Lakeview Surgery Center

APPLICATION FOR ALLIED HEALTH PROFESSIONAL

Complete this form and attach requested documentation.
If a question does not apply to you, write N/A. If additional space is necessary, add additional sheets of paper.

General Information (Print legibly with ink or type)

Legal Last Name | **First** | **Middle** | **Professional Title/Degree**

Other names which you have been identified under: (From – To)

Are you a citizen of the US or are you legally able to work in the US?

Supervising Physician | **Start Date with Physician** | **Office Manager:** | **Phone Number:**

Office Address | **City:** | **State:** | **Zip Code:** | **Office E-mail address**

Office Telephone | **Office Fax** | **Credentialing Contact** | **Phone Number:**

Residence Address | **City:** | **State:** | **Zip Code:** | **Personal Phone**

Social Security | **Birth Date** | **E-mail address**

Licensure Information (Provide all license information, **both current and expired.** Attach copies.) ❒ N/A

Professional #	Degree	Name of License	State Issued	Issue Date	Expiration Date

Professional Liability Information (List the names and address of ALL current and past (10 yrs) professional liability carriers, institutions, organizations with whom you hold / have held professional liability coverage. Attach copies as applicable)

Carrier Name | **Address**

Agent Name | **Agent Phone** | **Agent Fax**

Policy # | **Amount of Coverage** | **Dates of Coverage**

Education / Training Information (Attach documentation of completion of training)

Name of Institution | **Department** | **Address**

City | **State** | **Zip Code**

Telephone Number | **Fax Number**

Degree/Specialty | **Program Supervisor** | **Attendance Dates – From To**

Name of Institution | **Department** | **Address**

City | **State** | **Zip Code**

Telephone Number | **Fax Number**

Degree/Specialty | **Program Supervisor** | **Attendance Dates – From To**

Name of Institution | **Department** | **Address**

City | **State** | **Zip Code**

Telephone Number | **Fax Number**

Degree/Specialty | **Program Supervisor** | **Attendance Dates – From To**

Professional History (Last 10 years List in CHRONOLOGICAL order all professional career experiences beginning with the most current first.

Name of Facility / Employer Department **Address**

City **State** **Zip Code**

Telephone Number **Fax Number** **Supervisor**

Affiliation Dates **Description of Duties / Responsibilities**
.From **To**

Name of Facility / Employer Department **Address**

City **State** **Zip Code**

Telephone Number **Fax Number** **Supervisor**

Affiliation Dates **Description of Duties / Responsibilities**
.From **To**

Name of Facility / Employer Department **Address**

City **State** **Zip Code**

Telephone Number **Fax Number** **Supervisor**

Affiliation Dates **Description of Duties / Responsibilities**
.From **To**

Professional Affiliations (List any facilities where you currently have privileges and any other facilities where you have held privileges in the past)

Name of Facility **Address** **City** **State** **Zip**

Telephone Number **Fax Number** **Affiliation Dates**

Name of Facility **Address** **City** **State** **Zip**

Telephone Number **Fax Number** **Affiliation Dates**

Name of Facility **Address** **City** **State** **Zip**

Telephone Number **Fax Number** **Affiliation Dates**

Professional References (List three peer references that have had recent experience in observing and working with you and who can provide adequate information pertaining to your current professional clinical abilities and character)

Name **Title** **Relationship to applicant (Supervisor, coworker, etc.)**

Address **City** **State** **Zip Code**

Telephone Number **Fax Number** **Email**

Name **Title** **Relationship to applicant (Supervisor, coworker, etc.)**

Address **City** **State** **Zip Code**

Telephone Number **Fax Number** **Email**

Name **Title** **Relationship to applicant (Supervisor, coworker, etc.)**

Address **City** **State** **Zip Code**

Telephone Number **Fax Number** **Email**

Professional Liability Claims History (If you answer **Yes** to any of the following questions, a full explanation is required.)

1. Have any settlements or malpractice claims been paid by you or on your behalf by another entity? ❑ Yes ❑ No
2. Have you been a defendant in any malpractice lawsuits, which resulted in a jury verdict against you or a court judgment against you? ❑ Yes ❑ No
3. Are you currently involved in any professional liability suits or have you been named in any pending claims? ❑ Yes ❑ No
4. Have you been denied professional liability insurance; has your policy been cancelled; has your professional liability carrier refused to renew your policy or placed limitations on the scope of your coverage; or has any professional liability carrier expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or coverage? ❑ Yes ❑ No

Declaration of Ability to Practice

Are you able to perform your professional duties in a manner that does not in any way adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients? If no, explain. ❑ Yes ❑ No

Quality Focused Questions (If you answer Yes to any of the following questions, a full statement of explanation must be attached.)

5. Have any of the following been or are they currently in the process of being denied, cancelled, revoked, refused, suspended, reduced, limited, placed on probation, subjected to a reprimand, subjected to civil penalties, not renewed, challenged, investigated, sanctioned, voluntarily or involuntarily relinquished or withdrawn, by either yourself or the entity?
    - Professional License in any state? ❑ Yes ❑ No
    - Appointment to any medical or dental staff? ❑ Yes ❑ No
    - Clinical activities at any medical or dental facility? ❑ Yes ❑ No
    - Professional society memberships? ❑ Yes ❑ No
    - Academic appointments? ❑ Yes ❑ No
    - Medicare/Medicaid participation? ❑ Yes ❑ No
    - DEA or CSA registration? ❑ Yes ❑ No
    - Board certification? ❑ Yes ❑ No
    - Professional liability insurance coverage? ❑ Yes ❑ No
    - HMO/PPO or other managed health care plan membership? ❑ Yes ❑ No
    - Membership on any clinical, medical, dental or professional staff? ❑ Yes ❑No
    - Employment at any healthcare facility, healthcare plan, or other healthcare organization? ❑ Yes ❑No
6. Do you have any felony, grand jury indictment, or other criminal charges pending? ❑ Yes ❑ No
7. Have you been convicted of, found guilty or pled no contest to any felony, or any other crime other than a minor traffic offence? (Existence of a criminal record will not automatically bar appointment, but will be considered in relation to your specific duties.) ❑ Yes ❑No
8. Have you had any healthcare facility invoke probation, issue a reprimand, impose proctoring (other than proctoring when activities are initially granted), require a second opinion or initiate an investigation of your professional conduct or competency? ❑ Yes ❑ No
9. Are you currently performing or do you plan to perform any procedures for which you have ever been refused or lost clinical approval? ❑ Yes ❑ No
10. Has/have any adverse action(s) or malpractice report(s) about you been made to the National Practitioner Data Bank, or any other databank? ❑ Yes ❑ No
11. Have you been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction, from a clinical position with the armed forces, any federal, state, or local agency, or any other employment or practice arrangement? ❑ Yes ❑ No
12. Is there any other issue (s) that we need to be made aware of that could an adversely affect the quality of care rendered by you to patients or jeopardize the safety of patients or jeopardize this facility? ❑ Yes ❑ No

CONSENT, ATTESTATION & AUTHORIZATION FOR RELEASE OF INFORMATION

A copy will serve as original

I hereby authorize any third party, (including but not limited to individuals, medical groups, hospitals, insurance companies, health plans, licensing agencies, medical societies, agencies, corporations, companies, employers, etc.) to release information concerning my qualifications, credentials, clinical competence, quality assurance data, character, physical or mental health condition, behavior, ethics, claims history, disciplinary actions, or any other matter reasonably having bearing on qualifications. I release said third parties or entities from liability and hold harmless any entity or third party for their acts performed in connection with the release of such information and acknowledge that the information obtained is not a violation of my privacy.

I hereby authorize Lakeview Surgery Center (LSC), its medical staff and/or representatives to collect and review all records and documents, including records from previous education, training and licensure; board certification status; and responses to queries to the National Practitioner Data Bank, that may be material to an evaluation of my professional qualifications and competence. I also authorize consults with administrators, and members of medical staff of other institutions with which I have been associated, professional references and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release Lakeview Surgery Center and its employees, representatives, and affiliates from liability when gathering, obtaining and exchanging documents, records, and other information pertaining to my application.

It is my understanding that LSC shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, or as required under state or federal law or regulation. I hereby further authorize and consent to the release of information by LSC, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information LSC its representatives and the medical staff may have concerning me as long as such release of information is done and I hereby release from liability LSC and its staff for so doing.

I fully understand that any misstatements in or omissions from this application may constitute cause for denial of reappointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true and complete to my best knowledge and belief. I hereby signify my willingness to appear for the interviews in regard to my application,

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I agree to be bound by the bylaws of the medical staff, rules and regulations, policies and procedures as put forth by the governing body.

I also understand that certain fields of data on this application contain time sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize LSC to collect from me and other sources this information on an as needed basis.

I have read and understand the attestations, acknowledgements and releases outlined in this form and agree to them. I acknowledge that acceptance of this application does not constitute a contractual agreement for employment, membership, or granting of privileges. I agree to notify Lakeview Surgery Center within 10 working days of any material change to the information reported on the application, including but not limited to, changes in status at other organizations, restrictions to any license, commencement of a formal investigation, or changes in physical or mental health.

_____ _____

Printed Full Name Date

_____

Signature