

LANE REGIONAL MEDICAL CENTER
6300 Main Street, Zachary, LA 70791
APPLICATION FOR MEDICAL STAFF APPOINTMENT

Date of Application _____

Photo Required

Place
Photo
Here

Please type or print. All questions must be answered and accompanied by adequate explanation where appropriate. **"See CV" is not acceptable.** If more space is needed, attach additional sheets and make reference to the question being answered. **The following attachments must be included for the application to be considered complete:**

1. Current license(s) to practice medicine or dentistry
2. Professional liability insurance policy and certificate of coverage from carrier.
3. Evidence of participation in LA Patient Compensation Fund
4. Narcotics registration certification (Federal and State)
5. Evidence of board certification
6. Documentation of Continuing Medical Education
7. C.P.R., A.C.L.S., etc. certificates (if applicable)
8. Current C.V
9. Copy of current driver's license
10. Application fee of \$200.00.

Incomplete applications cannot be processed. If you have any questions or need further information, you may contact the Medical Staff Coordinator at (225) 658-4489. Return application to Medical Staff Coordinator at address above.

PERSONAL INFORMATION

Last Name _____ First _____ Middle _____

Social Security _____ Sex _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Listed? Yes No Beeper _____

Birth City _____ State _____ Country _____

Citizenship _____ Visa Status, if not a US Citizen _____

Languages Spoken Fluently _____

Marital Status Single Married Divorced Widowed Spouse's Name _____

Criminal History:

Have you ever been convicted of a felony or a misdemeanor which resulted in imprisonment? Yes No
If "YES" please describe the felony/misdemeanor and explain the circumstances on a separate page.

PRACTICE INFORMATION

Practice Name _____

Type of Practice Solo Group Partnership Other Tax ID _____

Name others with whom you are associated in practice _____

Primary Office Address _____ City _____ State _____ Zip _____

Office Phone _____ Fax Number _____ Answering Service _____

PRACTICE INFORMATION (Continued)

Primary Office Manager _____ Nurse _____

Approximate distance of office (in minutes) from Lane: _____

Office Hours _____ Practice Affiliation Date _____

Primary E-mail Address _____

Secondary Office Address _____ City _____ State ____ Zip _____

Office Phone _____ Fax Number _____ Answering Service _____

Secondary Office Manager _____ Nurse _____

Approximate distance of office (in minutes) from Lane: _____

Office Hours _____ Practice Affiliation Date _____

SPECIALTY INFORMATION

Practice Specialty _____ Subspecialty _____

Specialty Board _____ Certification Date _____

Expiration Date _____ Recertification Date _____ Recertification not applicable

If you are NOT currently board certified, please state your intent with respect to becoming certified. Document, in writing, past and present efforts and admissibility/eligibility including any failure of written or oral exams. Use additional pages if needed. Please attach a copy of your certificate or exam application if it exists.

PROFESSIONAL HISTORY

Please list in chronological order all hospitals, clinics, or other health care facilities at which you have had membership/privileges, other employers since residency, and locum tenens. Please account for all time and provide complete address. Do not include internships, residencies, preceptorships, and fellowships in this section. Use additional paper if needed.

Dates of Affiliations ___/___ to ___/___ Name of Institution/Practice _____

Address _____ City _____ State _____ Zip _____

Department/Division _____ Phone _____

Dates of Affiliations ___/___ to ___/___ Name of Institution/Practice _____

Address _____ City _____ State _____ Zip _____

Department/Division _____ Phone _____

Dates of Affiliations ___/___ to ___/___ Name of Institution/Practice _____

Address _____ City _____ State _____ Zip _____

Department/Division _____ Phone _____

EDUCATION

Medical School:

Name of Institution: _____ Dates Attended ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Did you complete this program? Yes No

Internship:

Name of Institution: _____ Dates Attended ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Program Director _____ Type /Specialty _____

Did you complete this program? Yes No

Residency:

Name of Institution: _____ Dates Attended ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Program Director _____ Type /Specialty _____

Did you complete this program? Yes No

Fellowship:

Name of Institution: _____ Dates Attended ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Program Director _____ Type /Specialty _____

Did you complete this program? Yes No

ACADEMIC APPOINTMENT

Please list all Academic/Teaching Appointments held. Use additional page if needed.

Name of Institution: _____ Dates of Affiliation ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Department _____

Name of Institution: _____ Dates of Affiliation ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Department _____

Name of Institution: _____ Dates of Affiliation ___ / ___ to ___ / ___

Address _____ City _____ State _____ Zip _____

Department _____

LICENSURE & REGISTRATION

State Medical Licenses: Please list all past and present state medical licenses held. Use additional page if needed.

State	License #	Date Issued	Expiration Date	Status

State Narcotics Registration: Please list all past and present state narcotics registrations held. Use additional page if needed.

State	License #	Date Issued	Expiration Date	Status

Federal DEA Registration _____ Date Issued ___ / ___ / ___ Expiration Date ___ / ___ / ___

ECFMG# (Foreign medical graduates only.) _____ UPIN # _____ Please provide a copy of ECFMG certificate.

PROFESSIONAL REFERENCES

Please list three professional peers who can provide adequate information based on their **current knowledge of your professional qualifications, professional competency, and ethical character.** Do not include relatives.

Name _____ **Phone** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Name _____ **Phone** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Name _____ **Phone** _____

Address _____ **City** _____ **State** ____ **Zip** _____

CONTINUING MEDICAL EDUCATION

Please attach documentation of all primary continuing medical education credits received in the **past two years.** Please include any Medical Publication, Essays, Papers, etc. you may have completed.

ACTIONS OR PENDING ACTIONS - LICENSURE, CERTIFICATIONS, STAFF MEMBERSHIP, PRIVILEGES

Has any action or disciplinary action, including an investigation, challenge or focused review, ever been instituted, or is pending, which involves limitation, reduction, suspension, revocation, denial, probation, non-renewal, or voluntary/involuntary relinquishment by resignation or expiration of your (please circle the appropriate answer): If you answer "Yes" to any of the following questions, please give complete details on separate page.

- 1. License or Certificate to practice medicine or dentistry in any state or country? Yes No
- 2. Federal DEA, State or any other controlled substance registration? Yes No
- 3. Specialty Board Certification? Yes No
- 4. Participation in any private, federal or state health insurance program? Yes No
- 5. Medical Staff membership at any hospital, clinic, or other health care facility? Yes No
- 6. Medical Staff privileges at any hospital, clinic, or other health care facility? Yes No
- 7. Medical Staff status at any hospital, clinic, or other health care facility? Yes No
- 8. Have you every been convicted of or are you currently named in a criminal proceeding related to the practice of medicine? Yes No

PROFESSIONAL LIABILITY HISTORY

Please list all past and present professional liability carriers from the last 10 years - include insurance companies, hospitals, clinics, and employers, who have provided liability coverage. Use additional page, if needed.

Current Insurance Carrier _____ Policy Number _____
 (Name and Address of Carrier)

Amount of Coverage _____ Dates of Coverage ___/___/___ to ___/___/___

Previous Insurance Carrier _____ Policy Number _____
 (Name and Address of Carrier)

Amount of Coverage _____ Dates of Coverage ___/___/___ to ___/___/___

Do you participate in the Louisiana Patients' Compensation Fund? Yes No If yes, please attach copy.

Do you currently or have you ever carried retroactive (tail) professional liability insurance? Yes No
 If yes, please explain. Use separate sheet if necessary.

PROFESSIONAL LIABILITY ACTIONS

If you answer " Yes" to any of the following questions, please give complete details on separate page. Additional Information may be required if details are not sufficient.

- 1. Have you ever practiced medicine without liability coverage? Yes No
- 2. Has a Louisiana medical review panel ever rendered a decision that was adverse to you in any manner, or has a complaint of malpractice ever been instituted in any administrative body in any other state? Yes No
- 3. Have you ever been named as a defendant in a malpractice or professional liability suit? Yes No
- 4. Are any professional liability claims pending against you? Yes No
- 5. Have any judgments been taken against you or have any claims been settled by you or on your behalf? Yes No
- 6. Has a professional liability insurer ever denied you insurance, canceled a policy, refused to renew your policy, or placed limitations on the scope of your coverage? Yes No

Lane Regional Medical Center
CONSENT AND RELEASE

I, the undersigned, apply for appointment to the medical staff of Lane Regional Medical Center with the clinical privileges as requested above.

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of this hospital, I acknowledge that

- a. I have received, or been given access to, and read the by-laws of the hospital and the by-laws, rules and regulations of the medical staff and Board of this hospital.
- b. I am familiar with the principles and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be by the terms thereof if I am granted membership or clinical privileges.
- c. I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointments to the medical staff.
- d. I further agree to abide by such hospitals and staff rules and regulations as may be from time to time enacted.

By applying for appointments to the medical staff I hereby

- a. signify my willingness to appear for the interviews in regard to my application.
- b. authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals and institutions with which I have been associated 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 by the hospital, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information the hospital, or, its medical staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital and medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

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 will not participate in any form of fee-splitting. Moreover, I pledge myself

- a. to shun unwarranted publicity, dishonest money-seeking, and commercialism;
- b. to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others;
- c. to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient;
- d. to make my fees commensurate with the service rendered and with the patients rights;
- e. to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

I hereby agree to promptly advise and notify the Hospital in writing regarding any changes in the information given by me in this application:

I agree to immediately notify the Hospital of any changes in my health status that would affect my ability to perform the privileges requested, and will agree to submit to a health examination acceptable to the Executive/Bylaws Committee should this be considered necessary.

I agree to notify the Hospital within three (3) days of the occurrence of any changes in my staff membership at other institutions during the next two (2) years. Further, I agree to immediately notify the Hospital of any limitations, suspension, revocation or condition(s) of probation affecting my license to practice medicine or license to prescribe medication. I agree to notify the Hospital no later than thirty (30) days prior to any change in coverage limits or cancellation of my professional liability insurance.

A photocopy of this release shall be effective as the original when so presented. This release shall remain in full force and effect for a period of two (2) years from the date shown below.

I acknowledge receipt and notice of the following Penalty Statement regarding attestation to the final diagnosis for all Medicare/Champus patients, which acknowledgment is required under Federal law and regulations.

PENALTY STATEMENT

NOTICE TO PHYSICIANS: Medicare/Champus payments to hospitals is based in 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 law.

Signature of Applicant _____ Date _____

Printed Name of Applicant _____