

APPLICATION FOR APPOINTMENT

MEDICAL CARE ASSISTANT

Medical Care Assistants are physician sponsored/employed Allied Health staff who are deemed competent in their specific area of practice, and are recommended for specific scope of practice, with the provision that all such scopes of practice are within the limits established by Christus Cabrini Surgery Center, and consistent with state practice acts. Decisions regarding appointment and clinical privileges are rendered based on the merits of the applicant's credentials. Discriminatory practices based on gender, race, creed, religion, handicap and/or national origin are not part of the decision-making process.

Please complete this form in its entirety, and attach additional sheets when additional space is needed for a complete response. Completed applications should be returned to the following address:

*Christus Cabrini Surgery Center LLC
Administration Office
3436 Masonic Drive
Alexandria, LA 71301*

PLEASE TYPE OR PRINT LEGIBLY.

PERSONAL INFORMATION:

Name in Full: _____

Residence Address: _____ Phone: _____

Office Address: _____ Phone: _____
Street City/State ZipCode Street City/State ZipCode

Fax Number: _____ Beeper Number: _____

Social Security Number: _____ Date of Birth: _____

Email Address: _____

Please list the name, address and phone number of all employing physicians.

PHYSICIAN NAME	ADDRESS	PHONE

EDUCATIONAL INFORMATION:

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

LICENSURE INFORMATION:

Are you licensed or certified Yes ___ No ___

Type of license/certification _____

Registration/license number: _____ State _____

List Any Other Licenses: _____

Is your License, Registration or Certification
Current (*Please attach a copy of current license*) Yes ___ No ___

GENERAL INFORMATION:

A. Disciplinary Actions: Have any of the following been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, or not renewed? Or have you voluntarily relinquished, withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action, for non-adverse reasons, or to preclude an investigation, or while under investigation relating to professional conduct? *If the answer to any of the following questions is YES, please provide full explanation, including resolutions of occurrence on a separate sheet and attach.*

License(s) for practice in any state Yes ___ No ___
Other health related professional registration/license Yes ___ No ___
Any other type of professional sanction Yes ___ No ___

Have you been convicted of, or pleaded no contest to any criminal charges, (other than motor vehicle speeding violations) brought against you? Yes ___ No ___

Have you been convicted of, or pleaded no contest to a drug or alcohol related offense? Yes ___ No ___

Have any disciplinary actions or investigations by any state licensing board been initiated against you? Yes ___ No ___

GENERAL INFORMATION - (continued)

B. Christus Cabrini Surgery Center Requirements for Professional Liability Coverage

**Christus Cabrini Surgery Center REQUIREMENTS
FOR PROFESSIONAL LIABILITY COVERAGE**
**SPECIFY PROFESSIONAL PERSONNEL UNDER CONTRACT BE HEREBY REQUIRED
TO CARRY, (1) PROFESSIONAL LIABILITY INSURANCE OR EVIDENCE OF PERSONAL
FINANCIAL RESPONSIBILITY IN THE AMOUNT TO BE NO LESS THAN THAT
REQUIRED BY THE LPCF (\$100,000/\$300,000) AND (2) MEMBERSHIP IN THE LPCF.**

Do you have Active Professional Liability Insurance, or are you covered under your physician employer's Professional Liability Insurance? *(Please provide documented evidence of coverage)* Yes____ No____

Has your professional liability insurance carrier and/or the amount of professional liability insurance changed recently? Yes____ No____

Name and Address of Carrier: _____

Limits of Professional Liability Insurance: _____

If the answer to any of the questions below is **YES**, please provide a full explanation of the details on a separate sheet and attach. *If the answer to Question #3 is YES, your explanation should include the following information: (a) date suit or claim was initiated; (b) brief description of the nature of the claim; and (c) current status, including the substance of the findings in each action that has been concluded and the amount of any final judgements or settlements made.*

1. Have you been denied professional liability insurance, or has your coverage been cancelled or has a surcharge been imposed based on your own claims experience? Yes____ No____

2. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? Yes____ No____

3. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional position? Yes____ No____

C. Medical Care Assistant Appointments: Please answer each of the following questions in full. *If the answer to any question is YES, please provide a full explanation of the details, including current status on a separate sheet and attach to your application.*

1. Have you applied for appointment to the Allied Health Professional staff of any other hospital(s)? Yes____ No____

Hospital(s): _____

Status of application(s): _____

GENERAL INFORMATION (continued)

2. Have you been appointed to the Allied Health Professional staff of any other hospital(s)? Yes____ No____

Hospital(s):_____

Status of application(s):_____

3. Have you resigned from the Allied Health Professional staff of any other hospital or institution? Yes____ No____

4. Has your application for appointment to the Allied Health Professional staff of any other hospital(s) been denied? Yes____ No____

5. Has your Allied Health membership been voluntarily or involuntarily limited or reduced, or a loss of clinical privileges resulted at any other hospital(s) Yes____ No____

6. Has the nature or scope of your clinical privileges changed at any other hospital or institution? Yes____ No____

7. Please list all current hospital affiliations

HOSPITAL	ALLIED HEALTH CATEGORY	DATES OF AFFIATION

8. Please list previous work experience:

EMPLOYER	POSITION HELD	DATES OF SERVICE

REFERENCES: (PEERS in the same field that you are applying for privileges)

REFERENCE NAME	ADDRESS

HEALTH STATUS:

Do you have any physical or mental limitations that might interfere with your ability to practice the prerogatives you have requested: Yes_____ No_____. *(If yes, please explain on a separate sheet)*

Please furnish the date of your last physical examination:_____

Significant Findings:_____

CONTINUING EDUCATION:

List any continuing education sessions that you have completed in the last two years. *(Please attach copies of certificates received)*

Attendance Dates	Subject or Title of Program	CME Hours	Sponsored By

SCOPE OF SERVICE:

Please complete the attached Scope of Service form.

All requests for additional clinical privileges must be submitted to the Credentials Committee, accompanied by documentation of recent training or experience.

