Check List

YOUR INITIAL APPLICATION WILL BE REVIEWED/CONSIDERED COMPLETE, WHEN ALL THE DOCUMENTS LISTED BELOW HAVE BEEN RECEIVED AND ALL INFORMATION HAS BEEN VERIFIED. IF NOT APPLICABLE, PLEASE DO NOT REMOVE FORMS FROM APPLICATION, INDICATED N/A AND SIGN. THANK YOU.

- ☐ A signed Application Form. All fields must be completed. If incomplete, application may be returned.
- ☐ A signed Clinical Privilege Form. (Indicate your desire scope of privileges in the column entitle "requested".
- ☐ 3 Professional References-give them the form and have them fax it to 310-730-6073 or email to eliteaccreditation@gmail.com

Make Copies of the documents below:

- ☐ A copy of Photo I.D. (valid picture ID issued by state, federal agency)
- ☐ A copy of your Curriculum Vitae (Please date CV)
- ☐ NPI (National Provider Identifier) To apply for this number go to https://nppes.cms.hhs.gov
- ☐ A copy of your CA Medical License and any special permits or certificates of training required to support your application/privilege request, i.e., Fluoroscopy, Radiology, Radiography, General Anesthesia permits, CPR certification, etc.

Sign the documents below:

- ☐ Affirmative Statement
- ☐ Medicare Acknowledgment Statement
- ☐ Data Security Acknowledgment Statement
- ☐ Tuberculosis Screening Letter

- ☐ Application

- ☐ Work History
- ☐ List for Hospital Staff Affiliations (during last 5 years)

You will be notified in writing when your application for membership and privileges has been approved by the Governing Body Representative. Be advised that until then, you cannot attend on any of the services at LAC+USC Medical Center and will not be covered for malpractice.

RETURN THE APPLICATION PACKET TO: Irma Estrada
Email: iestrada@dhs.lacounty.gov Phone: (323) 409-6225 FAX: (323) 441-8125
Attending Staff Office, 1200 N. State Street, Clinic Tower, Room 2D300 Los Angeles, CA 90033

INITIAL APPOINTMENT APPLICATION

IDENTIFYING INFORMATION

_____ _____ _____

* LAST NAME (Please Print) * FIRST NAME INITIAL

Is there any other name under which you have been known? Name(s) _____

Do you ☐ speak ☐ read ☐ write any language other than English? * Languages A_____ B_____

*** Refer to the bottom of this page**

DEPARTMENT (Specialty)	DIVISION (Subspecialty)
_____	_____

*** OFFICE**	**HOME**
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Telephone Number (Area Code)	_____ Telephone Number (Area Code)
_____ Email Address	_____ Email Address
_____ FAX Number	_____ FAX Number
Office Manager or Designee: _____	Cell Phone: _____

BIRTHDATE	PLACE OF BIRTH	Social Security #: ____-__-____	MARITAL STATUS ☐ Married ☐ Single

	NUMBER	DATE ISSUED	STATE	EXP. DATE
* PROFESSIONAL LICENSE (M.D., D.D.S., D.P.M., D.O.)			California	
*DEA CERTIFICATE				
Submit copy if require by the Department CPR CERTIFICATES: (i.e., ACLS, BLS, PALS, etc.)				
OTHER STATE MEDICAL LICENSES				
Other Certifications: (i.e., Fluoroscopy, Radiography, P.A. Supervisor, etc.)				

*NPI (National Provider Identification) #	ECFMG #

*** This information will be released to the public, managed care organizations and/or governmental agencies: Name, Professional Address, Training Year Graduated Professional School, Medical License Number, DEA, NPI, Board Certification, and Languages spoken other than English.**

*EDUCATION AND DEGREES:		
CONFERRED BY	DEGREE	DATE
A.		
B.		
C.		

INTERNSHIP OR POSTGRADUATE YEAR 1		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

RESIDENCY OR POSTGRADUATE YEARS 2-7		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

FELLOWSHIP TRAINING		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

CURRENT HOSPITAL STAFF AFFILIATIONS & PREVIOUS AFFILIATIONS DURING LAST 10 YEARS (Attach additional sheets as necessary)		
NAME OF HOSPITAL	STATUS	DATE OF APPOINTMENT
A.		
B.		

WORK HISTORY (Attach additional sheets as necessary) Provide chronological listing beginning with completion of training. If you have practiced fewer than five years from the date of credenatiling, the history begins with initial licensure. Provide detailed explanation of gaps six (6) months

NAME OF ORGANIZATION, HOSPITAL, OR OFFICE PRACTICE	POSITION	MM/YY – MM/YY
A.		
B.		

***BOARD CERTIFICATION (Attach copy of certificates)**

BOARD STATUS	NAME OF BOARD	ELIGIBLE-NOT CERTIFIED	DATE CERTIFIED	RECERTIFICATION DATE
Specialty/Subspecialty				
Specialty/Subspecialty				

Have you ever 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.

PROFESSIONAL PEER REFERENCES:

Please give names of three (3) persons (two of whom should be in the same specialty as yours) who can provide adequate references pertaining to your current professional competence and ethical character. Note: References will be evaluated primarily by the extent of direct clinical observation and other work with the applicant.

DR._____ ADDRESS:_____

DR._____ ADDRESS:_____

DR._____ ADDRESS:_____

ATTESTATION QUESTIONS

Please answer the following questions "YES" or "NO" If your answer to any of the questions is "YES" 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 minor traffic violation)? YES ☐ NO ☐

I. 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 ☐

J. 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 insurance or its coverage of any procedures?

YES ☐ NO ☐

Professional Liability Insurance Carrier_____

Policy Number_____ Expires:

PHYSICAL AND MENTAL HEALTH STATUS

If your answer to questions **A** through **D** is "Yes" give full details on a separate sheet of paper.

A. Are you aware of or have you been advised that you have any temporary or permanent physical, mental, or emotional condition or impairment, or substance abuse problem which, by it's nature, or as a result of its treatment, might interfere with your ability to practice your profession or exercise the clinical privileges requested with reasonable skill, competency and safety?

YES ☐ NO ☐

B. Have you ever become aware of or were you ever advised that you had any temporary or permanent physical or mental condition or impairment which might interfere with your ability to practice your profession with reasonable skill and safety, other than any such condition or impairment which you have indicated in response to the previous question?

YES ☐ NO ☐

C. Are you, or have you been addicted to the use of narcotics, barbiturates, alcohol or other drugs\or are you currently using any illegal substances:

YES ☐ NO ☐

D. Are you, or have you in the past five years, been in any voluntary treatment program for substance abuse?

YES ☐ NO ☐

E. Are you able to perform all the procedures for which you have requested privileges with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?

YES ☐ NO ☐

F. Do you require reasonable accommodation in order to exercise those privileges requested? Please use a separate sheet to describe the accommodation(s) which will enable you to perform the privileges you have requested.

YES ☐ NO ☐

(If you will require reasonable accommodation, please use a separate sheet to describe the accommodation(s) which will enable you to perform the privileges you have requested.)

STAFF MEMBERSHIP AND PRIVILEGES

APPLICANT'S

NAME:_____ has applied

for privileges in the specialty of: _____.

I have reviewed applicant's qualifications, credentials, and health status and recommended staff appointment with privileges as noted on attached privilege forms.

I further my review of this provider application to be clear of any issue with his/her training that has left the license in a compromised position that warrants further discussion with the review committee.

I am making the recommendation for the provider's appointment based merely on the cleanliness of his/her application, file, and third party agencies like the NPDB and the AMA profile queries.

_____

Credentials Committee Chair **Date**

GOVERNING BOARD APPROVAL
Approved by The Governing Board on: _____
For period ending: _____

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 the Credentialing Company (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any other credentialing 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 states 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 the Credentialing Company, and all persons and entities providing credentialing information to such representatives of the Credentialing Company 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 the entity I wish to be credentialed 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 current 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 this 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 the entity in which I am credentialed, 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 California; (ii) any suspension, revocation 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 entity where I hold priviledges 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 the application.

In making this application for appointment/reappointment to the privileged entity (if applicable), I acknowledge my obligation to provide continuous care and supervision of my patients, accept committee assignments, to accept consultation assignments and to participate in staffing the emergency service area and other special care units.

I acknowledge that I have received and read the Bylaws of the Credentialed Organization's Principles of Practice and agree to be bound by the terms thereof if I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment/reappointment.

I further acknowledge that I am familiar with the principles and standards of the Joint Commission or other accrediting agencies and will cooperate with them. I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee-splitting. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit other physicians and surgeons to collect fees from me, nor to make joint fees nor permit any associate of mine to do so. I also agree that I shall not receive any direct pecuniary gain from patient or similar sources as a result of research financed or sponsored by this association.

I particularly agree to subject my clinical performance to, this organization's quality improvement programs as the same shall from time-to-time be in effect, and I agree to hold members of the attending staff and other authorized representatives of this organization engaged in these quality activities free from liability for their actions performed in good faith in connection therewith.

Print Name Here_____

Date: _____

Physician Signature_____
(Stamped Signature Is Not Acceptable)

Rev. (07/13/2023)

DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF RADIOLOGY

NAME OF APPLICANT _____ **DATE** _____

☐ Initial Appointment and/or Additional Privileges ☐ Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Governing Body Chairman. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				Core Privileges in Radiology: includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans for the following ages:			
				IDTF INTERPRETING PHYSICIAN			
				IDTF SUPERVISING PHYSICIAN			
				CATEGORY I			
				1. GENERAL RADIOLOGY			
				• Plain Film Interpretation			
				• Use of Fluoroscopy, requires a California Radiology Supervisor and Operator Certificate.			
				2. GASTROINTESTINAL			
				• Upper GI contrast studies			

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				• Contrast enema studies			
				• Other GI contrast studies			
				• Tube placement			
				• Sinogram			
				• Fistulous tract injection			
				• T-tube cholangiography			
				• ERCP (Interpretation)			
				3. GENITO-URINARY			
				• Intravenous pyelography			
				• Cystography			
				• Loopogram			
				• Urethrography			
				• Voiding Cytography			
				4. MULTIPLANAR IMAGING (Including computed tomography, ultrasound and magnetic resonance imaging of:)			
				• Chest			
				• Abdominal			

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				• Head			
				• Neck			
				• Spine			
				• Musculoskeletal			
				5. NUCLEAR MEDICINE			
				• Planar imaging			
				• SPECT imaging			
				• Pharmaceutical enhanced imaging			
				CATEGORY II			
				6. NEURORADIOLOGY			
				• Myelography			
				• Angiography including aortic arch and major vessels			
				• Neuro Venography			
				• Therapeutic embolization			
				Intracranial/Spinal			
				Extracranial			
				• Cisternal puncture/C 1-2 puncture			

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				• Interventional Spine procedure (including cysts and cord puncture			
				• Temporary balloon test occlusion			
				7. HEAD AND NECK			
				• Angiography of the Head & Neck			
				• Sialogram			
				• Dacrocystography			
				8. INTERVENTIONAL RADIOLOGY			
				• Percutaneous biopsy			
				• Percutaneous aspiration and/or drainage			
				• Injection or sclerosis of tumor, lesion or cavity			
				9. CARDIOVASCULAR INTERVENTIONAL			
				• General angiography			
				• Venography			
				• Interpretation of Cardiac catheterization, coronary angiography, left ventriculography			
				• Pulmonary angiography, right heart catheterization			
				• Transluminal angioplasty, fibrinolysis, atherectomy, stent replacement			
				• Embolotherapy and infusion therapy			

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				• Percutaneous placement venous access device			
				• Vena Cava filter placement			
				• Hepatobiliary intervention (transhepatic cholangiography, endoprosthesis, biliary stone removal.			
				• Lymphangiography			
				• Fallopian tube recanalization			
				• Transjugular intrahepatic portacaval stent shunt			
				10. ABDOMINAL			
				• Percutaneous transhepatic cholangiography			
				• Biliary stone removal			
				11. GENITO-URINARY			
				• Percutaneous pyelography			
				• Percutaneous nephrostomy			
				• Retrograde urethrogram			
				• Hysterosalpingogram			
				• Ureteral stent			
				12. MAMMOGRAPHY			

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other
				• Screening Mammography			
				• Diagnostic Mammography			
				• Stereotactic Breast Localization and / or Biopsy			
				• Needle localization			
				• Ductogram			
				• Percutaneous aspiration and biopsy			
				13. MUSCULOSKELETAL			
				• Arthrography			
				14. NUCLEAR MEDICINE			
				• Radiotherapy with unsealed source			
				• Pet Imaging			
				15. MODERATE/DEEP SEDATION, requires competency exam.			
				16. OTHER			

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other

PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the credentials office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the Bylaws.

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise in each group of procedures requested. I understand that in making this request I am bound by the Bylaws and/or policies of the organization and its medical staff.

_____ _____

APPLICANT'S SIGNATURE DATE

Name: _____

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
						Competency	Other

Department Chair/Chief/Designee:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#:_____
Condition/Modification/Explanation:_____
_____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#:_____
Explanation for NOT recommending based on
COMPETENCY:_____
_____

If supplemental documentation provided, check here: ☐

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_____ _____
SIGNATURE OF THE CREDENTIALS PRINCIPAL DATE

APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

Name: _____

REQUEST FOR RECOMMENDATION -

Dr. _____ is being considered for appointment to the Staff.

Your confidential evaluation would be appreciated.

I have known the applicant for _____ years _____months.
I have known the applicant in the following capacities:

Have you evaluated the applicant's competency within the past 2 years? ☐ YES ☐ NO

EVALUATION ELEMENT DURING THE PAST 2 YEARS	Excellent	Good	Fair	Poor	Unknown
A. Medical Knowledge					
B. Technical Skills					
C. Patient Care and Clinical Judgement					
D. Professionalism					
E. Ethical Conduct					
F. Practice-based Learning and Teaching Skills					
G. Systems-based practice / Use of resources					
H. Maintenance of Medical Records					
I. Provider/Patient Relations/Grievances					
J. Communication Skills					
K. Interpersonal Skills					
L. Works within Delineated Privileges					

If you answered **Fair/Poor/Unknown** please explain:

This recommendation is based on: close observation / general impression / composite evaluation by others
Other _____

A. To the best of your knowledge, has the practitioner's license, clinical privileges, hospital staff membership, or other professional status ever been denied, restricted, suspended, or revoked? ☐ YES ☐ NO

If you answered "YES" please explain:

B. To the best of your knowledge, is the practitioner free of all physical, mental and behavioral impairments, which could potentially impair his/her ability to practice? ☐ YES ☐ NO

C. Do you recommend that the applicant be appointed/reappointed to the Staff? ☐ YES ☐ NO

D. To the best of your knowledge, can the individual perform to accepted standards of professional performance without posing a direct threat to patients? ☐ YES ☐ NO

If you answered "NO" to questions **B** through **D** please explain:

Print Name: _____ Signature: _____
Phone Number: _____ Date: _____

SEND TO: ***TROY LAIR***, **Fax: 310-730-6073 or Email: ELITEACCREDITATION@GMAIL.COM**

LIST ALL CURRENT HOSPITAL AFFILIATIONS & PREVIOUS AFFILIATIONS DURING LAST 5 YEARS

PHYSICIAN'S

NAME: _____ DATE:_____

Hospital Name: _____

Address:_____

City & Zip Code: _____

Date of Appointment: _____ Current Status:_____

Phone Number:_____ Fax Number:_____

Contact Person:_____

Hospital Name: _____

Address:_____

City & Zip Code: _____

Date of Appointment: _____ Current Status:_____

Phone Number:_____ Fax Number:_____

Contact Person:_____

Hospital Name: _____

Address:_____

City & Zip Code: _____

Date of Appointment: _____ Current Status:_____

Phone Number:_____ Fax Number:_____

Contact Person:_____

(ATTACH ADDITIONAL SHEETS AS NECESSARY)

TB Screening/Attestation

In order to maintain compliance with the Bylaws of this organization and the state requirements, documentation of health status is required.

Please complete and fax this form.

TUBERCULOSIS SCREENING

I have received a Mantoux (PPD) **or** chest film, if appropriate, within the past twelve (12) months with the following results:

PPD was Choose One and performed on this day: _____

A CXR Film was Choose One and performed on this day: _____.

Or, the following applies:

☐ The results were negative for tuberculosis.

☐ The results were a new positive for tuberculosis and I am currently being treated for tuberculosis.

☐ The results were a new positive for tuberculosis, but I do not have an active case of tuberculosis.

☐ I did not have a repeat skin testing since I have been positive by Mantoux (PPD) in the past.

Please forward documentation of the above.

SIGNATURE_____DATE_____

PLEASE PRINT YOUR NAME_____

PHONE NUMBER_____

* signature above is my attestation that I am aware that PPDs are required annually whereas CXRs are every two years

Notice and Acknowledgment of Data Security Responsibilities

Policy: Data Security Policy and Use of Electronic Equipment

I understand it is the policy of this organization that all personnel (defined as: employees, contractors, healthcare providers, doctors, techs, nurses, and all other providers mentioned or unmentioned, whether they are permanent, temporary, part-time or other) are personally responsible for the protection of all information data, and information processing resources which they have access to by virtue of employment or contractually by the organization.

I hereby acknowledge being responsible for the proper use of electronic equipment and the privacy, integrity and availability of data in compliance with Data Security Policy, whether it be patient data or otherwise.

ACKNOWLEDGMENT

1. I have received and carefully reviewed a copy of Data Security Policy.

2. I understand that I shall be held personally responsible and accountable for complying with this policy.

3. I am aware that if violate any provisions of the policy, I will be subject to disciplinary action which may include discharge from service, and/or agency as well as civil penalties allowed by law.

Last Name (Print):	First Name (Print):	Date:
Signature:	Job Title:	

MEDICARE ACKNOWLEDGMENT STATEMENT

NOTICE TO PHYSICIAN

MEDICARE PAYMENT TO ORGANIZATIONS IS BASED ON PART ON EACH PATIENT'S PRINCIPAL AND SECONDARY DIAGNOSES AND THE MAJOR PROCEDURES PERFORMED ON THE PATIENT, AS ATTESTED TO BY THE PATIENT'S ATTENDING PHYSICIAN BY VIRTUE OF HIS OR HER SIGNATURE IN THE MEDICAL RECORD. ANYONE WHO MISREPRESENTS, FALSIFIES, OR CONCEALS ESSENTIAL INFORMATION REQUIRED FOR PAYMENT OF FEDERAL FUNDS, MAY BE SUBJECT TO FINE, IMPRISONMENT, OR CIVIL PENALTY UNDER APPLICABLE FEDERAL LAWS.

****

_____ _____

APPLICANT'S SIGNATURE **DATE**

_____

PRINT YOUR NAME

FIVE YEAR WORK HISTORY TRACKING

NAME OF PRACTITIONER: ____

SPECIALTY: ____

List work history in reverse order, starting with the present.

Provide chronological listing of all work history beginning with completion of training. . If you have practiced fewer than five years from the date of credentialing, the history begins with initial licensure. Please include the beginning and ending month and year for each work experience.

Provide detailed explanation of any gaps exceeding one (1) month.

WORK HISTORY	WORK PERIOD:
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
____________________ Name of Organization, Hospital or Office Practice	From: ______________ MM/YYYY To: ______________ MM/YYYY
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ADD ADDITIONAL SHEETS IF NECESSARY

Reviewed by (Initials): ______________ **Date Reviewed:** ______________