Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER
Trusted Care. Close to Home.

Medical Staff Office
1014 Oswegatchie Trail
Star Lake, NY 13690
(315) 848-4264
Fax: (315) 848-2795
mriquelme@cfhis.org

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

DATE: _____

1) IDENTIFYING INFORMATION:

Name: _____ SS# _____

Home Address: _____ Home Telephone:
_____ (___)_____

Office Address: _____ Office Telephone:
_____ (___)_____

2) APPOINTMENT REQUEST:

E-mail: _____

Clinical Department: _____ Division: _____

Category: _____ **Active** _____ **Associate** _____ **Courtesy** _____ **Attending Consultant**
____**Provisional/Temporary** _____ **Honorary** _____ **Allied Health Professional**

Practice Limitations (if any): _____
_____

Special Interests (practice, research, teaching, or other): _____
_____

Practice affiliations and the nature of each affiliation: _____

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3) PERSONAL, PERSONAL HEALTH, EMERGENCY AND MILITARY INFORMATION:

a) Date of Birth: _____ Citizenship: _____

Place of Birth: _____
City State/Province Country

Marital Status: _____ Sex: _____Male _____ Female
Unique Physician Identification Number _____

b) Have you any physical/mental disabilities? _____
Have you had any major medical, emotional or surgical illnesses? _____
Have you ever been habituated to drugs or alcohol? _____
If you answered "yes" to any of the above, please provide additional information on a separate sheet.

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Date of last chest x-ray: _____ Provide copy of report.
Hospitalizations over the past five (5) years:
Clinical indication: _____ Dates: _____
Clinical indication: _____ Dates: _____

c) New York State Health Code requires a physical examination for all hospital affiliated persons. **Please submit written findings of your physical examination performed within the past twelve months. This must be signed by the evaluating physician.** Please note that a reassessment health evaluation must be completed annually.

I hereby attest to the fact that I am physically and mentally capable and competent to provide the patient care services for which I have applied.

_____ _____
Signature **Date**

d) Persons to be notified in the event of an emergency:
Name and Relationship: _____
Address and Phone # : _____

e) Military Status: _____ None _____ Active Duty _____ Reserve _____Retired
Type of Discharge if applicable: _____

4) EDUCATION:

a) **Undergraduate Education**:
College or University: _____
Address: _____
Dates: Attended _____ Graduated _____
Degree _____ Honors _____

b) **Graduate Education**:
College or University:
_____
Address: _____
Dates: Attended _____ Graduated _____
Degree _____ Honors _____

c) **Clinical Residencies:** (Fellowships, Preceptorships, Teaching Appointments and Post Graduate Education) List in chronological order: dates, location, Chiefs of Staff, Chairman of Departments, Program Directors and other Practitioners responsible for clinical performance. (Use a separate sheet if additional space is needed.)

Specialty _____ Dates Inclusive _____
Institutional Affiliation _____
Address _____
Program Director/Title _____

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Specialty _____ Dates Inclusive _____
Institutional Affiliation _____
Address _____

Program Director/Title _____

5) CONTINUING MEDICAL EDUCATION:

List CME programs which you have attended or for which you have received credit in the past two years. These must meet the requirements of your specialty society and be specific to your area of clinical practice. Please list subject, dates, category of credits and credit hours earned.

Certificates of attendance or CME certificates from your specialty society **MUST** also be submitted as further verification. A separate sheet may be used if additional space is needed.

Dates	**Subject/Program Title Sponsor and Location**	**Credits**	**Category**

6) EMERGENCY CARE TRAINING:

Do you hold the following certificates? If yes, please attach photocopies of each certificate held.

CPR _____ ACLS _____ ACLS Instructor _____ ATLS _____ ATLS Instructor _____

7) PUBLICATIONS:

List scientific papers, editorials, texts, chapters of texts, and essays published or presented.
A separate sheet may be used if additional space is required.

Publication: **Date:**

8) PROFESSIONAL SOCIETIES:

If a member, past or present, or an applicant to county, state or national professional societies, please list these below.

Society: **Type of Membership:** **Date:**

9) PROFESSIONAL RECOGNITION:

List prizes and awards granted in recognition of professional accomplishment.

Award: **Date:**

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10) PROFESSIONAL REGISTRATION:

Please attach a copy of your New York State certificate of registration for verification. In addition, copies of any other State or Canadian Provinces in which you are currently registered.

State/Province **Registration #** **Expiration Date**

Unique Physician ID # _____ **National Provider Identifiers:** _____
Medicaid # _____ **Medicare #** _____

11) DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBER:

DEA # _____ Expiration Date: _____

Please attach a copy of your DEA registration certificate.

12) BOARD CERTIFICATION:

Please list and describe any and all Board Certifications. If not Board Certified, are you Board Eligible?
YES _____ NO _____
Do you plan to be Board Certified within the next five (5) years? YES _____ NO _____

13) PROFESSIONAL LIABILITY INSURANCE:

a) Insurance Carrier: _____Policy #: _____
Policy Expiration Date: _____ Policy Limits: _____

b) Excessive Insurance Carrier: _____Policy #: _____
Policy Expiration Date: _____ Policy Limits: _____

c) Has your professional liability insurance coverage ever been terminated by action of the insurance company? YES _____ NO _____

d) Have you ever been denied professional liability insurance coverage? YES _____ NO _____

e) If the answer to either of the above questions is YES, state when and by what company.
_____

f) Has your present professional liability insurance carrier excluded any specific procedures from your coverage? YES _____ NO _____

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g) If the answer to question (f) is YES, list the procedures which have been excluded and provide a full explanation on a separate sheet, including the name of the carrier, the date and specific information concerning any limitation.

h) Please list previous professional liability carriers to include address and dates of coverage.

_____

_____

i) Have any judgments or settlements been made against you in a professional liability case(s)?
YES _____ NO _____

j) Have any professional liability suits been filed against you, which are presently pending?
YES _____ NO _____

If the answer to any of the above questions is yes, please provide a full explanation of the details on a separate sheet and attach. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney defending you, and all other relevant details.

14 AFFILIATIONS:
Chronology of Professional career affiliations (past ten years)

a) Facility/Location: _____

_____

_____

Clinical Department(s): _____
Department Chief: _____

Inclusive Dates:_____

b) Facility/Location: _____

_____

_____

Clinical Department(s): _____
Department Chief: _____

Inclusive Dates:_____

c) Facility/Location: _____

_____

_____

Clinical Department(s): _____
Department Chief: _____

Inclusive Dates:_____

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d) Facility/Location: _____
_____
_____

Clinical Department(s): _____
Department Chief: _____

Inclusive Dates:_____

e) Facility/Location: _____
_____
_____

Clinical Department(s): _____
Department Chief: _____

Inclusive Dates:_____

15) PROFESSIONAL SANCTIONS:

a) Have you ever been involved in a professional misconduct action? If so, describe the substance of these actions and resolution.
YES _____ NO _____

b) Has your license to practice medicine or dentistry ever been limited, suspended or revoked in any jurisdiction? If so, describe the substance of these actions and resolution.
YES _____ NO _____

c) Has your DEA number ever been limited, suspended or revoked? If so, describe the substance of these actions and resolution.
YES _____ NO _____

d) Has your membership, association, employment, or practice at another facility ever been limited, suspended, or discontinued? If so, describe the substance of these actions and resolution.
YES _____ NO _____

e) Have your privileges at any facility ever been denied, suspended, discontinued, or granted with stated limitations? If so, describe the substance of these actions and resolution.
YES _____ NO _____

f) Have you ever been denied membership or renewal of membership or been subject to disciplinary action in any medical or dental organization? If so, describe the substance of these actions and resolution.
YES _____ NO _____

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g) Has your application for privileges and/or appointment at any facility ever been denied? If so, describe the substance of these actions and resolution.
YES _____ NO _____

h) Do you have an application for Medical Staff privileges pending at any other facility? If so, please list. YES _____ NO _____

NOTE: A separate sheet may be used to provide additional information if responses are YES.

16) REFERENCES:

Please provide the names of **five** (5) professional references. Include titles, present position, position at the time of your association, address, and phone number, when possible. Avoid using professional partners or associates. Include those with whom you have had direct clinical involvement such as preceptors and Department Chairman or Chiefs. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you.

a) Name _____ Title _____

Present Position _____ Position at time of association _____

Address _____ Phone _____
E-Mail _____ Fax _____

b) Name _____ Title _____

Present Position _____ Position at time of association _____

Address _____ Phone _____
E-Mail _____ Fax _____

c) Name _____ Title _____

Present Position _____ Position at time of association _____

Address _____ Phone _____
E-Mail _____ Fax _____

d) Name _____ Title _____

Present Position _____ Position at time of association _____

Address _____ Phone _____
E-Mail _____ Fax _____

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e) Name _____ Title _____

Present Position _____ Position at time of association _____

Address _____ Phone _____
E-Mail _____ Fax _____

17) AUTHORIZATION AND CONSENT:

I hereby authorize Clifton-Fine Hospital, its Medical Staff and its representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I am or have been associated.

I also authorize Clifton-Fine Hospital, its Medical Staff and its representatives to consult with professional societies of which I am, or have been, a member, past and present malpractice carriers, and others who may have information bearing on my compliance, character and ethical qualifications.

I hereby further consent to the inspection by Clifton-Fine Hospital, its Medical Staff and its representatives of all documents. Including but not limited to medical records, (subject to patient consent), quality assurance files, and peer review reports at other hospitals 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/appointment.

Initials: _____

18) RELEASE FROM LIABILITY:

I hereby release from liability all representative of Clifton-Fine Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating my application, my credentials and qualifications.

I hereby release from any liability, any and all individuals and organizations who provide information to Clifton-Fine Hospital 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 such information

I hereby require written consent from me for the release of any information by this Hospital, or its Medical Staff, to other hospitals, medical associations and other interested persons regarding any information the Hospital and the Medical Staff may have concerning me, except for information the Hospital is required to release by statute, law, or regulation. I agree to hold the Hospital and its authorized representatives free from liability for providing, in good faith and without malice, such information.

Initials: _____

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19) ACKNOWLEDGEMENTS:

I understand and agree that I, as an applicant for Medical Staff membership or privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, or other qualifications and for resolving doubts about such qualifications.

I fully understand that any significant misstatement in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff. All information submitted by me in my application is true and accurate to the best of my knowledge or belief. I hereby signify my willingness to appear for interviews in regard to my application.

In making this application for appointment to the Medical Staff of Clifton-Fine Hospital, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments, to accept consultation assignments, and to participate in staffing the emergency service area and other special care units if applicable. I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff of the Hospital and agree to be bound by the terms thereof, if I am granted membership or clinical privileges. 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 to the Medical Staff and privileges.

I further acknowledge that I am familiar with the principles and standards of the Office of Health Systems Management and Part 405 of New York State Health Code and the Joint Commission on Accreditation of Healthcare Organizations. I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee-splitting. In complying with this principle, I also will not collect fees from others for referring patients, or permit any associate of mine to do so. Moreover, I pledge myself to shun unwarranted publicity, dishonest money seeking and commercialism; to refuse money trades with consultants, practitioner, makers of surgical appliances, optical instruments, vendors, or others; to make my fees commensurate with the service(s) rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensations.

I particularly agree to subject my clinical performance to, and faithfully participate in, the Hospital's Quality Assurance Program, Discharge Planning Program, Utilization Review Program, Medical Staff Peer Reviews and I agree to hold members of the Medical Staff and other authorized representatives of Clifton-Fine Hospital engaged in these activities free of all liability for their actions performed in good faith in connection therewith. I understand that similar provisions are contained in the Medical Staff Bylaws, and I acknowledge that I have read these provisions and have no objections to them.

I have not requested privileges for any procedures for which I am not qualified or unable to provide proof of qualifications. Furthermore, I realize that certification by the Board of Directors 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.

Signature _____ **Date** _____

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20) MEDICAL DIRECTOR REVIEW OF APPLICATION:

Clinical Privileges Requests:

_____ To the best of my knowledge and based on a review of this applicant's credentials and evidence of clinical competence, this physician possesses the knowledge, judgment, and technical skill required to practice within the scope of privileges as requested;

_____ Privilege changes are recommended based on documented evidence of current clinical competence. This information has been reviewed by me and has been found to support the request.

_____ The following exceptions are recommended:

_____

_____

_____

Health Status:

_____ I am not aware of any health impairment that would affect this physician's ability to meet professional or Medical Staff responsibilities;

_____ In my judgment, the following health impairment may affect this physician's ability to meet professional or Medical Staff responsibilities.

_____

_____

_____

Recommendation to the Credentials and Medical Staff:

_____ I recommend this physician be appointed to the Medical Staff within the Clinical Department(s) requested.

_____ I recommend this physician be appointed to the Medical Staff within the category requested.

_____ I further recommend that this physician be granted privileges as requested with exceptions, if pertinent.

_____ I recommend that this physician's request for membership and/or privileges be denied for the following reasons. (A separate report may be submitted with justification for denial.)

_____ _____

Signature of Medical Director **Date**

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Reviewed at Medical Executive Meeting on _____.

_____ Appointed _____ Not Appointed _____ Deferred

_____
Signature

_____
Printed Name and Title

Reviewed at Board of Directors Meeting on _____.

_____ Appointed _____ Not Appointed _____ Deferred

_____
Signature

_____
Printed Name and Title

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AUTHORIZATION TO RELEASE INFORMATION

I hereby consent to and authorize the Medical Staff, Credentials, and Executive Committees of the Clifton-Fine Hospital to consult with and obtain information from the Administrator and members of the Medical Staff of other hospitals, organizations, or institutions with which I have been associated, as well as any others who may have information material to my professional and ethical competence.

I hereby release from liability every representative of the Hospital and members of its Medical Staff for their acts done in good faith in obtaining information to evaluate and act upon my application for membership. I further release from any liability every person, organization, and institution who provides information to the Hospital's Medical Staff in good faith relating to my professional competence, ethics, and other qualifications for medical staff appointment and hereby consent to the release of such information.

_____ _____

Signature **Date**

_____

Printed Name and Title

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STATEMENT OF PRIVILEGES

For the purpose of this application for delineation of privileges:

I understand and agree that I, as an applicant for Medical Staff membership or privileges, have the burden of producing adequate information by supplying all data presently required by the Credentials Committee or Administration for proper evaluation of my professional competence, character, ethics, or other qualifications and for resolving doubts about such qualifications, and;

I fully understand that any significant misstatement in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal form the Medical Staff. All information submitted by me in my application is true and accurate to the best of my knowledge or belief. I herby signify my willingness to appear for interviews in regard to my application, and;

That by marking "X or ✓" after each procedure requested on the attached form for delineation of privileges, I am indicating that I am qualified to perform this procedure. Moreover, I have not requested privileges for any procedures for which I am not qualified or unable to provide proof of qualifications. Furthermore, I realize that certification by the Board of Directors 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, and;

In the case of an emergency, any practitioner with clinical privileges at the Hospital, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. For the purpose of this section, and "emergency" is defined as a condition of in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

_____ _____

Signature **Date**

_____

Printed Name and Title

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AUTHORIZATION TO OBTAIN CERTIFICATE OF INSURANCE

Physician/Dentist Name

Name of Insurance Company

Policy Number or ID

I hereby authorize the above named insurance company to furnish to the Clifton-Fine Hospital, a certificate of insurance for my professional liability coverage and notice of cancellation for that coverage.

Furthermore, the Hospital may also obtain all information regarding claims made against the policy.

The Clifton-Fine Hospital understands that ALL information obtained is confidential and the Hospital will not re-disclose said information unless the physician signs a written authorization.

Date

Signature of Physician / Healthcare Practitioner

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ACKNOWLEDGMENT STATEMENT

ALL PAYORS

Notice to Physicians: Payment to Hospitals for inpatient services is based 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 on the Physician's Attestation sheet placed in the patient's record. Anyone who misrepresents, falsifies or conceals this information may be subject to fine, imprisonment or civil penalty under applicable Federal and New York State Laws.

MEDICARE

Notice to Physicians: Medicare payment to Hospital 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.

CHAMPUS

Notice to Physicians: Champus payment to Hospital 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.

Hospital Compliance:

The physician further agrees to comply with the Hospital's policies and procedures of its established Compliance Program.

_____
Physician's Name (Please Print)

_____ _____
Physician's Signature Date