



APPLICATION FOR REAPPOINTMENT TO THE ALLIED HEALTH STAFF

DATE SENT: _____

Do you wish to reapply for Allied Health Staff membership and practice prerogatives at HealthSouth? Yes No
 IF "NO", do not complete this application. Sign and return to HealthSouth to discontinue your prerogatives.

Signature

Date

If "YES", please complete the rest of the application.

IDENTIFYING INFORMATION	Last Name	First Name	Initial	Date of Birth	Telephone ()	
	Residence Address		City	State	Zip	Office Telephone ()
	Office Address		City	State	Zip	Office Fax Number ()
	E-Mail Address			Office Manager		
	Sponsoring Physician			Physician's Specialty		
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		
	Street		City	State	Zip	Dates
	Facility (Full name)			Staff Category		
	Street		City	State	Zip	Dates
	Facility (Full name)			Staff Category		
	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	If yes, exp. date
	State License/Certification Number:			Date Issued:	Date Expires:	
LICENSING	List all past and present State Licenses/Certifications in chronological order (use additional space if necessary):					
	State Name	Profession	License Number	Expiration Date	Active?	Unlimited?
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

			<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.
	Prior Carriers, in the past two years.			
	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 All questions must be answered.	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.			
	License in any state			<input type="checkbox"/> Yes <input type="checkbox"/> No
	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 the answer is "no", provide full explanation on a separate sheet.			
	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
PROFESSIONAL REFERENCES	Name two individuals who are peers and who have personal knowledge of your current prerogative competencies, character, health status, and ability to work cooperatively with others not to 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 continue to 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 _____

**APPLICANT'S ACKNOWLEDGMENT
ALLIED HEALTH STAFF**

In applying for reappointment to the Allied Health Staff of HEALTHSOUTH, I certify that I am in good health, and have the physical and mental capabilities to carry out my duties and responsibilities as a member of the Allied Health Staff of HEALTHSOUTH. I agree that I will at all times abide by the Bylaws, Rules & Regulations of the Medical Staff. All information submitted by me in this application is true to the best of my knowledge and belief. In consideration of the Facility, I hereby release from any and all liability all representatives of the Facility and Medical Staff for any and all of their acts or statements at any time performed or communicated in good faith and without malice in connection with evaluating this application and my credentials and qualifications, and I hereby release from liability to the same extent 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, reappointment of 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 Facility, or its Medical Staff, to other interested persons on request regarding any information the Facility 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 Facility and Medical Staff for so doing. I further agree to report any changes in health status that would impact my ability to practice my profession at HEALTHSOUTH, and will submit to a medical and/or psychological examination deemed acceptable by the Medical Executive Committee. I will also maintain confidentiality of all information discussed in any committees for which I am a member or participant.

Signature

Date

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.)