

**APPLICATION FOR APPOINTMENT TO MEDICAL STAFF OF  
PARK PLACE SURGERY CENTER**

INITIAL APPOINTMENT PERIOD: from \_\_\_\_\_ to \_\_\_\_\_

NAME \_\_\_\_\_  
Last First Middle

HOME ADDRESS \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code

OFFICE ADDRESS: \_\_\_\_\_  
Street

\_\_\_\_\_ City State Zip Code

TELEPHONE NUMBER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Home Office FAX

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

Are you a citizen of the United States:    Yes     No

If not, Alien Registration Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Contact in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Optional:    Name of your office or organization (if any): \_\_\_\_\_

**I. EDUCATION**

	Name	Address	Dates Attended	Degree(s)
University				
Medical School				
Post Graduate				

## Foreign Medical Graduates

1. Date of ECFMG Exam: \_\_\_\_\_

2. ECFMG Certificate #: \_\_\_\_\_  
(Attach Copy)

## II. GRADUATE TRAINING

(Attach a copy of each certificate)

	Healthcare Facility	Specialty	Date Completed
A. Internships:			
B. Residencies:			
C. Fellowships:			

## III. LICENSES

A. Professional (attach current copies)

1. State Medical License #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

2. State Dental License #: \_\_\_\_\_ EIN #: \_\_\_\_\_

3. State Podiatry License #: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

B. Controlled Substances (attach current copies)

1. Federal DEA #: \_\_\_\_\_ 2. State DEA #: \_\_\_\_\_

C. Other States - List all license numbers and indicate whether current or expired.

\_\_\_\_\_  
\_\_\_\_\_

## IV. CERTIFICATION

1. Are you Board Certified: Yes  No

If yes, indicate which board(s) and certification. Attach a copy of certification(s).

\_\_\_\_\_  
\_\_\_\_\_

2. If no, are you in the board examination system? Yes  No

If yes, when do you expect to complete the process? \_\_\_\_\_

3. If "no" answered to #1, have you ever been Board Certified? Yes  No

## V. APPOINTMENTS

List hospitals and other healthcare facilities where you currently have privileges.

Healthcare Facility	Address (City/State)	Expiration

## VI. PROFESSIONAL SOCIETY MEMBERSHIPS

List current memberships:

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## VII. PROFESSIONAL AND PERSONAL SANCTIONS

1. Have any of the following ever been, or are any currently in process of being revoked, reduced, suspended, denied, not renewed, or voluntarily relinquished, either on a permanent or temporary basis?

- |  |     |                          |    |                          |
|--|-----|--------------------------|----|--------------------------|
| • Professional registration/license  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • DEA or other controlled substance registrations  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Appointments in any healthcare facility  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Professional privileges in any healthcare facility   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Membership in any local, state, or national professional society   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Professional liability insurance   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Participation as a provider in the Medicare or Medicaid programs   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Have you ever been charged with, pled guilty to, or been convicted of a felony?                            | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Have you ever been charged with, pled guilty to, or been convicted of drunk driving or disorderly conduct? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Have you ever received treatment or disciplinary action for substance abuse?                               | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

2. If any of the above questions are answered in the affirmative, please provide a full explanation below or on a separate sheet.

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## VIII. PROFESSIONAL LIABILITY INSURANCE

1. Name of insurance carrier: \_\_\_\_\_  
 (Attach face sheet of policy)

Amount of coverage \$ \_\_\_\_\_ per occurrence \$ \_\_\_\_\_ per aggregate

Effective dates of coverage: \_\_\_\_\_

2. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice, within the past ten years?      Yes       No

If yes, please provide a full description on a separate sheet of the nature of the action, date, location, amount settled, and current status.

2. Have you ever been denied professional liability coverage, or had such coverage cancelled or not renewed? If yes, please explain.      Yes       No

## IX. HEALTH STATUS

I certify that I am in good health and have no physical or mental limitations.

Yes  No

I do have a chronic illness, physical disability, and/or mental limitation to my health, which may include drug use.

Yes  No

If yes, I believe that this disability does not significantly impair my ability to render quality patient care.

Yes  No

## X. REFERENCES

Please provide the name, address and telephone number of three (3) references who have personal knowledge of your current professional abilities:

Name

Address

Phone Number

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## XI. AUTHORIZATIONS AND RELEASES

Your signature signifies that you agree to the following conditions pertaining to this application.

1. I attest to the correctness and completeness of all information furnished.
2. I am willing to appear for interviews in connection with this application.
3. I agree to abide by the terms of any bylaws, rules, regulations, policies and procedure manuals of *PARK PLACE SURGERY CENTER* as presently formulated or as later amended or modified.
4. I authorize a representative of *PARK PLACE SURGERY CENTER* to consult associates or others who may have information bearing on my qualifications and consent to their inspecting records and documents that may be material to their evaluation of my qualifications and competence.
5. I release from any liability all those who, in good faith review, act on or provide information regarding my competence, professional ethics, character, health status and other qualifications for clinical privileges.
6. I authorize any healthcare facility to release copies of my privileges and staff application to *PARK PLACE SURGERY CENTER*.
7. I authorize any medical school and healthcare facility to release any information on my medical training, internship, residency and fellowship to *PARK PLACE SURGERY CENTER*.
8. I agree to provide the Medical Director of *PARK PLACE SURGERY CENTER* of any change in the information submitted in this application within thirty days of such change.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

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APPLICANT'S NAME \_\_\_\_\_

**MEDICAL DIRECTOR**  
Temporary privileges granted \_\_\_\_\_  
Applicants recommended for staff privileges

**MEDICAL EXECUTIVE COMMITTEE**  
APPROVE  DEFER  DENY

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

**GOVERNING BODY**  
APPROVE  DEFER  DENY

\_\_\_\_\_  
Signature Date

Comments \_\_\_\_\_

\_\_\_\_\_

**PARK PLACE SURGERY CENTER**  
**AUTHORIZATION TO OBTAIN AND VERIFY INFORMATION**  
**RELEASE OF LIABILITY FOR PROVIDING INFORMATION**

I authorize the release of *any and all* information pertaining to my past and present staff medical staff appointments/privileges from all health care facilities. I also authorize my medical school and any health care facility to release any information regarding my medical training, internship, residency and fellowship.

I grant PARK PLACE SURGERY CENTER authority to consult associates or others who may have information pertinent to my qualifications for appointment to their medical staff. I also grant authority to inspect records and documents pertinent to the evaluation of my medical practice competence/surgical skill, patient management, record keeping, professional judgment, ethical conduct and health status.

I hereby certify that the information I provided in my application to PARK PLACE SURGERY CENTER is complete and accurate.

\_\_\_\_\_  
Practitioner Full Printed Name

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Date

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**HOSPITAL SERVICES CORPORATION  
CREDENTIALS VERIFICATION SERVICE  
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION  
("Release")**

**Authority to Release:** I have applied to participate as a provider for \_\_\_\_\_

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

**Authority to Redisclose:** Unless I have denied authority by initialing here \_\_\_\_\_, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

**The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.**

**Signature stamps and date stamps are not acceptable.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date (do not type)

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**DEFINITIONS** of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.