Families First

support for families...health care for all

APPLICATION FOR MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

GENERAL INSTRUCTIONS:

Please print or type all responses and complete the application in full. All questions must be answered even if they are not applicable. Attach additional sheets if there is insufficient space on this form for your responses.

Current copies of the following documents must accompany this application (if not already previously submitted):

- Curriculum Vitae
- Current license
- DEA registration/certificate
- Board Certification
- Professional Liability Policy and Current Coverage Certificate.
- ECFMG certificate, if international medical graduate
- Current passport or other government issued picture identification
- Proof of complete physical exam dated within 12 months of your start date. You may schedule a physical exam with Families First Health Center.
  Immunization records that include Varicella, Hepatitis B, MMR Titer and PPD – Mantoux.
  See form that is included.
- Three Letters of Recommendation. One could be from the Director of your training program and two additional letters of reference. **As we talked on the phone, I will send letters to your references when I have their addresses.**
- Copy of current Life Support Training Certificate
- Copies of certifications such as ACLS, ALSO, PALS ATLS or NALS
- Delineation of Privileges, attached

Please return all of the above to:
Wanda McDonough, Human Resources Director
100 Campus Drive, Suite 12
Portsmouth, NH 03801

If you have any questions please call me at 603-422-8208, x116 or e-mail wmcdonough@familiesfirstseacoast.org

FAMILIES FIRST
Employee Health Requirements

Pre-employment Physical Exam

A pre-employment physical, including a complete medical history and Review of Systems, has been completed on the above person. I have found this person to be free of communicable disease or other impairment that would affect their ability to perform the functions and duties of their position.

Provider' s Signature______________________________________
Date____________________

Documentation of Required Immunizations or Titers.

MMR - All Employees should have two documented MMR vaccinations or positive MMR titers.

MMR: Date of # 1 ________________#2 ______________(or) Date of Titer_______________

Varicella -Direct Clinical Employees are required to show proof of vaccination or immunity, either by titer or employee confirmation statement.
Varicella: Date of vaccination______________(or)Date of titer or Disease______________

Td/ Tdap-Direct Clinical Employees require a Td booster dose every 10 years, following the completion of the primary 3-dose series. Give a 1-time dose of Tdap to all direct clinical staff younger than age 65 years.
Td/ Tdap: Date of vaccination________________ Td_______ Tdap__________

Hepatitis B -Offered to all employees with occupational exposure to blood and body fluids.

Has had Hepatitis B series prior to employment here.____Yes ________No ________N/A
Date of last immunization____________________
New Series: Hep B # 1________________ Hep B # 2_____________Hep B # 3____________
(1-2 months after #1) (6 months after #1)
Post Titer Date/ Results_________________(repeat series if negative)

PPD-Direct Clinical Employees are required to provide documentation of testing within the 12 months prior to date of hire. A second PPD 2 -4 weeks after the first is required if more than 12 months since last PPD.
PPD # 1: Date given:___________Date Read :__________Results: __________
PPD #2: Date given: ____________Date Read :___________Results: ________

Attach copies of titers and prior PPD results to this form

Provider Signature______________________________________Date _________________

Families First

support for families...health care for all

PHYSICIAN/NURSE PRACTITIONER APPLICATION

Personal Information

Name____
Last First Middle

Alternative names used during professional career (maiden name or previous married names)

____

Residence Address ____
Street Suite/Apartment #

______________________________ ______________________________
City State Zip Code Telephone #

Email address: ______________________________

Date of Birth_________ Place of Birth_____________________ Citizenship__________

Social Security Number ___ - __ - _______ Driver's License Number and State____________________

Please list any languages other than English spoken by you: ______________________________

Previous addresses for the last 7 years (use additional page if needed)

______________________________ ______________________________
Street Address City, State and Zip Code

______________________________ ______________________________
Street Address City, State and Zip Code

______________________________ ______________________________
Street Address City, State and Zip Code

Licensure/Registrations

Medical/Dental/Other License: List all current and past and specify type. Indicate any restrictions on any current or prior license.

State/Country	Type	Number	Yr. Issued	Exp.Date	Restrictions

______________ _______ _______ _______ _______ ______________

Controlled Substance Registration (DEA): (Circle or list authorized schedules)

Federal Number______________ Date Expires_________________ Schedules: 2 2N 3 3N 4 5

NPI #______________________ User Name_______________________ Password___________________

CAQH #___________________ User Name_______________________ Password___________________

ECFMG Certification (if applicable):

Certificate # _________________Year Issued _________________ Date Expires________________

Education

Undergraduate:

Institution____ Dates ___/___ /___ to ___ /___ /___

Full Address:____

Degree Awarded____ Date of Degree ______________

Medical School

Institution____ Dates ___/___ /___ to ___ /___ /___

Full Address:____

Degree Awarded____ Date of Degree _____________

Residency/Fellowship/Internship:

Institution____ Dates ___/___ /___ to ___ /___ /___

Full Address:____

Institution____ Dates ___/___ /___ to ___ /___ /___

Full Address:____

Specialty Training

Institution____ Dates ___/___ /___ to ___ /___ /___

Full Address:____

Specialty______________________________________ Program Director __________________

Employment (for past 10 years) Any gaps of more than 3 months must be explained.

Employer Name____________________________________ Dates ___/___ /___ to ___ /___ /___

Address and Phone Number____

Job Title_____________________________________ Reason for Leaving_______________________

Employer Name____________________________________ Dates ___/___ /___ to ___ /___ /___

Address and Phone Number____

Job Title_____________________________________ Reason for Leaving_______________________

Employer Name____________________________________ Dates ___/___ /___ to ___ /___ /___

Address and Phone Number____

Job Title_____________________________________ Reason for Leaving_______________________

Employer Name____________________________________ Dates ___/___ /___ to ___ /___ /___

Address and Phone Number____

Job Title_____________________________________ Reason for Leaving_______________________

Practicing Specialty

Primary Specialty(ies)____

Initial Certification Date:_______________ Expiration Date: ____________________

Board Certified? Yes/No Last Recertification Date:_____________________________

If not certified, why not? ____

Secondary Specialty(ies) ____

Initial Certification Date:_______________ Expiration Date: ____________________

Board Certified? Yes/No Last Recertification Date:_____________________________

If not certified, why not? ____

Professional Career

List all current and prior affiliations/appointments in chronological order OR attach a current *Curriculum Vitae.*

Hospital Affiliations:

Name & Full Address	Department	Category	Inclusive Dates
1. ______________________ ______________________	____________	____________	___ / ___ / ___

Prior Practice Affiliations:

Name & Nature of Practice	Inclusive Dates
1. ____	___ / ___ / ___
Address ____________________________________	
2.. ____	___ / ___ / ___
Address ____________________________________	

Academic Appointments:

School Name and Location	Rank	Department	Inclusive Dates
1. ______________________ ______________________	____________	____________	___ / ___ / ___
2. ______________________ ______________________	____________	____________	___ / ___ / ___
3. ______________________ ______________________	____________	____________	___ / ___ / ___

Other Institutional Affiliations: (industrial, military service, etc.)

Name	Address	Inclusive Dates
1. ______________________	________________________	___ / ___ / ___

____________________________ ____________________________

2. __________________________ ____________________________ ___ / ___ / ___

____________________________ ____________________________

Peer References

Please list three peer references:

1) Name: ____

Institution Name & Address: ____

____

Telephone: ____

2) Name: ____

Institution Name & Address: ____

____

Telephone: ____

3) Name: ____

Institution Name & Address: ____

____

Telephone: ____

I hereby authorize Families First Health and Support Center to contact the references stated above and any other references they feel are appropriate.

Signature:____ **Date:**______________________

Professional Liability Insurance

Current Company_____________________________________Policy Number____________________

Full Address____

Effective Date ___ / ___ / ___ Expiration Date ___ / ___ / ___ Amount of Coverage________________

If insured less than five (5) years:

Previous Company_______________________________________Policy Number_____________________

Full Address____

Effective Date ___ / ___ / ___ **to** ___ / ___ / ___ Amount of Coverage________________

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual surcharge placed on you based on your individual experience?

YES NO

If yes, please explain: ____

____

____

____

PROFESSIONAL LIABILITY ADDENDUM
TO INITIAL/REAPPOINTMENT APPLICATIONS

If you answered yes to disclosure question #9, please provide the following detailed information for each malpractice claim brought against you, including pending claims, lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments. (Please make additional copies of this page if needed.)

Claim #1

Date of Occurrence__________ Amount paid/in reserve to resolve claim______________________

Institution Involved (i.e. hospital, etc.)____

Name of Insurance Carrier____

Insurance Carrier Address/City/State/Zip____

Current status of claim (open/closed/pending/resolved, etc.)_______________ Date Closed_________

Details of Allegations____

____

____

Claim #2

Date of Occurrence_________ Amount paid/in reserve to resolve claim____________________

Institution Involved (i.e. hospital, etc.)____

Name of Insurance Carrier____

Insurance Carrier Address/City/State/Zip____

Current status of claim (open/closed/pending/resolved, etc.)______________ Date Closed_________

Details of Allegations____

____

____

____ ____________________

Signature Date

____ ____________________

Print Name SSN

DISCLOSURE QUESTIONS

Please provide a complete, signed and dated explanation on a separate sheet if any of the following questions are answered in the affirmative.

1. Yes No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board of any health-related agency or organization, or is there a review pending?

2. Yes No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you ever voluntarily relinquished your DEA registration, or is there a review pending?

3. Yes No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?

4. Yes No Have you ever voluntarily or involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration as an alternative to disciplinary action, or prior to or during an investigation into your professional conduct or competence?

5. Yes No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any **medical education**

institution/program, **licensing board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization**?

6. Yes No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

7. Yes No Are there any **charges pending or are you currently charged with** or have you ever been indicted or found guilty of a felony, misdemeanor (other than a minor traffic violation), **or other offense involving** fraud, misrepresentation, dishonesty or deceit?

8. Yes No Have you ever been the **subject or target of a sexual harassment complaint** or investigation or other complaint or investigation involving sexual misconduct or impropriety?

9. Yes No Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Professional Liability Addendum. You may be asked for additional information by individual organizations.**

10. Yes No Has your **professional liability carrier** ever refused or canceled your coverage?

11. Yes No **Have you ever been convicted of using illegal drugs?**

12. Yes No **Have you ever been convicted of driving under the influence?**

13. Yes No **Do you have any reason to believe that you may not be able to obtain hospital privileges?**

14. Yes No **Do you have permanent legal authorization to work in the United States? If no, please indicate your current work status:____**

Families First

support for families...health care for all

Please explain any yes answers in the space provided or by attaching a separate sheet. This form will be kept confidential in your credentials file.

1. Do you presently have any physical mental condition that may affect your ability to perform clinical or professional duties? Yes_______ No___________
   If yes, please explain:
   ____
   ____

2. Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to any physical or mental condition that may affect your ability to perform clinical or professional duties? Yes_______ No___________
   If yes, please explain:
   ____
   ____

3. Do you presently suffer from an addiction to drugs, alcohol, or other chemical substances that my affect your ability to perform clinical or professional duties? Yes_______No___________
   If yes, please explain:
   ____
   ____

4. Within the past five years have you been treated in an inpatient or outpatient facility or have you missed work due to an addiction to drugs, alcohol or other chemical substances?
   Yes_______ No___________
   If yes, please explain:
   ____
   ____

5. Do you any communicable diseases? Yes_______ No___________
   If yes, please explain:
   ____
   ____

6. What is the date of your last physical? _________________________
   Performed by____

I (please print full name) _____________________________________can attest that I am in good health and have no physical or mental conditions that may affect my ability to perform clinical or professional duties. I can also attest that I have not current addictions to drugs, alcohol or any other recreational chemical substances. I understand that I may not hold Families First Health and Support Center responsible for any physical or mental conditions or addictions that I have or have not discussed.

Clinician
Signature____Date____________________________

Families First

support for families...health care for all

I understand that Families First is required to credential and re-credential providers every two years and therefore, I agree to make available to Families First any documents or records, either in my possession or in the possession of another, which may have a material and reasonable bearing on my suitability as a contracted provider.

I hereby authorize any and all persons, institutions and organizations with information pertaining to my professional standing or qualifications as a provider to furnish upon request, all such information to Families First its employees and agents. In consideration for the furnishing by a person, institution or organization from and against any and all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to Families First made in good faith and without malice in conformance with this authorization.

A copy of this document shall be considered as valid as the original.

Print Name____

Signature____

Date ____

ATTESTATION SIGNATURE AND DATE

I hereby certify that all the information on this application form is complete, true and accurate.

Signature ____ Date ______________

Name____NPI#:_________________________
(please print or type)

SSN ____

Families First

support for families...health care for all

REQUEST FOR PRIVILEGES

Granting, reviewing and changing of clinical privileges for the staff of Families First Health Center will be in accordance with policy. Assignment of such clinical privileges is based upon education, clinical training, experience, demonstrated current competence, documented results of patient care and other quality review, as appropriate.

The principle of "documented competency" will prevail. Adult medicine, pediatrics, perinatal care and minor surgical care are all aspects of Families First Health Center's continuity of care. As a result, privileges in these areas are identified to pertain to primary care specialties of pediatrics, internal medicine, family medicine, allergy, dermatology, and obstetrics/gynecology.

Check all that you are applying for:

OPTION 1: GENERAL FAMILY MEDICINE **Yes_____ No_____**

OPTION 2: GENERAL PEDIATRICS **Yes_____ No_____**

OPTION 3: INTERNAL MEDICINE **Yes_____ No_____**

OPTION 4: OBSTETRICS AND GYNECOLOGY (Women's Health) **Yes_____ No_____**

OPTION 5: ALLERGY/IMMUNOLOGY **Yes_____ No_____**

OPTION 6: DERMATOLOGY **Yes_____ No_____**

OPTION 7: GENERAL PSYCHIATRY **Yes_____ No_____**

OPTION 8: SPECIFIC PROCEDURES:

Procedure	
Acupuncture	Yes____ No____
Allergy testing	Yes____ No____
Casting	Yes____ No____
Cryosurgery	Yes____ No____
Cryotherapy of Cervix	Yes____ No____
Diaphragm Fitting	Yes____ No____
Endometrial Biopsies	Yes____ No____
Incision and Drainage	Yes____ No____
IUD Insertion	Yes____ No____
Joint Aspiration/Injection	Yes____ No____
Laceration Repair	Yes____ No____
Skin Biopsy/Excision	Yes____ No____
Trigger Point Injection	Yes____ No____
Vulvar Biopsy	Yes____ No____
Wart Removal	Yes____ No____

I hereby request clinical privileges as indicated above.

Signature: ___________________________________ Date: ___________

Medical Director's Signature______________________________ Date: ___________

Approved by Board of Directors on ____

Chair of the Board of Directors signature____