ATTACH SMALL PHOTO HERE

MEDICAL STAFF APPLICATION

PREAPPLICATION QUESTIONNAIRE & APPLICATION FOR MEDICAL MEMBERSHIP

Instructions:
1. This form must be legible
2. Please include COMPLETE addresses including ZIP CODES
3. If more space is needed, attach additional sheets and reference question being answered.
4. All dates must include MONTH and YEAR.

☐ Please Mark - if you will be submitting your **State Standardized Credentiling Application**
If yes, then only complete **Identifying Information, Part I, and Consent and Release** portions.

IDENTIFYING INFORMATION

LAST NAME | FIRST NAME | INITIAL | IF MARRIED, NAME OF SPOUSE

HOME ADDRESS | CITY | STATE | ZIP CODE

HOME TELEPHONE NUMBER | SPECIALTY

Office Phone: | Office Fax | Cell Phone:

EMAIL:

SS NUMBER | DATE OF BIRTH | PLACE OF BIRTH | CITIZENSHIP

PART I – PREAPPLICATION QUESTIONNAIRE / MINIMUM QUALIFICATIONS FOR MEMBERSHIP

Part I is designed to help you determine whether or not you meet the minimum requirements for membership with **IHS Portico**. Please read this section carefully. If you meet the qualifications outlined below, you may complete the medical staff application under Part II of this form.

1. Are you licensed to practice in your State and (if practicing clinical medicine, dentistry or podiatry) do you have a federal DEA number?

☐ Yes – Attach a copy of your current state license & your DEA registration certificate, and proceed to question #2. Additional information regarding your license and DEA registration will be requested under Part II – Application for Membership.

☐ **No – STOP**. You do not meet the minimum requirements for membership and clinical privileges.

2. Do you have a state narcotic license?

☐ Yes - Attach a copy of your current state narcotic license. Additional information regarding your state narcotic license will be requested under Part II – Application for Membership.

☐

☐ N/A Not applicable

3. Do you have (or will you be acquiring) professional liability insurance coverage?

☐ Yes - Attach a copy of your professional liability policy overage limits & effective dates, and proceed to question #4. Additional information regarding your professional liability will be requested under Part II – Application for Membership.

☐ **No –** Why: _____

4. Are you board certified or eligible for certification by a Medical Board or approved specialty board?

☐ Yes – Proceed to question #5. Additional information regarding your board status will be requested under Part II – Application for Membership.

☐ No - Specialty board status is one factor considered in determining eligibility for MD membership. If you answered "No", you may still qualify for membership.

Have you successfully completed Medical School and an Internship/Residency Program in the specialty you plan to practice as a member of **IHS Portico**?

☐ Yes - Proceed to Part II – Application for Membership.
☐ No – Please state why *(i.e. I am a Chiropractor or I am applying as an Imaging Center)*

VERY IMPORTANT NOTE: If you meet the minimum requirements specified in questions 1 through 5 above, please complete Part II – Application for Membership. If you do NOT meet these requirements, do not continue beyond this page. Please make certain that you have included copies of all required documentation. Incomplete applications will be RETURNED to the applicant.

PART II – APPLICATION FOR MEMBERSHIP

LICENSING

STATE MEDICAL LICENSE NUMBER _____ EXPIRATION _____

DRUG ENFORCEMENT ADMINISTRATION REGISTRATION NUMBER _____ EXPIRATION _____

NARCOTIC LICENSE NUMBER (IF APPLICABLE) _____ EXPIRATION _____

NPI NUMBER: _____

Other State Medical Licenses (certificates; all past/present)

STATE _____ LICENSE NUMBER _____ EXPIRATION _____

Has your license to practice medicine or DEA registration in any jurisdiction Ever been limited, suspended or revoked, or is any such action pending? ☐ Yes ☐ No

Have you ever voluntarily relinquished your license to practice medicine or DEA registration? ☐ Yes ☐ No

If yes, please provide full details on a separate sheet and attach it to the application.

PROFESSIONAL LIABILITY

CURRENT INSURANCE CARRIER _____ CURRENT AMOUNT OF COVERAGE _____

Have any judgments/settlements been made against you in professional Liability cases, or are any cases pending? ☐ Yes ☐ No

If yes, please explain on a separate sheet and attach it to the application.

List all other carriers used during the past five years:

_____

EDUCATION AND TRAINING

MEDICAL SCHOOL _____ DATE OF GRADUATION _____

COMPLETE ADDRESS _____

MEDICAL EDUCATION

GRADUATE SCHOOL _____ DATE OF GRADUATION _____

COMPLETE ADDRESS _____

INTERNSHIP

TYPE OF INTERNSHIP _____ SPECIALITY _____ DATES OF AFFILLIATION _____

List preceptorships, teaching appointments & postgraduate education in chronological order. Include hospital name, address, city, state and zip code, dates, and Chiefs of Staff.

RESIDENCIES

HOSPITAL

COMPLETE ADDRESS

SPECIALTY CHIEF OF STAFF DATES OF AFFILLIATION

FELLOWSHIP

SPECIALTY CHIEF OF STAFF DATES OF AFFILLIATION

COMPLETE ADDRESS

SPECIALTY CHIEF OF STAFF DATES OF AFFILLIATION

COMPLETE ADDRESS

CERTIFICATION I am certified by the following board(s):

NAME OF BOARD DATE CERTIFIED

NAME OF BOARD DATE CERTIFIED

Have you been recertified? ☐ Yes ☐ No

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

NAME OF BOARD DATE CERTIFIED

NAME OF BOARD DATE CERTIFIED

Have you applied for Board Certification? ☐ Yes ☐ No

If not, please give current status: _____

NOTE: Evidence of Certification or eligibility must be attached to the application.

PRACTICE PLAN

OFFICE ADDRESS CITY STATE ZIP CODE OFFICE TELEPHONE #

PRACTICE LIMITED TO OFFICE FAX #

OTHER MEDICAL INTERESTS IN PRACTICE, RESEARCH, ETC.

PRACTICING WITH WHOM AND NATURE OF AFFILLIATION

HOSPITAL AFFILLIATIONS

List all current and previous hospital affiliations, starting with the most current. (Include assistantships and appointments.) Attach a separate sheet if necessary. (PLEASE PROVIDE 3 AFFILIATIONS)

NAME OF HOSPITAL STATUS FROM TO

ADDRESS OF HOSPITAL

NAME OF HOSPITAL STATUS FROM TO

ADDRESS OF HOSPITAL

NAME OF HOSPITAL STATUS FROM TO

ADDRESS OF HOSPITAL

Please answer the following questions and provide full details of any "Yes" answers on a separate sheet attached to the application.

Have your privileges at any hospital ever been suspended, diminished Revoked, or not renewed, or is any such action pending? ☐ Yes ☐ No

Have you ever been denied membership or renewal thereof on the basis of formal Peer review, or been subject to disciplinary action in any medical organization (*e.g*., medical staff, HMO, etc.) or is any such action pending? ☐ Yes ☐ No

Have you ever resigned from a hospital medical staff or surrendered clinical privileges To avoid disciplinary action? ☐ Yes ☐ No

MEMBERSHIP IN PROFESSIONAL SOCIETIES

List all professional societies of which you are a member.

NAME MEMBERSHIP STATS DATE ELECTED

NAME MEMBERSHIP STATS DATE ELECTED

PREVIOUS PRACTICE

List all previous office addresses and military experience, including dates (list chronologically).

ADDRESS FROM TO

ADDRESS FROM TO

ADDRESS FROM TO

MEDICAL REFERENCES

Please provide three peer references that have had experience in observing a working with you in the past five years, who can provide adequate information about your professional competence and ethical character. At least three references should be physicians of the same (or similar) specialty. Only one reference may be an associate.

NAME FAX NUMBER PHONE #

ADDRESS

NAME FAX NUMBER PHONE #

ADDRESS

NAME FAX NUMBER PHONE #

ADDRESS

CONTINUING MEDICAL EDUCATION On a separate piece of paper, list all CME for which you have received credit in the past two years.

OTHER Please answer the following questions and provide full details of any "Yes" answer on a separate sheet attached to the application.

Have you ever been treated for any mental condition?	☐ Yes	☐ No
Has any hospital ever asked you to take a leave of absence for any mental or physical health condition?	☐ Yes	☐ No
Have you ever been convicted of a felony?	☐ Yes	☐ No
Are there any time gaps in your education, training, or experience of greater than 6 months?	☐ Yes	☐ No
Are you able to perform all the procedure for which you have requested privileges (with or without reasonable accommodation) according to accepted standards of practice and without posing a direct threat to patients?	☐ Yes	☐ No

ABILITY TO PERFORM – Please complete attach documentation of your mental and physical ability to fulfill the responsibilities of medical staff membership and to perform the privileges that you are requesting. Such documentation may be your own written statement that no mental or physical problems exist which could affect your practice; however such statement MUST be countersigned prior to your appointment by: 1) the director of your training program; 2) the chief of services or chief of staff at the hospital where you are currently practicing; or 3) by a licensed physician of your choice.

APPLICANTS CONSENT AND RELEASE

I hereby apply for medical doctor membership with **IHS Portico.** I am willing to make myself available for interviews by IHS staff, should IHS Portico deem such interviews necessary. As an applicant for membership with IHS Portico, I have the burden of responsibility in producing adequate information to allow the proper evaluation of my application. I further agree to provide IHS Portico with updated, current information regarding all questions on this application as such information becomes available and such additional information as may be requested by the Facility. I understand that my failure to provide such requested information would prevent the processing and evaluation of my application.

Information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capabilities and competency to practice the clinical privileges requested. I understand that as a condition to making this application, any misrepresentation or misstatement in, or omission from this application, whether intentional or otherwise, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of my appointment and clinical privileges. In the event that appointment or clinical privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in the immediate termination of such appointment and/or privileges.

By applying for membership, I accept the following conditions during the processing and evaluation of my application, regardless of whether or not I am granted membership, and for the duration of such membership as I may be granted.

A. I extend absolute immunity to and release from any and all liability **Integrated Health Services / Portico**, its authorized representatives and any third parties, as defined in subsection © below, for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by the Facility and its authorized representatives, from, or by any third party, including otherwise privileged or confidential information, relating to the following:

1. Application for membership;
2. Periodic reappraisals for the purpose of renewal or modifications;
3. Proceeding for suspension or reduction of privileges, or for denial or revocation of membership or any other disciplinary sanction;
4. Summary suspensions;
5. Hearing and appellate reviews;
6. Medical care evaluations;
7. Utilization reviews;
8. Matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
9. Any other matter that might directly or indirectly have an affect on my competence, on patient care or on the operation of Portico.
10. IHS Portico maintains a website. Do we have your permission to list you as a participating provider and link to your website?

No ☐ Yes ☐ WEB ADDRESS: _____

B. I specifically authorize IHS Portico and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, that has a bearing on my professional qualifications, credentials, clinical competency, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfying the criteria for initial or continued membership with IHS Portico, as well as to inspect and obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to IHS Portico and its authorized representatives upon request.

I acknowledge that (1) MEMBERSHIP with IHS Portico is not a right of every licensed professional who make application for the same; (2) my request will be evaluated in accordance with prescribed procedures, rules and regulations; (3) all membership recommendations relative to my application are subject to the ultimate action of IHS' Governing Body, whose decision shall be final; (4) if granted membership, my initial membership shall be provisional for the time period determined by the Governing Body; (5) I have the responsibility to keep this application current by informing IHS Portico, of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical staff status at any other health care facility; and (6) reappointment an/or continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, as evidenced by admission, treatment and continuous care and supervision of patients for who I have responsibility and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by IHS Portico. Renewal of membership shall be granted only on formal application, according to Integrated Health Services staff bylaws, rules and regulations, and upon final approval by IHS Portico Governing Body.

I agree to abide by IHS Portico's Privacy Policy and Procedures. I further agree to use IHS Portico's Notice of Privacy Practices as a joint notice of privacy for patients I consult, and I agree to abide by the Notice of Privacy Practices.

If granted membership, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment of services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care as needed to all patients in the IHS Portico System for whom I have responsibility.

Applicant's Signature: _____ **Date:** _____