



IT'S ABOUT YOU!

Dear Allied Health Professional,

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
Allied Health Professional 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 ()	
SOCIAL SECURITY NUMBER:			MARITAL STATUS: M S W D Spouses Name, if applicable:	
CITIZENSHIP:	IF NOT U.S. CITIZEN, PLEASE GIVE ALIEN OR ADMINISTRIVE NUMBER			
NAME AND TELEPHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY				
HEALTH PROFESSION (circle):	PHYSICIAN'S ASSISTANT	NURSE PRACTITIONER	NURSE CLINICIAN	
UPIN #:	SPONSORING PHYSICIAN (if applicable):			
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:	
PROFESSIONAL INFORMATION				
School Attended			Degree Received:	
Address (Street address, city, state, zip code)			Date of Graduation	
POST-GRADUATE CLINICAL TRAINING (Include all Preceptorships, Internships, Residencies, Fellowships)				
Name of Hospital/University			Type of Program	
Address (Street address, city, state, zip code)			Inclusive Dates:	
Program Director Name and Full Address			PHONE: ()	
Supervising Practitioner Name and Full Address			PHONE: ()	

Practitioner Name: _____

ADDITIONAL POST GRADUATE CLINICAL TRAINING	
Name of Hospital/University	Type of Program:
Address (Street address, city, state, zip code)	Inclusive Dates:
Program Director Name and Full Address	PHONE: ()
Supervising Practitioner Name and Full Address	PHONE: ()
ADDITIONAL POST GRADUATE CLINICAL TRAINING	
Name of Hospital/University	Type of Program:
Address (Street address, city, state, zip code)	Inclusive Dates:
Program Director Name and Full Address	PHONE: ()
Supervising Practitioner Name and Full Address	PHONE: ()
AFFILIATIONS: List all present and previous hospital affiliations (attach on separate sheet if necessary)	
Name of Facility	Capacity (Circle One): ACTIVE / COURTESY / CONSULTING OTHER:
Address (Street address, city, state, zip code)	Dates of Affiliation
Name of Facility	Capacity (Circle One): ACTIVE / COURTESY / CONSULTING OTHER:
Address (Street address, city, state, zip code)	Dates of Affiliation
Name of Facility	Capacity (Circle One): ACTIVE / COURTESY / CONSULTING OTHER:
Address (Street address, city, state, zip code)	Dates of Affiliation
MEMBERSHIP IN PROFESSIONAL SOCIETIES	
LIST MEMBERSHIPS	
_____	_____
_____	_____
_____	_____
LICENSURE	
Licensee, Type of License, name of Board Issuing License:	License Number:
State Licensed:	Expiration Date:
Other Licensure: (Type/State)	Number:
	Expiration Date:
UPIN Number (if applicable):	
EFCMG Number (if applicable):	Date Issued:

Practitioner Name: _____

PROFESSIONAL REFERENCES: List one (1) practitioner, of which can be a physician, and one (1) of same license, who has personal knowledge of your current 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.</u>	
Name and Full Address	Phone: ()
Name and Full Address	Phone: ()
Name and Full Address	Phone: ()
PREVIOUS EXPERIENCE (Military Service, Private Practice, but EXCLUDING training and teaching)	
Institution/Location	Dates:
Institution/Location	Dates:
Institution/Location	Dates:
LIABILITY 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 Name and Full Address	Policy Number:
Agent Name:	Phone: ()
Limits Per Occurrence:	Aggregate Amount:
INSURANCE HISTORY: 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 preceding five (5) years.	
Name and Full Address of Carrier	Dates:
	Policy Number:
Name and Full Address of Carrier	Dates:
	Policy Number:
IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE FULL DETAILS ON SEPARATE SHEET.	
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 cancelled, has your 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
2. Has any action, proceeding or investigation ever been initiated or taken against you by any governmental or law enforcement agency for you alleged violation of law which may be applicable to your professional practice or provision of care to patients?	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 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
6. 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	No
DISCIPLINARY ACTIONS		
IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS, 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 membership to any hospital, clinical or other healthcare facility ever been voluntarily or involuntarily surrendered, denied, suspended, revoke, limited or restricted?	Yes	No
6. Has your privileges at any hospital, clinic, or other health care facility ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	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 from any such experience?	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

<i>DISCIPLINARY ACTIONS (Cont'd)</i>		
12. Have you ever been charged with or convicted of any crime related to your clinical practice, including Medicare or Medicaid related crimes?	Yes	No
13. Have you ever been subjected to civil money penalties under the Medicare or Medicaid program?	Yes	No
14. Have you ever been suspended from participation in or sanctioned by Medicare or Medicaid?	Yes	No
15. Have you ever been voluntarily or 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
16. 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 Allied Health Professionals 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 Allied Health Professionals 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 STATEMENT

By signature below, I acknowledge that Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis 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.

ACKNOWLEDGMENT:

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 Number

Practitioner's Signature

Practitioner's Initials

Date

CC: Pharmacy Department
Health Information Services
Business Office

CAROLINAS SPECIALTY HOSPITAL

CLINICAL PRIVILEGE DELINEATION REQUEST FORM ALLIED HEALTH PROFESSIONAL

Last Name:	First Name:	Middle Initial:
Circle appointment type requesting: Initial Reappointment Temporary/Locum Tenens		
Circle age specification for privileges requesting: Adults (adult age to 61) Geriatrics (age 62 or older)		
Professional Category (circle): Nurse Practitioner Physician Assistant		
Name of Sponsoring Physician:		

<input checked="" type="checkbox"/> Indicate the privilege(s) you are requesting by placing a check mark in the box to the left of the privilege(s):	Granted	Conditions	Denied
<input type="checkbox"/> Obtain patient histories and perform physical examination			
<input type="checkbox"/> Patient Rounds			
<input type="checkbox"/> Develop and implement a treatment plan			
<input type="checkbox"/> Monitor the effectiveness of therapeutic interventions			
<input type="checkbox"/> Complete progress notes			
<input type="checkbox"/> Document in medical record, write and/or dictate H&P, dictate discharge summaries, and authorize verbal and written orders. <i>(All documentation in the patient's chart must be validated & countersigned every 48 hours by their sponsoring physician.)</i>			
<input type="checkbox"/> Instruct/teach patients			
<input type="checkbox"/> Remove sutures/drains			
<input type="checkbox"/> Venipuncture as appropriate to documented education/training or licensure.			
<input type="checkbox"/> Irrigation/packing wounds			
<input type="checkbox"/> Debride and care for superficial wounds including sharps removal of necrotic tissue only			
<input type="checkbox"/> Make appropriate referrals			
<input type="checkbox"/> Additional Treatments/Procedures (must specify):			

APPLICANT SIGNATURE

Date

SPONSORING PHYSICIAN: (By signature below, I have reviewed and approve the requested privileges)

SIGNATURE OF SPONSORING PHYSICIAN

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.