

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

- Please specify Medical Staff Category desired:**
- Admitting** – Physicians who regularly admit and attend to patients in the Rehab; have the rights and responsibilities as defined in the Bylaws, to include voting and committee participation.
 - Consulting Active** – Physicians who regularly provide consultative services and desire to regularly participate in the operational processes of the facility, to include voting and committee participation.
 - Consulting Only** – Physicians who desire to only provide consultative services without the rights and responsibilities of active physicians.

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	Telephone ()	
	Citizenship	Place of Birth	List all names used for licensing, enrollment				Office Fax Number ()	
	Office Manager or Credentialing Contact			Phone Number		Fax Number	NPI Number	
	Pager/Beeper #			E-mail Address			UPIN Number	
	ECFMG Number			Languages Spoken in Addition to English			Answering Service #	
	DESCRIPTION OF CURRENT PRACTICE	Clinical Specialty/Subspecialty					Practice Name	
Practicing with Whom and Nature of Affiliation:					Name(s) of Covering Physicians			
PREMEDICAL EDUCATION	College or University					Degree		Honors
	Street			City	State	Zip	Date of Graduation	
MEDICAL EDUCATION	College or University					Degree		Honors
	Street			City	State	Zip	Date of Graduation	
INTERNSHIPS RESIDENCIES, FELLOWSHIPS PRECEPTORSHIPS	LIST IN CHRONOLOGICAL ORDER. IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET.							
	Internship (Institution name)				Phone Number ()		Fax Number ()	
	Street			City	State	Zip	Dates	
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)						
	Residency (Institution name)				Phone Number ()		Fax Number ()	
	Street			City	State	Zip	Dates	
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)						
	Residency (Institution name)				Phone Number ()		Fax Number ()	
	Street			City	State	Zip	Dates	
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)						

	Fellowship (Institution name)		Phone Number ()	Fax Number ()
	Street	City	State	Zip
	Dates			
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)			
TEACHING APPOINTMENTS	LIST IN CHRONOLOGICAL ORDER. IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET.			
	Facility (Full name)		Phone Number ()	Fax Number ()
	Street	City	State	Zip
	Dates			
	Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)		
	Facility (Full name)		Phone Number ()	Fax Number ()
	Street	City	State	Zip
Dates				
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)			
CONTINUING MEDICAL EDUCATION	ON A SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES THAT YOU HAVE ATTENDED OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWO YEARS RELATED TO THE CLINICAL PRIVILEGES REQUESTED.			
AFFILIATIONS (Medical Staff Memberships at Hospitals, etc)	LIST ALL PRESENT AND PREVIOUS AFFILIATIONS WITH HEALTH CARE FACILITIES, IN CHRONOLOGICAL ORDER. Include assistantships, appointments and military experience. If more space is needed, attach additional sheet.			
	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				
BOARD CERTIFICATION	If Board Certified, State Name of Board		Initial Certification Date	Most Recent Recertification Date
	If Board Certified by secondary board, state name of board		Initial Certification Date	Most Recent Recertification Date
	If not certified, give present status.			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If no, do you intend to apply for examination?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you been accepted to take the certification examination?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been examined by any specialty board, but failed to pass? If yes, please provide details.				

LICENSING	State Medical License Number:		Date Issued:	Date Expires:	Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	LIST ALL PAST AND PRESENT STATE LICENSES/CERTIFICATIONS IN CHRONOLOGICAL ORDER.					
	State Name	License Number	Expiration Date	Active? <input type="checkbox"/> Yes <input type="checkbox"/> No	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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	State Controlled Substance Certificate, if applicable		Expiration Date:			
	Drug Enforcement Administration Number		Expiration Date:			
LIABILITY INSURANCE	Insurance Carrier	Amount of Coverage	Expiration Date	Policy No.		
	Agent (Full Name and Address)		Type of Coverage <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence			
	Prior Carriers (Use additional sheet if necessary)					
	<p>If either of the following is answered in the affirmative, provide full explanation on a separate sheet.</p> <p>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</p> <p>Have you ever been denied Professional Liability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
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	Medical license in any state				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Other professional registration/license				<input type="checkbox"/> Yes <input type="checkbox"/> No
		DEA Registration				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Academic appointment				<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
		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
		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
		Driver's License				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Clinical Privileges				<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 there been any felony criminal charges brought against you in the last 5 years? If yes, please provide full explanation on separate sheet, including resolution of charges.				<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		
Have you ever entered into an Asset Purchase or other agreement with the Hospital, or any of its Affiliates, subsidiaries or parent in which you agree not to refer any patients to it?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
HEALTH STATUS	IF ANY OF THE FOLLOWING IS ANSWERED IN THE AFFIRMATIVE, PROVIDE FULL EXPLANATION.					
	1. Are you able to perform, with or without accommodation, all of the essential functions, both medical and mental, necessary to provide patient care services for which you are seeking Clinical Privileges?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	2. Are you presently taking medications or other substances that could impair your ability to provide patient care services for which you are seeking Clinical Privileges?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
	3. In the past three years, have you had a physical or mental health condition, including alcohol or drug dependence, or have you participated in a drug, alcohol or similar rehabilitation program, that affects or is reasonably likely to affect your ability to perform professional duties?		<input type="checkbox"/> Yes <input type="checkbox"/> No			

	4. During the past three years, have you used illegal drugs or illegally used prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Are you currently engaged in any rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No
	6. Do you have a physical or mental condition that could affect your ability to exercise those privileges safely and competently? <input type="checkbox"/> Yes <input type="checkbox"/> No
PEER REFERENCES	Name two individuals who are peers <i>in the same specialty</i> , other than family or affiliated by marriage, who have personal knowledge of your recent professional performance, ethical character, current competence, current health status, and ability to work cooperatively with others. 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 ()

DO NOT write in "see attached" or "see resume or CV". All sections must be completed by the applicant or else will be considered incomplete. Incomplete applications cannot be processed.

1. Please attach current copies of the following:
 - a. State Medical License
 - b. State Controlled Substance Certificate, if applicable
 - c. Federal DEA Certificate
 - d. Certificate of malpractice liability showing current malpractice insurance in an amount not less than \$1 million/\$3 million.
 - e. 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

Expect a time period of 8-12 weeks for action by the HealthSouth Governing Body. During this time your application will be reviewed by the Medical Director, forwarded to the Medical Executive Committee and transmitted to the Governing Body for final approval. You can expedite this process by returning a completed application along with the requested documents.

Should you have any questions, please contact, Heather Podolan, Administrative Assistant to the CEO, at 505/344-9478 between the hours of 7:30 a.m. and 4:30p.m. Monday through Friday.

Thank you.

APPLICANT'S ACKNOWLEDGMENT

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

In making this application for appointment to the facility, I acknowledge that I have received, read and been oriented to the by-laws, rules and regulations 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 clinical privileges, and 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 appointment. 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 Medical 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 clinical privileges 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 clinical privileges. 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 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. 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 privileges 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 privileges.

As required to make my appointment to the Medical Staff effective, I agree that I will at all times:

- a. Provide continuous medical care and supervision to all patients within the Facility for whom I am responsible;
- b. Abide by all the Bylaws, policies and directives of the Facility applicable to me, including the bylaws, policies, rules and regulations of the Medical Staff and its programs, as shall be in force from time to time during the term of my appointment to the Medical Staff;
- c. Accept committee assignments and such other reasonable duties and responsibilities as may be assigned to me by the applicable authorities of the Governing Body and the Medical Staff;
- d. Abide by generally recognized principles of medical and professional ethics;
- e. Refrain from delegating responsibility for diagnosis or care of facility patients to a medical, dental, or other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;
- f. Seek consultation whenever necessary;
- g. Immediately inform your office of any change made or proposed in the status of my license to practice, DEA, or controlled substances registration, professional liability insurance coverage, and membership or clinical privileges at other institutions, and on the status of current or initiation of new malpractice claims;
- h. Participate in facility Medical Staff Orientation; and
- i. Maintain confidentiality of all information discussed in any committees for which I am a member or participant.

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.)