



IT'S ABOUT YOU!

Dear Doctor:

Thank you for your interest in joining the Medical Staff of Carolinas Specialty Hospital.

To facilitate this process, please return the following:

- Completed and signed application
- Copy of North Carolina Physicians License
- Copy of DEA Permit
- Copy of Photo Identification
- Copy of current Malpractice Insurance Coverage
- Release of Liability Consent
- Completed Pharmacy and Medical Record Form
- Completed and Signed Delineation of Privileges
- Three (3) Peer References

We welcome you to our hospital and look forward to a mutually successful venture. We are dedicated to providing high quality caring to our patients and a nurturing environment for our staff that rewards growth and development. If you have any questions please feel free to call me at (704) 335-9113.

Yours truly,

Susan Davis

Susan Davis, CEO

Carolinas *Specialty* Hospital
MEDICAL STAFF APPLICATION

IDENTIFYING INFORMATION				
LAST NAME	FIRST NAME	MI	BIRTHPLACE	DATE OF BIRTH
OFFICE ADDRESS	CITY, STATE	ZIP CODE	OFFICE TELEPHONE NUMBER ()	
HOME ADDRESS	CITY, STATE	ZIP CODE	HOME TELEPHONE NUMBER ()	
BEEPER/PAGER TELEPHONE NUMBER ()			OFFICE FAX TELEPHONE NUMBER ()	
IF GROUP, GROUP NAME:				
PARTNERS & ASSOCIATES:				
Credentialing Contact Person:				
Address if different from above:				
SOCIAL SECURITY NUMBER:			NPI NUMBER	
UPIN NUMBER:				
MEDICARE PROVIDER NUMBER:			MEDICAID PROVIDER NUMBER:	
CITIZENSHIP:	IF NOT U.S. CITIZEN, PLEASE GIVE ALIEN OR ADMIN. NUMBER:			
MARITAL STATUS (circle): M S W D		SPOUSE NAME, if applicable		
NAME AND TELEPHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY				
HEALTH PROFESSION (circle):		PHYSICIAN		DENTIST PODIATRIST
COVERAGE ARRANGEMENT: (I have made arrangements for coverage of my patients in my absence)				Yes No
Name:				
Telephone Number:				
Beeper/Pager Number:				
YOUR CLINICAL FIELD:			YOUR SPECIALITY/SUBSPECIALTY:	
PRE-PROFESSIONAL INFORMATION				
College or University:			Degree Received:	
Address (Street address, city, state, zip code)			Date of Graduation:	
MEDICAL EDUCATION <i>(Graduates of foreign medical schools must provide a copy of their ECFMG Certification or evidence of completion of a Fifth Pathway Program)</i>				
School Attended				Degree Received:
Address (Street address, city, state, zip code)			Date of Graduation	
ECFMG Number (If applicable)				Date Issued

Practitioner Name: _____

POST GRADUATE CLINICAL TRAINING (Include all Preceptorships, Internships, Residencies, Fellowships)		
Inclusive Dates	Institution/Location	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
Program Chairman	Address (Street address, city, state, zip code)	Telephone Number ()
ADDITIONAL POST GRADUATE CLINICAL TRAINING		
Inclusive Dates	Institution/Location	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
Program Chairman	Address (Street address, city, state, zip code)	Telephone Number ()
ADDITIONAL POST GRADUATE CLINICAL TRAINING		
Inclusive Dates	Institution/Location	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
Program Chairman	Address (Street address, city, state, zip code)	Telephone Number ()
ADDITIONAL POST GRADUATE CLINICAL TRAINING		
Inclusive Dates	Institution/Location	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
Program Chairman	Address (Street address, city, state, zip code)	Telephone Number ()

Practitioner Name: _____

ADDITIONAL POST GRADUATE CLINICAL TRAINING		
Inclusive Dates	Institution/Location	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
Program Chairman	Address (Street address, city, state, zip code)	Telephone Number ()
TEACHING APPOINTMENTS (If necessary, list additions on a separate sheet of paper)		
Inclusive Dates	Institution/Address (Street address, city, state, zip code)	
Type of Program	Specialty	
Accredited By	Sponsored by/Affiliated With	
CONTINUING EDUCATION		
<i>On a separate sheet of paper, list all other clinical training for which you have received credit in the past two (2) years. Please furnish a list of scientific papers or essays you have written and scientific meetings you have attended during the past two (2) years (include reprints), unless already included on attached CV.</i>		
AFFILIATIONS (List present and previous health care entity affiliations)		
Present Capacity with this Hospital, If any	Dates	
<i>List all present and previous hospital affiliations in chronological order (include assistantships and appointments). Specify all departments, in which privileges were granted, and nature and extent of such privileges. Attach an additional sheet of paper if necessary.</i>		
Name and Location of Hospital (please include street address, city, state, and zip code)		
Capacity (Active, Courtesy, Etc)	Department	Dates
Name and Location of Hospital (please include street address, city, state, and zip code)		
Capacity (Active, Courtesy, Etc)	Department	Dates
Name and Location of Hospital (please include street address, city, state, and zip code)		
Capacity (Active, Courtesy, Etc)	Department	Dates

Practitioner Name: _____

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS			
BOARD CERTIFICATION <i>(Evidence of board certification or application to take the board examination, if eligible, must be attached to this application)</i>			
Certified by American Board (Name of Board):		Date Certified:	Date Expires:
Subspecialty Board Status (Name of Board):		Date Certified:	Date Expires:
If not Board Certified, Give Intentions and Status:			
Is Re-certification Required? Yes No	If yes, your re-certification status:	Have you ever taken and failed a Board Exam? Yes No	
PROFESSIONAL SOCIETIES			
American College of :		Date	
American College of:		Date	
Fellowship in Other Specialty Colleges			
LICENSURE <i>(Please submit a copy of your State License certificate)</i>			
Licensee, Type Of License, Name of Board Issuing License:			
Name of State in Which License is Held	License Number	Date Issued	Date Expires
Other License (Name of State)	License Number	Date Issued	Date Expires
Other License (Name of State)	License Number	Date Issued	Date Expires
DRUGS AND NARCOTIC REGISTRATIONS <i>(Please submit a copy of your current DPS certificate and DEA certificate)</i>			
Classes of Drugs/Medications used in your field:			
Classes of Drugs/Medications you are authorized to prescribe:			
DEA Registration Number	Date Issued	Scope	Limitations
State Registration Number (DPS)	Date Issued	Scope	Limitations

Practitioner Name: _____

PROFESSIONAL REFERENCES List three (3) practitioners, of which at least one must be a colleague in your specialty, who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others who will provide specific written comments on these matters upon request from Hospital authorities. <u>The named individuals must have acquired the requisite knowledge through observation of your professional practices over a reasonable period of time, and are not formerly, currently, or about to become associated with you in practice.</u>		
Name		Telephone Number ()
Address (Street address, city, state, zip code)		
Name		Telephone Number ()
Address (Street address, city, state, zip code)		
Name		Telephone Number ()
Address (Street address, city, state, zip code)		
PREVIOUS EXPERIENCE (Military Service, Private Practice, But excluding training and teaching)		
List in Chronological Order		
		Dates
		Dates
		Dates
LIABILITY INSURANCE COVERAGE (Please submit a copy of your Liability Insurance Coverage certificate that includes carrier name, amounts and dates of coverage with your application)		
Current Carrier		Agent Name and Phone Number:
How long with Carrier?	Inclusive Dates	
PI Limits per Occurrence	PI Limits Aggregate	Policy #
INSURANCE HISTORY		
<i>Please provide the Name and Address of any carrier, other than your current carrier, that has provided professional liability coverage to you at any time during the proceeding five (5) years.</i>		
Name of Carrier	Inclusive Dates: Policy #:	
Name of Carrier	Inclusive Dates: Policy #:	
Name of Carrier	Inclusive Dates: Policy #:	

Practitioner Name: _____

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

1. Have any professional liability claims been made against you?	Yes	No
2. Has any judgment been entered against you in any professional liability case?	Yes	No
3. Has any settlement been made in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment?	Yes	No
4. Have you been denied professional liability insurance, has your policy been canceled, has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any professional liability carrier expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?	Yes	No

HEALTH STATUS

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

1. Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?	Yes	No
3. Do you presently have a physical or mental health condition, including alcohol or drug dependence that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately?	Yes	No
4. Are you currently under care for a continuing health problem that would impair your ability to exercise the clinical privileges requested?	Yes	No
5. Have you at any time during the past five (5) years been hospitalized or received any other type of institutional care for a health problem? If yes, did it place any limitations on your ability to exercise the clinical privileges you have requested?	Yes Yes	No No
6. Have you ever taken a leave of absence from you medical practice for any reason for 30 days or more? If yes, please provide inclusive date and reason for leave.	Yes	No

PRACTICE HISTORY

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

1. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	Yes	No
2. Is there any state in which you were previously licensed in which you are not licensed today?	Yes	No
3. Have you ever been formally charged with infractions or professional misconduct by the licensing authority of any jurisdiction?	Yes	No
4. Has any federal or state license, registration, or permit to prescribe narcotics or other drugs ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited, or restricted?	Yes	No
5. Has your Medical Staff Membership at any hospital, clinic or other health care facility ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	Yes	No

Practitioner Name: _____

6. Has your Medical Staff privileges at any hospital, clinic, or other health care facility ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted? Voluntarily relinquished?	Yes	No
7. Has your status as a student or participant in good standing in any clinical school, internship, residency, fellowship, preceptorship, or other clinical education program ever been voluntarily or involuntarily withdrawn, suspended or terminated?	Yes	No
8. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited, or restricted?	Yes	No
9. Have you ever been subjected to sanctions by professional standard review organization (PSRO), or by a utilization and quality control peer review organization (PRO)?	Yes	No
10. Has your employment or other relationship with an HMO, PPO, IPA, or other alternative health delivery system ever been voluntarily or involuntarily denied, suspended, revoked, limited or restricted?	Yes	No
11. Have you ever been convicted of a felony?	Yes	No
12. Have you ever been convicted of or pleaded no contest to any criminal charges (other than motor vehicle speeding violations)?	Yes	No
13. Have you ever been convicted of or pleaded no contest to a drug or alcohol related offense?	Yes	No
14. Have you ever been charged with or convicted of any crime related to your clinical practice, including Medicare or Medicaid related crimes?	Yes	No
15. Have you ever been subjected to civil money penalties under the Medicare or Medicaid program?	Yes	No
16. Have you ever been suspended from participation in or sanctioned by Medicare or Medicaid?	Yes	No
17. Have you ever been involuntarily terminated or forced to resign, or have you ever resigned voluntarily while under investigation or threat of sanction, from a clinical position with the Armed Forces, any federal, state, or local agency, or any other employment or practice arrangement?	Yes	No
18. Have you voluntarily accepted any of the above sanctions or restrictions under threat of same and/or voluntarily resigned under threat of same?	Yes	No
19. Have you ever executed or are you currently subject to an agreement limiting or prohibiting the geographic area or hospitals in which you can provide medical services?	Yes	No

I fully understand that any significant misstatements 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 this application is true to the best of my knowledge and belief. In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the Medical Staff Bylaws of the hospital 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 all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and medical staff policies and rules and regulations as may be from time to time enacted.

Practitioner's Signature

Date

AUTHORIZATION AND RELEASE OF LIABILITY

I fully understand that any significant misstatements 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 this application is true to the best of my knowledge and belief.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals 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 hospital, and its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the 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, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital 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 hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have 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.

I have not requested privileges for any procedures for which I am not certified. 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.

Date

Signature of Practitioner

Printed Name of Practitioner



NOTICE TO PHYSICIANS
Content of physician acknowledgement statement

By signature below, I acknowledge the following:

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 to fine, imprisonment, or civil penalty under applicable Federal laws.

Medicare Payment under the *long-term acute care hospital* prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section. 42 CFR 412.508

ACKNOWLEDGEMENT:

SIGNATURE

DATE

Printed Name

PHARMACY/MEDICAL STAFF SIGNATURE FORM

In accordance with the policy of the Hospital and The Joint Commission on Accreditation of Healthcare Organizations, this form is to be completed/signed and returned with your completed application. It will be filed in the Medical Staff Office, Health Information Management Department and Pharmacy for reference.

Practitioner's Name Printed

Office Address

City, State, Zip Code

DEA Number

UPIN / NPI Number

Practitioner's Signature

Practitioner's Initials

Date

CC: Pharmacy Department
Health Information Services
Business Office

Carolinas *Specialty* Hospital

MEDICAL SERVICES DELINEATION OF PRIVILEGES

APPLICANT'S NAME: _____ DATE: _____

This is my:	<input type="checkbox"/> Initial Application	<input type="checkbox"/> Re-appointment Application	<input type="checkbox"/> I am modifying my privileges	
Status:	<input type="checkbox"/> Active	<input type="checkbox"/> Courtesy	<input type="checkbox"/> Consultan	<input type="checkbox"/> Temporary

I. Training: Successful completion of an approved residency training program in Internal Medicine or Family Practice, certification by the applicable Board, or admissibility to take the Board with achievement of Board Certification within (two years for FP & six years for IM) of completion of residency training.

II. Experience: The successful applicant must be able to demonstrate provision of inpatient service to at least 15 patients in the past 12 months. (Note: Applicants who are unable to document compliance with noted experience requirements may work on under a preceptor member of the Medical Staff in order to attain required experience).

III. Check the applicable category:

- CATEGORY I:** Core privileges include the admission, work up, diagnosis and provision of non-surgical treatment including consultation patients admitted to the hospital or in need of care to treat general medical problems. These privileges do not include any of the procedures listed in the special requests nor any of the privileges included in the subspecialty areas.

Check the appropriate designations listed below:

- Internal Medicine**
 Family Practice

- CATEGORY II:** Successful completion of an approved residency training program in Internal Medicine followed by an approved fellowship in the area sub-specialization. Applicant must achieve Internal Medicine Board certification as listed above, and must be qualified for certification by the applicable subspecialty Board and achieve subspecialty certification within six years of completing subspecialty training. These physicians may admit and treat without limitation. These physicians may also act as consultants to others and provide care for complex problems in their sub-specialty area. In turn, they should request consultation whenever needed.

Check the appropriate designations listed below:

- Internal Medicine**
 Family Practice

Check the appropriate specialty designations listed below:

- Allergy/Immunology
 Cardiology
 Endocrinology/Metabolism
 Emergency Medicine
 Gastroenterology
 Geriatric Medicine
 Hematology
 Infectious Diseases
 Metabolic Immunology
 Nephrology
 Oncology
 Pulmonary Medicine
 Rheumatology

Other (Specify) _____

Check the specific tasks/procedures listed below for which privileges are requested. Report number of procedures performed within the last 12 months, or the number of procedures performed in Residency program if within the past 5 years, or number of proctored procedures by a member of our medical staff. Numbers in **Bold** are required.

	Category II		# Performed last 12 months	or	# Performed Residency	or	Proctored Procedures
	Internal Medicine						
IM 1	<input type="checkbox"/> Biopsy: specify	10		10		5	
IM2	<input type="checkbox"/> Cardioversion	*		*		*	
IM3	<input type="checkbox"/> Central Lines; Arterial and Venous Insertion	20		20		10	
IM4	<input type="checkbox"/> Femoral line Placement	20		20		10	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Pulmonary						
PU1	<input type="checkbox"/> Bronchoscopy with Conscious Sedation	10		10		5	
PU2	<input type="checkbox"/> Central lines: Arterial and Venous Insertion	20		20		10	
PU3	<input type="checkbox"/> Chest tube Insertion - Thoracostomy	*		*		*	
PU4	<input type="checkbox"/> Indirect Laryngoscopy	*		*		*	
PU5	<input type="checkbox"/> Endotracheal intubation with conscious sedation	20		20		10	
PU6	<input type="checkbox"/> Thoracentesis	*		*		*	
PU7	<input type="checkbox"/> Pulmonary Function Testing ; includes hypoxic and hypercarbic stimulation of ventilation and bronchial provocation tests.	*		*		*	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Category II		# Performed last 12 months	or	# Performed Residency	or	Proctored Procedures
	Cardiology						
CA1	<input type="checkbox"/> Central lines insertion; Arterial and Venous	20		10		10	
CA2	<input type="checkbox"/> Femoral line placement	20		20		10	
CA3	<input type="checkbox"/> Insertion of transvenous cardiac pacemaker	20		10		10	
CA4	<input type="checkbox"/> Pericardialcentesis	5		5		5	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Renal						
RE1	<input type="checkbox"/> Hemodialysis	20		20		10	
RE2	<input type="checkbox"/> Femoral line insertion	20		10		10	
RE3	<input type="checkbox"/> Hemofiltration	20		20		10	
RE4	<input type="checkbox"/> Peritoneal dialysis; Acute and Chronic	15		15		5	
RE5	<input type="checkbox"/> Renal biopsy - Percutaneous	5		5		5	
RE6	<input type="checkbox"/> Apheresis (Phersis); includes plasmapheresis, leukopheresis, platelet pheresis, red cell pheresis	5		5		5	
CS1	<input type="checkbox"/> Moderate Sedation						
RE6	<input type="checkbox"/> Other (specify)						
	Neurology						
NE1	<input type="checkbox"/> EEG Interpretation	50		50		25	
CS1	<input type="checkbox"/> Moderate Sedation						
NE2	<input type="checkbox"/> Other (specify)						

* Considered core competency in this specialty. If physician is not in this specialty credentialing committee to review and approve.

	Other Specialty (specify)						
	<input type="checkbox"/>						

Life Threatening Emergency: At the time of a clinical emergency, a practitioner who holds clinical privileges and is a member of the medical staff may render whatever care he/she believes to be indicated.

Applicant Signature

Date

Medical Executive Committee

Date

* Considered core competency in this specialty. If physician is not in this specialty credentialing committee to review and approve.

Carolinas Specialty Hospital

SURGICAL SERVICES

DELINEATION OF PRIVILEGES

APPLICANT'S NAME: _____ DATE: _____

This is my:	<input type="checkbox"/> Initial Application	<input type="checkbox"/> Re-appointment Application	<input type="checkbox"/> I am modifying my privileges
Status:	<input type="checkbox"/> Active	<input type="checkbox"/> Courtesy	<input type="checkbox"/> Consultant

Surgical Services: Physicians with Surgical Services privileges will have training and/or experience on a level commensurate with that provided by the specific approved surgical specialty and subspecialty training program. Applicants will have successfully completed an approved residency training program in the surgical specialty or subspecialty and achieve certification by the applicable specialty or subspecialty Board, or for new graduates, achieve Board Certification with three years of completion of the training program.

These physicians may admit and treat without limitation. They should request consultation for complex and/or multi-system problems and conditions outside their specialty area of training or experience.

Check the appropriate specialty listed below:

- Cardiovascular
- Head/Neck
- General Surgery
- Gynecology
- Neurosurgery
- Ophthalmology
- Oral/Maxillofacial surgery
- Orthopedic Surgery
- Otolaryngology
- Plastic Surgery
- Thoracic
- Urology
- Other (Specify) _____

Life Threatening Emergency: At the time of a clinical emergency, a practitioner who holds clinical privileges and is a member of the medical staff may render whatever care he/she believes to be indicated.

Check the specific tasks/procedure listed below for which privileges are requested:

SPECIFIC TASKS/PROCEDURES	ACTION REQUIRED					
	APPROVAL		DENIAL		SPEC COND	
	MEC REC	Board App	MEC REC	Board App	MEC REC	Board App
<input type="checkbox"/> Consultation						
<input type="checkbox"/> Diagnostic Evaluation						
<input type="checkbox"/> Surgical Care management						
<input type="checkbox"/> History & Physical						
GENERAL SURGERY						
<input type="checkbox"/> Repair of Laceration						
<input type="checkbox"/> Lumbar Puncture						
<input type="checkbox"/> Moderate Sedation						
<input type="checkbox"/> Debridement						
<input type="checkbox"/> Tracheostomy						
<input type="checkbox"/> Thoracentesis						
<input type="checkbox"/> Resection of Skin Lesions						
<input type="checkbox"/>						
OTOLARYNGOLOGY						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
OPHTHALMOLOGY						
<input type="checkbox"/> General Ophthalmic care						
ORTHOPEDICS						
<input type="checkbox"/> Nails						
<input type="checkbox"/> Skin Lesions						
<input type="checkbox"/>						

Applicant Signature

Date

Medical Executive Committee

Date

CAROLINAS *SPECIALTY* HOSPITAL
ADDENDUM TO APPLICATION FOR MEDICAL STAFF
MEMBERSHIP/CLINICAL PRIVILEGES

Practitioner Name: _____

Credentialing Contact Name: _____
Email: _____ Phone: _____
Fax: _____

Practitioner NPI: _____

Tax ID: _____

Medicare: _____	Medicaid: _____
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HEALTH STATUS
Date of Latest Tuberculin (PPD) Test: Results: _____ Negative _____ Positive X-rays Taken _____ Yes _____ No: Results _____

KMS Credentialing Resources

P.O. Box 570, Tomball, Texas 77377, Phone: (512) 799-9144 Fax: (281) 257-5403

Information provided for and on behalf of the hospital's medical peer review committee for purposes of medical peer review only. Information will be maintained in a confidential manner consistent with the statutory privileges for medical peer review.

February 20, 2009

PLEASE FAX RESPONSE TO (281) 257-5403
This page only.

RE: _____

Specialty: _____

Credentialing Services Provided for: _____

The above named practitioner is seeking staff appointment/privileges and has given your name on the application as someone who has personal knowledge of his/her clinical abilities, ethical character, health status, and ability to work cooperatively with others. Based on your knowledge of this practitioner, please complete the following information.

Areas Of Evaluation	Superior	Above Average	Average	Poor	Insufficient Information
Basic Clinical Knowledge					
Clinical Judgment, Technical Skill, Current Competence					
Cooperativeness with others					
Ethical Conduct					
Emotional Stability					
Physical Health					
Rapport with Peers					
Rapport with Patients					
Sense of Responsibility					
Thoroughness of Medical Records					
Work habits					
Professional Attitude					
Professional Character					
Participation in Medical Staff Activities					

If you indicated "poor" to any of the above questions, please provide explanation: _____

Length of time you have known this practitioner: _____

RECOMMENDATION:

- _____ Recommend without reservation
- _____ Recommend with reservation
- _____ Do not recommend
- _____ I do not feel I have sufficient knowledge to evaluate

Would you like someone from our office to contact you for additional information about this practitioner? (Y/N)_____**

**If "YES" please provide a phone number that we can contact you _____

Please review the attached request for clinical privileges and give us your opinion as to the above referenced professional's competency and training to conduct those privileges and provide your comments: _____

Signature: _____ Date: _____

NOTE: Credentialing services are being provided by the KMS Credentialing Resources. All correspondence resulting from this request should be forwarded directly to KMS Credentialing Resources. This document contains confidential information that is legally privileged, belonging only to the sender. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this faxed information is strictly prohibited. If you receive this document in error, please notify the sender immediately by calling 512-799-9144 Thank you.