.

In general, conflicts of interest relate to the potential for self-gain typically, but not always, of a fiscal nature. Potential for self-gain can serve to undermine the judgment or objectivity of licensed independent practitioners (LIPs), administrators, employees, consultants and designated contractors such that their mission and dedication to the values and activities of this healthcare institution are compromised.

The goal of the Conflict of Interest Policy is to ensure that the mission and responsibility to the residents and community served by this facility are not harmed by any professional, ownership, contractual or other relationships. This policy aims to preserve the integrity of decision making, and to ensure that directors and staff act in the best interests of the organization.

Members of this facility's patient care team and staff are required to disclose all professional and personal relationships, and/or interests, from which any financial or personal profit and/or gain may be directly or indirectly derived, or that otherwise conflict, or have the potential to conflict, with this facility's responsibilities to patients and their families, its public service mission, and its adherence to ethical business practices.

Please select either YES or NO and sign where indicated below.

☐ **YES, I may have conflicts of interest to disclose.**

Please describe below any relationships, positions, or circumstances in which you are involved in which you believe could contribute to a Conflict of Interest arising:

____

____

☐ **NO, I have no conflicts of interest to disclose at this time.**

I hereby certify that the information set forth above is true and complete to the best of my knowledge. I have reviewed, and agree to abide by, the Policy of Conflict of Interest of this facility, which is currently in effect.

Print Name: ____________________ Date: ____________________

Signature: ____________________

HEALTH RE-ATTESTATION FORM

INSTRUCTIONS: Please explain any "yes" answers in the space provided on this form or by attaching a separate sheet. This form is confidential and will be kept in your credentials file.

Do you presently have any physical or mental conditions that may affect your ability to perform clinical or professional duties? If yes, please explain: ______________________	☐Yes ☐No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: ______________________	☐Yes ☐No
Do you presently suffer from an addiction to drugs, alcohol, or other chemical substances that may affect your ability to perform clinical or professional duties? If yes, please explain: ______________________	☐Yes ☐No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to an addiction to drugs, alcohol, or other chemical substances? If yes, please explain: ______________________	☐Yes ☐No
Are you currently taking any medications that may affect your ability to perform clinical or professional duties? If yes, please explain: ______________________	☐Yes ☐No
Do you have any communicable diseases? If yes, please explain: ______________________	☐Yes ☐No

Please provide the date of your most recent physical exam: ______________________

Performed by: ______________________

Please provide dates for the following vaccinations/tests and attach supporting documentation:

- Annual TB Screening: PPD______________ (Result__________) or Chest X-ray___________ (Result____________)
- Annual Influenza: ________________, or check here ____ to decline (complete Influenza Declination and attach).
- Hepatitis B (initial attestation only): ____ ____ ____, or check here ____ to decline (complete HEP B Declination and attach)
- HIV Test (initial attestation only): ____________, or check here ____ to decline (complete HIV Test Declination and attach).

* **COVID 19 VACCINE + BOOSTERS MUST BE PROVIDED, PROOF YOU ARE VACCINATED**

ATTESTATION

I, ______________________ attest that I am in good health and have no physical or mental conditions that may affect my ability to perform clinical or professional duties. I also attest that I have no current addictions to drugs, alcohol, or any other recreational chemical substances. I understand that I may not hold [name of health center] responsible for any physical or mental conditions or addictions that I have or have not disclosed.

Staff Member signature: ______________________ **Date:** ______________

** PPD tests are only good for one year, if you've had the test within the past 12 months, then a copy of that test with whomever gave it to you can be used for this requirement. If you've previously tested positive then a chest x-ray every two years is required. You do not need a chest x-ray if you've never tested positive. Flu Vaccines are valid for one year only. Only direct-patient caregivers need to have a PPD test on an annual basis. If you do not come into contact with patients, then there is no need or requirement for you to comply to the annual PPD (TB) testing.

SEASONAL INFLUENZA VACCINATION PROGRAM

Please select either YES or NO and sign where indicated below.

☐ **YES, I will participate in the Influenza Vaccination Program.**

I choose to participate in this healthcare facility's seasonal influenza vaccination program. I understand I am responsible for procuring my own vaccination and agree to provide evidence of having been vaccinated for inclusion in my employee health record. I further agree to reaffirm my participation in this program annually.

☐ **NO, I will not participate in the Influenza Vaccination Program.**

This healthcare facility recommends that I participate in its Influenza Vaccination Program to protect the patients I serve, in part, because of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread it to others and they can become seriously ill, even if my symptoms are mild or non-existent.
- The strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.

After reviewing information given to me regarding my occupational risk to the Influenza virus and measures to safeguard against infection, including seasonal vaccination, I choose not to participate in this healthcare facility's Influenza Vaccination Program. I understand the consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, my coworkers, my family, and my community. Knowing these facts, I still choose not to participate in the Influenza Vaccination Program at this time for the following reason:

☐ I am allergic to components of the vaccine (specify): ______________________

☐ I don't believe in vaccines.

☐ I won't take the vaccine because of side effects.

☐ I never get influenza.

☐ I have had Guillen Barre or other medical problems that preclude me from receiving the vaccine.

☐ I got severe influenza-like symptoms from the influenza vaccine and won't get it again.

☐ Other (specify): ______________________

I have read and fully understand the information on this page.

Signature: ______________________ Date: ______________________

Print Name: ______________________