



APPLICATION FOR APPOINTMENT TO THE ALLIED HEALTH STAFF

General Instructions: Application must be typed or legibly printed in ink.
Where requested, and when there is insufficient space to complete your response, attach additional sheets.

IDENTIFYING INFORMATION	Last Name	First Name	Initial	Date of Birth	Social Security No.	
	Residence Address		City	State	Zip	Home Telephone ()
	Office Address		City	State	Zip	Office Telephone ()
	Citizenship	If not a citizen of the U.S., state status of Visa		Expiration Date	Office Fax Number ()	
	Place of Birth	Office Manager or Credentialing Person		Phone Number ()	Fax Number ()	
	List all names under which you were enrolled, licensed, etc.			Language(s) Spoken in Addition to English		
	Sponsoring Physician			Physician's Specialty		
EDUCATION Use additional sheet, if necessary.	LIST IN CHRONOLOGICAL ORDER. IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET.					
	College or University			Degree	Honors	
	Street		City	State	Zip	Date of Graduation
	College or University			Degree	Honors	
	Street		City	State	Zip	Date of Graduation
	College or University			Degree	Honors	
	Street		City	State	Zip	Date of Graduation
CONTINUING EDUCATION	On a separate sheet, list additional continuing education obtained in the past two years specifically related to prerogatives requested.					
AFFILIATIONS	List all present and previous affiliations with health care facilities in chronological order. Include assistantships, appointments and military experience. (Use additional sheet, if necessary.)					
	Facility (Full name)		Staff Category			
	Street		City	State	Zip	Dates
	Facility (Full name)		Staff Category			
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Street		City	State	Zip	Dates	

	Facility (Full name)		Staff Category		
	Street	City	State	Zip	Dates
CERTIFICATION	If Certified, State Name of Certifying Agency		Type of Certification		Date
	ACLS Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, exp. Date	BCLS Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, exp. Date	CPR Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSING	State License/Certification Number:			Date Issued:	Date Expires:
	List all past and present State Licenses/Certifications in chronological order (use additional space if necessary):				
	State Name	Profession	License Number	Expiration Date	Active? <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
LIABILITY INSURANCE	Insurance Carrier	Amount of Coverage		Expiration Date	Policy No.
	Agent (Full Name and Address)				
	Prior Carriers				
	If either of the following is answered in the affirmative, provide full explanation on a separate sheet.				
	During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements, judgments, or arbitration proceedings involving your professional practice? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever been denied Professional Liability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
DISCIPLINARY ACTIONS	Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, modified, not renewed, voluntarily or involuntarily relinquished? If Yes, please provide full explanation on a separate sheet.				
	All questions must be answered.	License in any state			
	Other professional registration/license				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Academic appointment				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Managed care organization, i.e., HMO, PPO, IPA, etc.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Membership on any hospital Medical Staff				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Practice Prerogatives				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Prerogatives/rights on any Medical Staff				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other institutional affiliation or status				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Professional society membership or fellowship/Board certification				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Professional office				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Medicare, Medicaid, or other private, federal or state health insurance program				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Driver's License				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Any other type of professional sanction, investigation, hearing, etc.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been convicted of any crime, whether it be classified as a felony or misdemeanor, other than a minor traffic violation? If yes, please provide full explanation on separate sheet.				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever discontinued practice for any reason (other than for routine vacation, formal education/training) for 30 days or more?				<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH STATUS	If any of the following is answered in the affirmative, provide full explanation on a separate sheet (except for #2).	
	1. Are you presently taking medications or other substances that could impair your ability to provide patient care services for which you are seeking Practice Prerogatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Are you able to perform, with or without accommodation, all of the essential functions, both physical and mental, necessary to provide patient care services for which you are seeking Practice Prerogatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. In the past 3 years, have you had a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or Medical Staff duties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. During the past 3 years, have you used illegal drugs or illegally used prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Are you currently in a rehab program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
PROFESSIONAL REFERENCES	Name two peers (in the same profession) who have personal knowledge of your current prerogative competencies, ethical character, health, status and ability to work cooperatively with others. Do not include sponsoring physician(s). The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time.	
	Name and Address	Telephone ()
	Name and Address	Telephone ()

STATEMENT OF SPONSORING PHYSICIAN

I hereby verify that _____ will be sponsored by me. He/she will be under my direction at all times and I agree to assume full responsibility for his/her actions in dealing with my patients at HEALTHSOUTH. I also agree to notify the facility if this person should ever leave my employment.

Signature _____ **Date** _____

1. Please attach current copies of the following:
 - a. State License/Certificate
 - b. Certificate of malpractice liability showing current malpractice insurance in an amount not less than \$1 million/\$3 million.
 - c. Small photograph
2. The application must be signed by the applicant before we can begin processing the application.
3. The Medical Staff Bylaws require verification of malpractice insurance and lawsuit history. Please only sign the authorization form attached to the application - leave the middle section of the form blank.
4. Return the application and requested documents to -

**HEALTHSOUTH Rehabilitation Hospital
7000 Jefferson NE
Albuquerque, NM 87109**

MEDICAL STAFF SERVICES

**APPLICANT'S ACKNOWLEDGMENT
MEDICAL STAFF**

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 Allied Health Professional 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 Allied Health Professional Staff of this facility, I acknowledge that I have received, read and been oriented to the by-laws, rules and regulations of the Medical Staff of this facility, and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms thereof if I am granted membership or Practice Prerogatives, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or Practice Prerogatives in all matters relating to the consideration of my application for appointment to the Allied Health Professional Staff. I further agree to abide by such facility and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the Allied Health Professional Staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the facility, its Medical Staff and their representatives to consult with administrators and members of Medical Staffs of other facilities or 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 facility, its Medical Staff and its representatives, of records and documents, including medical records at other facilities, that may be material to an evaluation of my professional qualifications and competence to carry out the Practice Prerogatives requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the facility and its Medical Staff for their acts performed in good faith, without malice, in connection with evaluating my application, credentials and qualifications. I further hereby release from liability any and all individuals and organizations who provide information to the facility or its Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and Practice Prerogatives. I hereby consent to the release of all such information.

I hereby further authorize and consent to the release of information by this facility or its Medical Staff to other facilities, medical associations and other interested persons regarding any information the facility and the 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 facility and its staff for so doing.

I understand and agree that I, as an applicant for Allied Health Professional 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. Upon request by the facility, I agree to submit to a medical and/or psychological examination and to take a drug-screening test.

I have not requested Prerogatives for any procedures for which I am not certified or qualified. 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 Prerogatives.

Signature of Applicant

Date

Applicant's Printed Name



Date

RE: _____

Dear Sir/Madam:

The above referenced practitioner is applying for Medical Staff membership and/or clinical privileges at HEALTHSOUTH and has indicated your company as his/her insurance carrier for professional liability.

Would you be kind enough to verify the malpractice professional liability insurance coverage and lawsuit history? Please enclose a current certificate of insurance. Below is the applicant's statement authorizing us to obtain this information.

Thank you for your prompt response.

Sincerely,

Medical Staff Coordinator/Administrator

To be completed by the Insurance Company

Name of Applicant: _____ Specialty: _____

Date of initial policy with your company: _____

Insurance classification: _____

Have there been any malpractice actions against this individual during the past five years? Yes No

If yes, please give the nature of the action(s) _____

Have there been any settlements? Yes No If yes, explain _____

Have there been any judgments? Yes No If yes, explain _____

Completed by _____ Date _____

Title _____

I hereby authorize _____ to issue a lawsuit history report concerning
(Insurance Company)

information on past or pending lawsuits and a certificate of current insurance.

Practitioner Signature

Date

**MEDICARE ATTESTATION ACKNOWLEDGEMENT STATEMENT
NOTICE TO PHYSICIANS**

“Medicare payment 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 funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

I, _____, the undersigned, acknowledge having received the
(Print or type name) above notice.

(Legal Signature)

(Date)

(Legal signature means that which you would normally use on documents such as a will, checks, etc.
Initials are not acceptable.)