



NON-PHYSICIAN PROVIDER

APPLICATION

NAME: _____

PROFESSIONAL SCHOOL

1. _____
Undergraduate School Major/Program

Address City State Zip

Degree Awarded Date of Graduation

2. _____
Graduate School Major/Program

Address City State Zip

Degree Awarded Date of Graduation

3. _____
Additional Education Major/Program

Address City State Zip

Degree Awarded Date of Graduation

TIME INTERVALS

Explain any time intervals not accounted for.

Suspended from Practice _____ From _____ To _____

Loss of License _____ From _____ To _____

Served in Military _____ From _____ To _____

Personal Leave _____ From _____ To _____

Other _____ From _____ To _____

PROFESSIONAL REFERENCES

List three professional references, preferably from your specialty area, not including relatives. **NOTE: The first reference must be from your current supervisor or most recent supervisor.** The other two must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

1. _____
Current Supervisor/Most Recent Supervisor Title/Relationship Telephone Number

Address City State Zip Fax Number

2. _____
Current Supervisor/Most Recent Supervisor Title/Relationship Telephone Number

Address City State Zip Fax Number

3. _____
Current Supervisor/Most Recent Supervisor Title/Relationship Telephone Number

Address City State Zip Fax Number

CHRONOLOGY/EMPLOYMENT, HOSPITAL AFFILIATIONS AND PRACTICE HISTORY

List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous work experience during the past ten years. This includes hospitals, ambulatory facilities, residential treatment and rehabilitation centers, surgery centers, institutions, corporations, military assignments, or government agencies. This history should include self-employment. If more space is needed, attach additional sheets(s). **A CURRICULUM VITAE (CV) IS NOT SUFFICIENT AS REPLACEMENT FOR THIS SECTION.**

1.

Current Employer/Practice			Contact Name	
Address	City	State	Zip	Telephone Number
Dates: From		To	Position Held/Title	
Did this employer provide Professional Liability Insurance on your behalf?			• Yes • No	
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)		Type of Coverage	Exclusions form Coverage	
Initial Date of Coverage		Retroactive Date of Coverage	Expiration Date	

2.

Current Employer/Practice			Contact Name	
Address	City	State	Zip	Telephone Number
Dates: From		To	Position Held/Title	
Did this employer provide Professional Liability Insurance on your behalf?			• Yes • No	
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)		Type of Coverage	Exclusions form Coverage	
Initial Date of Coverage		Retroactive Date of Coverage	Expiration Date	

3.

Current Employer/Practice			Contact Name	
Address	City	State	Zip	Telephone Number
Dates: From	To	Position Held/Title		
Did this employer provide Professional Liability Insurance on your behalf?			• Yes • No	
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)	Type of Coverage	Exclusions form Coverage		
Initial Date of Coverage	Retroactive Date of Coverage	Expiration Date		

4.

Current Employer/Practice			Contact Name	
Address	City	State	Zip	Telephone Number
Dates: From	To	Position Held/Title		
Did this employer provide Professional Liability Insurance on your behalf?			• Yes • No	
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)	Type of Coverage	Exclusions form Coverage		
Initial Date of Coverage	Retroactive Date of Coverage	Expiration Date		

5.

Current Employer/Practice			Contact Name	
Address	City	State	Zip	Telephone Number
Dates: From	To	Position Held/Title		
Did this employer provide Professional Liability Insurance on your behalf?			• Yes • No	
Insurance Carrier Name			Policy Number	

Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)	Type of Coverage		Exclusions form Coverage	
Initial Date of Coverage	Retroactive Date of Coverage		Expiration Date	

6.

Current Employer/Practice				Contact Name
Address	City	State	Zip	Telephone Number
Dates: From	To	Position Held/Title		
Did this employer provide Professional Liability Insurance on your behalf?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)	Type of Coverage		Exclusions form Coverage	
Initial Date of Coverage	Retroactive Date of Coverage		Expiration Date	

7.

Current Employer/Practice				Contact Name
Address	City	State	Zip	Telephone Number
Dates: From	To	Position Held/Title		
Did this employer provide Professional Liability Insurance on your behalf?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Carrier Name			Policy Number	
Address	City	State	Zip	Telephone Number
Coverage Amount (claim/Aggregate)	Type of Coverage		Exclusions form Coverage	
Initial Date of Coverage	Retroactive Date of Coverage		Expiration Date	

PROFESSIONAL LIABILITY CARRIER INFORMATION

What professional liability insurance has been issued to you under your own name anytime during the past ten years?

Please list all of your professional liability carriers for the past ten years: (Attach a separate sheet, if necessary)

1. _____
 Current Carrier Policy Number

 Address City State Zip

 Coverage Amount (Claim/Aggregate) Type of Coverage Coverage Dates

2. _____
 Previous Carrier Policy Number

 Address City State Zip

 Coverage Amount (Claim/Aggregate) Type of Coverage Coverage Dates

CLAIM/LAWSUIT HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached Supplemental Claims Information Form. Please explain any surcharge to your professional liability coverage on a separate sheet.

	YES	NO
Have there been, or are there currently pending, any malpractice claims, suits, judgments, settlements, or arbitration proceedings involving you in the past ten years?		
Has your professional liability insurance ever been terminated or restricted or modified (e.g. reduced limits, restricted coverage, surcharges), or have you ever been denied professional liability insurance?		

HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.

	YES	NO
Do you have a mental or physical condition, which in any way may impair or limit your ability to carry out clinical responsibilities with reasonable skill and safety?		
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to carry out clinical responsibilities with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a history of impairment due to chemical dependency/substance abuse?		

CONTINUING EDUCATION

	YES	NO
Do you achieve Continuing Education Credits, which allows you to maintain your certification and state license/registration?		

PROFESSIONAL PRACTICE

Have any of the following ever been or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, reduced, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily, on a permanent or temporary basis in this or any other state, territory or county? **If “YES” provide full explanation and resolution of charges on a separate sheet and attach.**

	YES	NO
License/registration in any State		
Other Professional License/ Registration/ DEA		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Membership on any Hospital/Institution Staff		
Authorization to perform services at any Hospital/Institution		
Employment at any Hospital/Institution		
Professional office		
Professional Society Membership or Fellowship		
Professional Certification		
Any other type of Professional Sanction		
Any other type of disciplinary investigation		
Have you ever been charged with a criminal offense		
Have you ever been convicted of a criminal offense or pleaded guilty to a crime in any jurisdiction		
Have you ever, at any time, either voluntarily or involuntarily withdrawn your application or request for clinical responsibilities at any facility		

CURRENT PROFESSIONAL SOCIETIES

1. _____
2. _____
3. _____
4. _____

ST. JOHN HEALTH ATTESTATION

(TO BE COMPLETED BY ALL NON-PHYSICIAN PROVIDER APPLICANTS)

In making this application to provide services in St. John Health, I agree to abide by the hospital/facility specific policies and appropriate excerpts of the Bylaws of the Medical Staff, Rules and Regulations, and Policies.

I fully understand that any significant misstatement in, or omission from this application could constitute cause for summary suspension of the authorization to perform services in St. John Health.

I further agree to report any changes in my health status that would affect my ability to practice and will submit to a physician examination acceptable to the Credentialing Committee and Medical Staff Executive Committee should this be considered necessary.

I agree to report immediately to the Medical Staff Office any changes in the status of my licensure or registration or any changes in my authorization to perform services at other hospitals.

The above information is true and complete to the best of my knowledge.

Signature

Date

To be completed for practitioners other than St. John Health employees:

STATEMENT OF EMPLOYING PHYSICIAN

(TO BE COMPLETED BY THE PHYSICIAN EMPLOYING THE NON-PHYSICIAN PROVIDER)

I hereby verify that _____ is in my employment in the capacity of _____. 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 who are hospitalized within St. John Health. I also agree to notify the Medical Staff Office if this person should ever leave my employment.

Physician Signature

Date

Physician Name Printed

ST. JOHN HEALTH
CONSENT TO RELEASE OF INFORMATION

I understand that this Consent to Release Information is made in connection with Physician/Practitioner/managed care contracting /credentialing, re-credentialing or reappointment activity of SJH. By signing and submitting this application for staff privileges, I acknowledge and agree to the following: I understand that SJH and /or its member entities are responsible for the evaluation of my professional competence, training, experience, health, professional conduct, character, and judgment and to make appropriate recommendation to the governing body of this facility. I acknowledge to this facility is not a guarantee that privileges will be granted.

I acknowledge that I have received and read the bylaws or policies of the Professional Staff, the St. John Health Code of Conduct, and that I am familiar with the principles and medical ethics of the American Medical Association or the American Osteopathic Association and/or the national, state, and local associations that apply to and govern my profession and/or specialty. I pledge to provide continuous care for my patients. I acknowledge to be bound by the terms thereof with regard to the consideration of my application, in the event I am granted staff membership or clinical privileges.

I acknowledge, understand and agree that it is my duty and ethical responsibility as a physician and as an applicant, to produce adequate information for proper evaluation of my professional competence, training, experience, character, ethics, health, professional conduct and judgment and for resolving any doubts about such qualifications. I acknowledge that I will cooperate with and assist the Professional Staff in evaluating not only my professional qualifications and conduct but also those of my colleagues. I agree to appear before officers and/or committees of the Professional Staff for interviews or inquiries at reasonable time and places. If there is any doubt as to whether the information should be disclosed, it should so be disclosed. I also agree to provide the facility with updated current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the facility or its authorized representatives or attorneys.

I hereby authorize SJH and its representatives to contact, consult with and obtain information and documents from any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and past and present professional liability insurance carriers) with which I have been associated, have used for liability insurance or who may have information relevant to my professional competence, training, experience, character, conduct, health and ethical qualifications whether or not such persons or institutions are listed as references by me. I authorize the release and communication of information and documents between SJH and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, health, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions for acts performed in good faith and without malice in gathering or exchanging information in the credentialing or re-credentialing process. This release and hold harmless provision applies to all person, entities and institutions who will provide and/or receive, as part of SJH credentialing or re-credentialing process and managed care contracting, information which may relate to my past or present physical and/of mental condition, including substance abuse, alcohol dependency, and mental health information.

I further authorize the release of the above information or any other information obtained from the application by SJH to any health care organization or health plan designated by me or one that has entered into an agreement with SJH where I currently have, am currently applying, or in the future will be applying for participation. I also authorize SJH to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I hereby affirm that all information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief and is furnished in good faith. I fully understand that any omissions, misrepresentations, whether intentional or not, may result in summary dismissal/denial, modification or revocation of my Professional Staff membership, and/or clinical privileges.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Signature: _____

Practitioner's Printed Name: _____

Date: _____



Addendum to Medical Staff Application

MEDICARE ACKNOWLEDGEMENT STATEMENT FROM ATTENDING PHYSICIAN

“Notice to physician: 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 essential information required for payment of Federal funds, may be subject of fine, imprisonment, or civil penalty under applicable Federal laws.”

I hereby acknowledge that I have received the above notice.

Provider Name Printed

Provider Signature

Date

CHAMPUS ACKNOWLEDGEMENT STATEMENT

“Notice to physician: CHAMPUS 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 essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws”

I hereby acknowledge that I have received the above notice.

Provider Name Printed

Provider Signature

Date

