



# **Application for Employment**

**Kentucky**

**Copies of the following must be included in your packet:**

- All State Medical Licensure**
- State Controlled Substance License**
- DEA Certificate**
- ACLS, ATLS, PALS, BLS etc**
- Driver's License**
- Color Photo - Clear and Current**
- Proof of CME - Past 3 Years**
- ECFMG - if applicable**
- Copy of Medical School Diploma**
- CV (current)**
- Board Certificate - if applicable**
- Recent TB Test Results**
- NPI Letter or Email**
- Birth Certificate**



## Contact Information

**Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_

**Pager & Pin:** \_\_\_\_\_

**Other Number:** \_\_\_\_\_



**Please List at least 5 peer references:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

## Immunity and Release

I understand and agree that I am in the process of applying as an Independent Contractor to staff contracts held by Hospital Care Consultants and that no agreement will be effective until signed by both Hospital Care Consultants and me nor will I have any contractual agreement with Hospital Care Consultants until that occurs.

I hereby confirm that the information contained in my application is complete and accurate. Material omissions or false statements may be grounds for Hospital Care Consultants disregarding this application or terminating my Independent Contractor status. I authorize Hospital Care Consultants to contact the references listed in this application and to conduct a customary investigation of my professional background and personal history, including contacting sources not listed by me. A photocopy of this authorization shall be as valid as the original.

I hereby release and hold harmless from and against any and all liability all representatives of Hospital Care Consultants and the Hospital(s) for their acts and communications performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I also hereby release from any liability any individuals and organizations who provide information to Hospital Care Consultants and the Hospital(s) in good faith and without malice concerning my professional competence, ethics, character and other qualifications for employment, clinical privileges and staff appointments, and I hereby consent for the release of such information.

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**Signature**

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**Printed Name**

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**Date**



# Emergency Department Experience



\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

# Other Hospital/Practice Experience

(continued - if necessary)



\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

\_\_\_\_\_  
Hospital/Practice Name Chief of Staff/Supervisor Name

\_\_\_\_\_  
Street Address City, State, Zip

\_\_\_\_\_  
Department Start Date End Date

# Physician's Authorization

I hereby authorize Hospital Care Consultants or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at any facility contracted by Hospital Care Consultants of the amount payable to such individual under Part B or Title XVIII of the Social Security Act and to receive on my behalf any payments that may be made pursuant to such assignment. It is understood and agreed that the reasonable charge, which will serve as the basis for payments in accordance with the terms of such assignment, shall be the full charge for the service.

This authorization may be withdrawn at any time upon giving at least 30 days prior written notice to the administrator.

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**Physician's Signature**

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**Printed Name**

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**Date**



## Health Statement

I hereby declare that \_\_\_\_\_ is in good physical health, mentally and emotionally stable, further more, has no health impairments affecting the priveleges requested in his/her application to Hospital Care Consultants. This physician has not been hospitalized or institutionalized for any significant health problems during the past five years and is not receiving current therapy for any health problems.

**\*\*to be completed by a physician other than yourself\*\***

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**



# Emergency Medicine Delineation

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform in an emergency situation

3 - I have not performed, and I am not comfortable in performing in an emergency situation

1 2 3	<b>Management of electrolyte disturbances</b>	1 2 3	<b>Treatment of diabetic ketocidosis</b>
1 2 3	<b>Suturing, including facial lacerations</b>	1 2 3	<b>Treatment of snakebite</b>
1 2 3	<b>Treatment of common poisonings</b>	1 2 3	<b>Routine x-rays for fracture</b>
1 2 3	<b>Management of pediatric emergencies</b>	1 2 3	<b>Anesthesia (IV conscious sedation)</b>
1 2 3	<b>Management of severe head injuries</b>	1 2 3	<b>Bladder Cath/Irrigation</b>
1 2 3	<b>Treatment of hypovolemic shock</b>	1 2 3	<b>Cardiac Massage (closed/open)</b>
1 2 3	<b>Anesthesia (IV/regional block)</b>	1 2 3	<b>Central Lines</b>
1 2 3	<b>Arthrocentesis</b>	1 2 3	<b>Foreign Body Removal</b>
1 2 3	<b>Cardiac Electroconversion</b>	1 2 3	<b>Gastric Lavage</b>
1 2 3	<b>Cricothyotomy</b>	1 2 3	<b>Lumbar Puncture</b>
1 2 3	<b>Endotracheal intubation (nasal/oral)</b>	1 2 3	<b>Nasal Packing/Cautery</b>
1 2 3	<b>Fracture/Dislocation (Reduc./Immobil.)</b>	1 2 3	<b>Wound repair/Dressing</b>
1 2 3	<b>Incision/Drainage</b>	1 2 3	<b>Paracentesis</b>
1 2 3	<b>Interosseous IV</b>	1 2 3	<b>Pericardiocentesis</b>
1 2 3	<b>Nail Trephination/Removal</b>	1 2 3	<b>Surgical Debridement</b>
1 2 3	<b>Pacemaker/IV or transcutaneous</b>	1 2 3	<b>Thoracostomy Tube Drainage</b>
1 2 3	<b>Peritoneal Lavage</b>	1 2 3	<b>Treatment of common orthopedic problems</b>
1 2 3	<b>Spinal Immobilization</b>	1 2 3	
1 2 3	<b>Thoracentesis</b>	1 2 3	
1 2 3	<b>Precipitous Vaginal Delivery</b>	1 2 3	
1 2 3	<b>Diagnosis &amp; treatment of common cardiac arrhythmias</b>		
1 2 3	<b>Familiar with Public Health recommendations regarding venereal disease</b>		
1 2 3	<b>Diagnosis/mangement of respiratory failure, including mechanical ventilation</b>		

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



# Hospitalist Delineation

Please circle the appropriate number for each item

1 - I am familiar with this procedure/have performed and competent to perform

2 - I have not performed, but I have been trained; competent to perform

3 - I have not performed, and I am not comfortable in performing

- |       |   |       |   |
|-------|---|-------|---|
| 1 2 3 | <b>Arterial catheterization for monitoring</b>          | 1 2 3 | <b>Paracentesis</b>                       |
| 1 2 3 | <b>Arterial puncture for ABG</b>                        | 1 2 3 | <b>Pericardiocentesis - emergent</b>      |
| 1 2 3 | <b>Arthrocentesis</b>                                   | 1 2 3 | <b>Placement transvenous pacer</b>        |
| 1 2 3 | <b>Bone marrow biopsy</b>                               | 1 2 3 | <b>Rhythm strip interpretation</b>        |
| 1 2 3 | <b>Bone marrow aspirate</b>                             | 1 2 3 | <b>Simple Peripheral IV catheter</b>      |
| 1 2 3 | <b>Bronchoscopy, diagnostic</b>                         | 1 2 3 | <b>Swan-Ganz catheter</b>                 |
| 1 2 3 | <b>Cardioversion - emergent</b>                         | 1 2 3 | <b>Thoracentesis</b>                      |
| 1 2 3 | <b>Central venous catheter placement and management</b> | 1 2 3 | <b>Thrombolysis infusion</b>              |
| 1 2 3 | <b>Chest tube</b>                                       | 1 2 3 | <b>Ventilator management</b>              |
| 1 2 3 | <b>Code Team Leader</b>                                 | 1 2 3 | <b>Endotracheal intubation</b>            |
| 1 2 3 | <b>Conscious sedation</b>                               | 1 2 3 | <b>Lumbar puncture</b>                    |
| 1 2 3 | <b>External jugular catheterization</b>                 | 1 2 3 | <b>Neonatal Privileges</b>                |
| 1 2 3 | <b>External/transcutaneous pacemaker</b>                | 1 2 3 | <b>Suprapubic Bladder Catheterization</b> |
| 1 2 3 | <b>Aspiration &amp; Joint injection</b>                 | 1 2 3 | <b>Interosseous IV</b>                    |

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date





# Past and Pending Claims Information



\*Please copy this form for each incident reported

**Physician Name:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Date of Claim:** \_\_\_\_\_

**Patients Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**Nature of treatment and diagnosis at time of incident:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allegations made against you:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did the patient expire? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Disability:** \_\_\_\_\_

**Was the case settled? Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Amount of settlement?** \_\_\_\_\_

**Pending:** \_\_\_\_\_ **Settled:** \_\_\_\_\_

**Mediation/Arbitration:** \_\_\_\_\_ **Suit Dropped:** \_\_\_\_\_

**Trial:** \_\_\_\_\_

**Names of other doctors and hospitals, if any, involved in the claim of this suit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Date completed**

\_\_\_\_\_  
**Signature of Applicant**

## Billing Information

In order to expedite the billing process for the facilities you will be working at, please provide the following information:

**Physician Name:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_

**UPIN Number:** \_\_\_\_\_

**Medicare Number:** \_\_\_\_\_

**Medicaid Number:** \_\_\_\_\_

**Drivers License Number:** \_\_\_\_\_

**Drivers License Expiration Date:** \_\_\_\_\_

**Drivers License State:** \_\_\_\_\_



# Authorization for Enumeration for NPI

I, \_\_\_\_\_ (please print name and credentials), with  
\_\_\_\_\_ (name of group), hereby authorize Hospital Care  
Consultants (HCC) to cause to be submitted an application enumeration under the NPI  
system (NPPES) on my behalf.

I further authorize HCC to acquire a user name and log-in ID for the NPPES account  
created in my name, to enable updates and correction to the information as required  
by the rules and regulation governing the National Provider Identifier standard. I will  
supply any changes and correction to such information to HCC in a timely fashion, to  
allow them to appropriately perform this function on my behalf.

This authorization shall continue until such time as: 1) I request in writing, HCC to turn  
over the NPPES user name and log-in ID to me for upkeep on my account, or 2) I am  
no longer affiliated with the group, name above, or 3) until the relationship between  
the group and HCC terminates, pursuant to the terms of the Billing Services Agreement  
between the same.

Executed this \_\_\_\_\_ day of \_\_\_\_\_ (month), \_\_\_\_\_ (year)

\_\_\_\_\_  
**Signature**



# **Form KAPER-1 (03/2007)**

## **Part B, Section 2**

**For Health Care Providers Desiring Reappointment  
for Health Care Facility Privileges.**

## Commonwealth of Kentucky

### Instructions - Form KAPER-1 (03/2007) Part B, Section 2

**A. Uniform Application for Re-evaluation (Recredentialing) Form.** Following is the form KAPER-1 (03/2007), Part B, Section 2 developed pursuant to KRS 304.17A-535(5) for re-evaluation (recredentialing) of health care providers. The form is available on the Web site of the Kentucky Office of Insurance (<http://doi.ppr.ky.gov/kentucky/>). Prior to completing this form, a health care provider who desires re-evaluation (recredentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete form KAPER-1 (03/2007), Part B, Section 2 and required attachments as applicable and specified in item C of this instruction.

**B. Cover Letter.** A cover letter, which is signed and dated by the provider, who desires re-evaluation (recredentialing) by a hospital or health care facility, requesting consideration of the complete form KAPER-1 (03/2007), Part B, Section 2 and required attachments as applicable and specified in item C of this instruction, may be required.

**C. Required Attachments.** Unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (03/2007), Part B, Section 2 in the following order:

1. Current medical, dental or professional license;
2. Current federal drug enforcement agency (DEA) certificate for each state of practice;
3. Current state substance registration certificate;
4. Proof of current professional liability insurance, including name, limits of liability and expiration dates. Additionally, if an affirmative response is entered for any question in Section VII of this section, provide a written explanation on an additional page of this attachment;
5. Proof of continuing medical education (CME) or continuing education unit (CEU) credits obtained in the past two (2) years [Please note: In lieu of this, please return CME Attestation Form with your application]; and
6. Separate pages, as applicable, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: Last Suffix First Middle Maiden Name Degree

Medical Staff Allied Health (please specify)

Residence: Phone: Fax:

Primary Office Address: Phone: Fax:

Secondary Office Address: Phone: Fax:

Billing Office Address: Phone: Fax:

Credentialing Address: Phone: Fax:

Credentialing Contact: Credentialing Email:

Preferred Mailing Address: Primary Office Residence Other (please specify)

Phys. Email Address: Prac. Admin's Email: Office Web Address:

Date of Birth: Gender: Place of Birth:

Social Security #: Marital Status:

Citizenship: Spouse:

(If not a US citizen, please complete the next three fields)

Visa Status: Alien Reg. #: Exp. Date:

Language Spoken:

ECFMG #: Pager #: Alpha Digital Voice

Medicare #: Cellular #:

Medicaid #: Answering service #:

UPIN #: Are you taking new patients? :

EIN #: Taxonomy Code:

NPI #:

Clinical Specialty/Subspecialty:

Other interests in practice, research, etc.:

Name others with whom you are or will be associated in practice:

Nature of association: Solo Group Partnership Corporation Effective Date:

Other: (please specify):

Name of Practice (if applicable):

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: Specialty: Telephone:

Name: Specialty: Telephone:

Name: Specialty: Telephone:

**II. TEACHING APPOINTMENTS**

Name: \_\_\_\_\_ Department Chief \_\_\_\_\_ Type of Appointment \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_ / \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ ZIP \_\_\_\_\_ ZIP+ \_\_\_\_\_ From (mm/yy) \_\_\_\_\_ To (mm/yy) \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**III. POST-GRADUATE AND CONTINUING EDUCATION COURSES**

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance. **[Please note: In lieu of this question, please return CME Attestation Form with your application.]**

YES  NO  List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____

**Please attach copies of all certificates.**

**IV. LICENSURE INFORMATION**

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

State:	License #:	Date Issued:	Expiration Date:	Status:	License Obtained by:
KY State: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

**V. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)**

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: \_\_\_\_\_ Expiration: \_\_\_\_\_

Federal DEA Certificate #: \_\_\_\_\_ Expiration: \_\_\_\_\_

**VI. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)**

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: \_\_\_\_\_

Certificate #: \_\_\_\_\_ Expiration: \_\_\_\_\_

State: \_\_\_\_\_

Certificate #: \_\_\_\_\_ Expiration: \_\_\_\_\_

**VII. PROFESSIONAL LIABILITY DATA**

**Answer the following questions as they apply to the last two (2) years:**

- 1. Has your professional liability insurance coverage been terminated by action of the insurance company?  Yes  No
- 2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?  Yes  No
- 3. Has your present professional liability insurance carrier excluded any specific procedures from our coverage?  Yes  No
- 4. Have any professional liability suits or claims been filed against you?  Yes  No
- 5. Have any professional liability suits or claims been filed against you which are presently pending?  Yes  No
- 6. Have any judgments or settlements been made against you in professional liability cases?  Yes  No
- 7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund?  N/A  Yes  No
- 8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act?  N/A  Yes  No

**If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.**

**PROFESSIONAL LIABILITY DETAIL SHEET**

**(Please copy this page if additional sheets are needed)**

CHECK HERE IF NOT APPLICABLE

**Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:**

Pending  Settled Date: \_\_\_\_\_

List the allegations: \_\_\_\_\_

Date of occurrence: \_\_\_\_\_

Name of institution involved (i.e., hospital): \_\_\_\_\_

Name and address of insurance carriers involved: \_\_\_\_\_

**Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.**

Title of the court case: \_\_\_\_\_

The court case number: \_\_\_\_\_

The venue of the case (place where court case took place, such as County District Court or Circuit Court): \_\_\_\_\_

Allegations listed in complaint: \_\_\_\_\_

Date of incident leading to complaint: \_\_\_\_\_

Place of incident: \_\_\_\_\_

Name and address of malpractice insurance carrier: \_\_\_\_\_

Amount of jury award or amount awarded by the court: \_\_\_\_\_

**VIII. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION**

**(Allied Health Professional: list national certifications)**

- 1. Are you board certified?  Yes  No (If not Board admissible, please explain on separate sheet and attach)
- 2. If yes, list full name of certifying board and date which you obtained certification/recertification:  
\_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_
- 3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:  
\_\_\_\_\_ Date: \_\_\_\_\_
- 4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: \_\_\_\_\_
- 5. List date of next required recertification (if applicable): \_\_\_\_\_
- 6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain.  Yes  No

**IX. INDIVIDUAL PRACTICE INFORMATION**

**Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.**

- 1. Are there any actions that have been initiated or are any pending against you by any state licensing board?  Yes  No  
 Pending  Resolved
- 2. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed?  Yes  No
- 3. Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s).  Yes  No
- 4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?  Yes  No
- 5. Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed?  Yes  No
- 6. If applicable, is your federal and/or state narcotics registration certificate being challenged?  Yes  No
- 7. Have you been named as a defendant or convicted of a felony or misdemeanor?  Yes  No
- 8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility?  Yes  No
- 9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?  Yes  No
- 10. Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility?  Yes  No
- 11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?  Yes  No

**X. PERSONAL HEALTH STATUS**

**Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.**

- 1. Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?  Yes  No
- 2. Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?  Yes  No
- 3. Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?  Yes  No

**XI. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS**

**A. Employment [Commonwealth Credentialing requires only information relating to the past 2 years.]**

List in chronological order all **professional employment** since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

**B. Affiliations [Commonwealth Credentialing requires only information relating to the past 2 years.]**

List in chronological order all **professional affiliations** since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) / To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) / To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_ / \_\_\_\_\_  
From (mm/yy) / To (mm/yy)  
Address: \_\_\_\_\_ Type of Privileges/Position: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_  
City St ZIP ZIP+ Country  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

## XII. PEER REFERENCES

Name two peers who have personal knowledge of your current clinical abilities, ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_ Country: \_\_\_\_\_  
Fax: \_\_\_\_\_

Reference: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/St/ZIP: \_\_\_\_\_ Country: \_\_\_\_\_  
Fax: \_\_\_\_\_

**XIII. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)**

**(Please read carefully before signing)**

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

**Applicant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_