

CHRISTUS CABRINI SURGERY CENTER

***APPLICATION FOR MEDICAL STAFF
MEMBERSHIP/PRIVILEGES***

Decisions regarding Medical Staff Appointment and clinical privileges are rendered based on the merits of the Applicant's credentials. Discriminatory practices based on age, gender, race, creed, religion, color, handicap or national origin, are not part of the decision-making process.

I WISH TO APPLY FOR THE FOLLOWING AT CHRISTUS CABRINI SURGERY CENTER LLC

MEDICAL STAFF MEMBERSHIP: _____ **CLINICAL PRIVILEGES:** _____

Please complete this form in its entirety, and attach your curriculum vitae, any other requested copies, and additional sheets, if there is insufficient space on this form to complete responses. The completed and signed application should be submitted to:
ADMINISTRATION, CHRISTUS CABRINI SURGERY CENTER LLC, 3436 Masonic Drive, Alexandria, LA 71301

Please note that an application shall be deemed complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall be incomplete if the need arises for new, additional or clarifying information at any time during the evaluation process, and any application that continues to be incomplete 90 days after date of receipt, shall be deemed withdrawn. It is the responsibility of the applicant to assure that the application is complete, including adequate responses from references.

PLEASE TYPE OR PRINT LEGIBLY.

I. PERSONAL INFORMATION:

Name in Full: _____

Current Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Social Security Number: _____ Date of Birth: _____ Place of Birth: _____

Citizenship: _____ and/or Visa Status: _____

Marital Status: _____ Spouse's Name: _____

ECFMG No. (if applicable): _____ UPIN #: _____ NPI #: _____

Email Address: _____

II. EDUCATIONAL INFORMATION:

School Name/Address	Major/Type	Degree Awarded	Dates Attended	Graduation Date
<i>Undergraduate</i>				
<i>Medical</i>				
<i>Other Graduate/Professional</i>				

Applicant's Name: _____

II. EDUCATIONAL INFORMATION (cont.)

GRADUATE MEDICAL TRAINING	Institution: Address: Internship Type: Dates Attended: Program Director:	Institution: Address: Internship Type: Dates Attended: Program Director:
RESIDENCIES	Institution: Address: Program Type: Dates Attended: Program Director:	Institution: Address: Program Type: Dates Attended: Program Director:
FELLOWSHIPS	Institution: Address: Program Type: Dates Attended: Program Director:	Institution: Address: Program Type: Dates Attended: Program Director:
PRECEPTORSHIPS	Institution: Address: Program Type: Dates Attended: Program Director:	Institution: Address: Program Type: Dates Attended: Program Director:

III. LICENSURE, REGISTRATIONS, BOARD CERTIFICATION & PROFESSIONAL MEMBERSHIP

List all current and past licensure, and specify type (M.D., D.O., D.D.S., D.M.D, D.P.M., Other). Submit a copy of current licensure if not forwarded with pre-application form.

STATE	TYPE	NUMBER	ISSUE DATE	EXPIRATION DATE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Federal DEA Registration:		_____	_____	_____
Louisiana Narcotics License:		_____	_____	_____

BOARD CERTIFICATION/ELIGIBILITY INFORMATION

BOARD NAME	DATE CERTIFIED	DATE RECERTIFIED	BOARD ELIGIBLE UNTIL (Please Give Date)

Applicant's Name: _____

IV. Submit the following in chronological order with most current information first. (Attach additional sheets if necessary)

ACADEMIC APPOINTMENTS	HOSPITAL AFFILIATIONS	PROFESSIONAL PRACTICE <i>(Solo, Partnership, Group, HMO, IPA, PPA)</i>
School Name Address Rank Inclusive Dates	Hospital Name Address Department/Service Department Chairperson Staff Category Inclusive Dates	Name of Practice Address Nature of Practice Inclusive Dates
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OTHER PROFESSIONAL ACTIVITIES

Please attach a current curriculum vitae to this application, including information on any professional society membership. In addition, please attach copies of CME certificates which apply to requested additional privileges.

V. PROFESSIONAL LIABILITY INSURANCE

Please submit your certificate of insurance, showing policy limits, any coverage limitations, and expiration date, if this information was not forwarded with your pre-application form.

Present Carrier:

_____		_____
<i>Name</i>		<i>Address</i>
_____		_____
<i>Expiration Date</i>		<i>Class of Coverage</i>
_____	_____	_____
<i>Agent Name</i>	<i>Agent Address</i>	<i>Agent Phone</i>

Prior Carriers:

<i>Name</i>	<i>Address</i>

1. Have there been *within the past two years*, any malpractice claims, suits, settlements, or arbitration proceedings *finalized* involving your professional practice? YES _____ NO _____
2. Have you ever been denied professional liability insurance or has your coverage been canceled, or has a surcharge been imposed based on your own claims experience? YES _____ NO _____
3. Has your present professional liability insurance carrier excluded any specific procedures from your insurance Coverage? YES _____ NO _____

If you answered "YES" to question #1, please provide, for each situation: (a) Date suit or claim was initiated; (b) Name and location of the court, and case number; (c) Names of parties involved; (d) A brief description of the nature of the claim; (e) current status of situation; (f) final judgment.

VI. HEALTH STATUS

Do you have any physical or mental limitations that might interfere with your ability to practice medicine within the requested privileges or would require an accommodation in order for you to exercise the privileges requested safely and competently?:
 YES _____ NO _____ *(If yes, please explain below)*

VII. DISCIPLINARY ACTIONS

Have any of the following ever been, or, are currently in the process of being, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished, or have you even voluntarily or involuntarily withdrawn, or failed to proceed with an application for any of the following before final decision by a hospital or board?
Please provide a full explanation on a separate sheet for any of the following that are answered in the affirmative.

- | | | |
|--|-----------|----------|
| Medical license in any state | YES _____ | NO _____ |
| Other professional registration/license | YES _____ | NO _____ |
| DEA/controlled substances registration | YES _____ | NO _____ |
| State controlled substances registration (Louisiana) | YES _____ | NO _____ |
| Academic Appointment | YES _____ | NO _____ |
| Membership on any hospital medical staff | YES _____ | NO _____ |
| Clinical privileges | YES _____ | NO _____ |
| Prerogatives/rights on any medical staff | YES _____ | NO _____ |
| Other institutional affiliation or status | YES _____ | NO _____ |
| Local/State or National professional society membership or Board certification | YES _____ | NO _____ |
| Any other type of professional sanction | YES _____ | NO _____ |
| Have there ever been any criminal charges (other than minor vehicle violations) brought against you? | YES _____ | NO _____ |

Applicant's Name: _____

VII. DISCIPLINARY ACTIONS - (cont.)

Have you ever been named as a defendant in a criminal action and/or convicted of a crime? YES ___ NO ___

Have you ever been convicted of a drug or alcohol related offense? YES ___ NO ___

To your knowledge, have you ever been the subject of an individual focused review required by PRO, or a similar agency? YES ___ NO ___

To your knowledge, has an action report on you ever been made to the National Practitioner Data Bank? YES ___ NO ___

VIII. REFERENCES

Please provide the names and complete addresses of at least four actively practicing physicians (one or more must be a peer practicing the same specialty), who have had extensive experience in observing and working with you and who can provide adequate information regarding your present professional competence, judgement, clinical and/or technical skills and ethical character. References should exclude colleagues that are current or future associates, family members or recently initiated, or impending professional partnership/financial associates.

NAME	ADDRESS	PHONE
1.		
2.		
3.		
4.		

IX. MEDICAL STAFF SECTION REQUESTED

Please indicate the Section in which you are requesting membership appointment.

- ___ Surgery ___ Anesthesiology ___ Gastroenterology
- ___ Gynecology ___ Podiatry ___ Oral Surgery
- ___ Pathology ___ Otolaryngology ___ Ophthalmology

COVERAGE ASSIGNMENT

I have made arrangements for coverage of my patients at Christus Cabrini Surgery Center.

YES ___ NO ___

NAME: _____ ADDRESS: _____

Applicant's Name: _____

STAFF CATEGORY REQUESTED

Please indicate below the medical staff membership category your seek. All medical staff appointees are assigned as associate staff members for a provisional period of at least one (1) year, or longer if deemed necessary.

_____ Active The Active Medical Staff shall have unlimited admissions, be located closely enough to the hospital to provide continuous care to their patients, assume all the functions and responsibilities of the active medical staff, including, where appropriate, emergency service care and consultation assignments. Active medical staff appointees shall be assigned to a specific department, shall be eligible to vote, to hold office and to serve on medical staff committees, and shall be encouraged to attend medical staff meetings. The active staff may include non-admitting physicians such as Anesthesiologists, and Pathologists.

_____ Courtesy The Courtesy Medical Staff shall consist of physicians qualified for staff appointment but (1) who only occasionally admit patients to the Center or (2) who act only as consultants or (3) who have limited privileges. Courtesy medical staff appointees shall be assigned to a specific department but shall not be eligible to vote or hold office, and are limited to the admission or treatment of twelve (12) outpatients per year at Christus Cabrini Surgery Center.

_____ Affiliate The Affiliate Medical Staff shall consist of physicians who hold active state licenses and are associated with CCSC, but who do not attend patients nor intend to establish a practice at the Center. The affiliate staff member will be permitted to use the Center services for their patients by making direct referral of patients to an active member of the Medical Staff for admission, evaluation and/or care treatment. The affiliate medical staff member may visit their patients at the Center, but must have approval from the attending physician prior to reviewing the patient's medical records. The affiliate staff member shall not be permitted to admit, attend, consult, write orders or progress notes, or hold clinical privileges. They shall not be eligible to vote, hold office or serve on any Center committee. An individual is not entitled to the procedural rights set forth in the Medical Staff Bylaws because a request for Affiliate Staff is refused.

APPLICANT CONSENT AND RELEASE

In making application for appointment to the medical staff of CHRISTUS CABRINI SURGERY CENTER, I hereby agree to abide by all policies of the Center, including all Bylaws and Rules and Regulations of the Medical Staff, and the Ethical and Religious Directives for Catholic Health Care Facilities. I agree to cooperate in maintaining accreditation by the JCAHO, to provide for continuous care for my patients, to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned, and to use the Center and its equipment sufficiently to allow the Center, through assessment by appropriate medical staff committees and section chairpersons, to evaluate my current competence. I agree to be interviewed by the medical staff or Center representatives in connection with this application, to permit medical staff and Center representatives to consult with prior associates and others and to inspect all records and documents that may be pertinent to this application, to provide, with or without request, new or updated information pertinent to this application, to permit medical staff and Center representatives to release to other health care organizations and professional organizations information that may be material in connection with membership and clinical privileges, to permit inquiries into my physical, intellectual, and emotional health, submit any reasonable evidence of current health status that may be requested by the Medical Executive Committee, to exhaust internal administrative remedies before pursuing litigation in the event of adverse decision regarding my appointment or scope of clinical privileges, to acknowledge any provisions in the Medical Staff and Center bylaws for release and immunity from all liability, and I release from liability all who in good faith and without malice act on or provide information regarding my application. I acknowledge the requirement of Christus Cabrini Surgery Center to query the National Practitioner Data Bank. I understand that significant misstatements in, or omissions from this application form, whether intentional or not, may constitute cause for denial of appointment and/or clinical privileges. I further acknowledge that in the event discovery of misrepresentation, misstatement or omission of information pertinent to my application occurs after appointment and/or clinical privileges have been granted, such discovery may result in summary dismissal from the medical staff. I agree to abide by the OSHA Blood Borne Pathogen guidelines as set forth in the Exposure Control Plan. I do hereby certify that I have no physical, mental or substance abuse impairment that would prohibit me from carrying out any of the privileges I have requested. I hereby certify that I have received and reviewed the CCSC Medical Staff By-Laws, Rules and Regulations.

Signature

Date

FOR OFFICE USE ONLY

This application was reviewed and the following, has been recommended by the Credentials Committee/Medical Executive Committee:

Medical Executive Chairman

Date

Governing Board Chairman

Date

_____ **ASSOCIATE MEDICAL STAFF MEMBERSHIP** (Pending Advancement To)
_____ Active Staff _____ Courtesy Staff

_____ **CLINICAL PRIVILEGES IN** _____
WITH LIMITATION OF _____

The recommendation(s) noted above, were approved by the Local Governing Board on:

Date

Secretary, Local Governing Board