



APPLICATION FOR REAPPOINTMENT TO THE MEDICAL STAFF

Please complete this reappointment application and return to Medical Staff Services. Please do not return until all questions are answered completely and appropriate attachments are enclosed.

Do you wish to reapply for Medical Staff membership and clinical privileges at HealthSouth? Yes No

IF "NO", do not complete this application. Sign and return to HealthSouth to discontinue your staff privileges.

Signature

Date

If "YES", please indicate staff category and complete rest of application.

- 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 only desire to provide consultative services without the rights and responsibilities of active physicians.

IDENTIFYING INFORMATION	Last Name	First Name	Initial	Date of Birth	Office Fax Number	
	Office Address		City	State	Zip	Telephone
	Specialty			Office Manager or Credentialing Contact		Contact Number ()
	Name of Group Practice			E-mail Address		NPI Number
	Name(s) of Physicians in your Group			Name(s) of Covering Physicians		
CONTINUING MEDICAL EDUCATION	On a separate sheet, list all educational (CME) activities that you have attended or for which you have received credit since your last appointment, specifically those related to the clinical privileges granted at this facility.					
AFFILIATIONS	List all present affiliations with health care facilities. If more space is needed, attach additional sheet.					
(Medical Staff memberships at Hospitals, etc)	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	
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	Street	City	State	Zip	Dates	
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	Street	City	State	Zip	Dates	
BOARD CERTIFICATION	If Board Certified, State Name of Board		Initial Certification Date		Last Recert Date	
	If Board Certified by secondary board, state name of board		Initial Certification Date		Last Recert Date	
LICENSING	State Medical License Number:		Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No		Exp. Date:	
	LIST ALL PAST AND PRESENT STATE LICENSES/CERTIFICATIONS IN CHRONOLOGICAL ORDER.					
	State Name	License Number	Exp. 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	
					Exp. Date:	
	Drug Enforcement Administration Number:				Exp. Date:	
LIABILITY INSURANCE	Insurance Carrier	Amount of Coverage	Policy No.		Exp. Date:	
	If you have had any other malpractice carriers in the past two years, please provide additional information on a separate sheet.					
	If either of the following is answered in the affirmative, provide full explanation on a separate sheet.					
	During the past 2 years, have there been, or are there currently pending, any malpractice claims suits, settlements, judgments, or arbitration proceedings involving your professional practice?				No <input type="checkbox"/> Yes <input type="checkbox"/>	
	If yes, please complete the attached claims form.					
	Does your current liability insurance policy cover you for the privileges you have requested?				No <input type="checkbox"/> Yes <input type="checkbox"/>	
DISCIPLINARY ACTIONS	In the past two years, have any of the following 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/State controlled substance 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 sanction			<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 2 years?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, please provide full explanation on separate sheet, including resolution of charges.				
Have you discontinued practice for any reason (other than for routine vacation, formal education/training) for 30 days or more in the last two years?			<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	<p>If any of the following is answered in the affirmative, provide full explanation on a separate sheet.</p> <p>1. 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 Clinical Privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is there any additional information which may possibly influence your appointment to the Medical Staff of HealthSouth relating to the performance of your medical duties or reflect unfavorably upon your ability to interact with patients, hospital staff or other members of the Medical Staff? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
PEER REFERENCES	<p>Name two individuals who are peers in the same specialty, 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.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Name and Address</td> <td style="width: 30%;">Telephone</td> </tr> <tr> <td> </td> <td>()</td> </tr> <tr> <td>Name and Address</td> <td>Telephone</td> </tr> <tr> <td> </td> <td>()</td> </tr> </table>	Name and Address	Telephone		()	Name and Address	Telephone		()
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APPLICANT'S ACKNOWLEDGMENT

In applying for reappointment to the Medical 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 Medical 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 medical/dental/podiatric associations and 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.)