ACUTECARE HEALTH SYSTEM

Specialty Hospital At Monmouth/ Specialty Hospital At Kimball

Allied Health Professional Application

IDENTIFYING INFORMATION		
LAST NAME FIRST NAME MI	BIRTHPLACE	DATE OF BIRTH
OFFICE ADDRESS CITY, STATE ZIP CODE		TELEPHONE NUMBER ( )
HOME ADDRESS CITY, STATE ZIP CODE		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 ADMINISTRATIVE NUMBER	
NAME AND TELEPHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY		
HEALTH PROFESSION:		
PRACTICE LIMITED TO:	SPONSORING PHYSICIAN (if applicable):	
CLINICAL FIELD:		
PRE-PROFESSIONAL INFORMATION		
COLLEGE OR UNIVERSITY	DEGREE RECEIVED	
FULL ADDRESS	DATE OF GRADUATION:	
PROFESSIONAL INFORMATION		
SCHOOL ATTENDED	DEGREE:	
FULL ADDRESS	DATE OF GRADUATION:	
POST-GRADUATE CLINICAL TRAINING		
NAME OF HOSPITAL/UNIVERISTY	TYPE OF PROGRAM:	
FULL ADDRESS	INCLUSIVE DATES:	
PROGRAM DIRECTOR NAME AND FULL ADDRESS	PHONE: ( )	
SUPERVISING PRACTITIONER NAME AND FULL ADDRESS	PHONE: ( )	

ADDITIONAL POST GRADUATE CLINICAL TRAINING	
NAME OF HOSPITAL/UNIVERISTY	TYPE OF PROGRAM:
FULL ADDRESS	INCLUSIVE DATES:
PROGRAM DIRECTOR NAME AND FULL ADDRESS	PHONE: ( )
SUPERVISING PRACTITIONER NAME AND FULL ADDRESS	PHONE: ( )

ADDITIONAL POST GRADUATE CLINICAL TRAINING	
NAME OF HOSPITAL/UNIVERISTY	TYPE OF PROGRAM:
FULL ADDRESS	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): ACTIVE / COURTESY / CONSULTING* *OTHER:*
FULL ADDRESS	DATES OF AFFILIATION
NAME OF FACILITY	Capacity *(circle): ACTIVE / COURTESY / CONSULTING* *OTHER:*
FULL ADDRESS	DATES OF AFFILIATION
NAME OF FACILITY	Capacity *(circle): ACTIVE / COURTESY / CONSULTING* *OTHER:*
FULL ADDRESS	DATES OF AFFILIATION

MEMBERSHIP IN PROFESSIONAL SOCIETIES	
LIST MEMBERSHIPS	
_____	_____
_____	_____
_____	_____

LICENSURE	
LICENSEE, TYPE OF LICENSE, NAME OF BOARD ISSUING LICENSE:	LICENSE NUMBER:
SATE LICENSED:	EXPIRATION DATE:
OTHER LICENSURE: (TYPE/SATE)	NUMBER: EXPIRATION DATE:

UPIN Number (if applicable):	
ECFMG NUMBER (if applicable):	DATE ISSUED:

PROFESSIONAL REFERENCES: List three (3) practitioners, two of which can be physicians, 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. The named individuals must have acquired the requisite knowledge through observation of your professional practices over a reasonable period of time.

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 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 judgement 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 you r policy been cancelled, 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
2. Has any action, proceeding or investigation ever been initiated or taken against you by any governmental or law enforcement agency for your 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?	Yes	No
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, PLEASE GIVE FULL DETAILS ON SEPARATE SHEET.

1. Has your license to practice 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 surrendered, denied, suspended, revoked, limited or restricted?	Yes	No
5. Has your membership at any hospital, clinical or other healthcare facility ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	Yes	No
6. Has you r privileges at any hospital, clinical or other healthcare 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 withdrawn, or have you ever been suspended or terminated from any such experience?	Yes	No
8. Has your membership or fellowship in a 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 ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	Yes	No
11. Have you ever been convicted of a felony?	Yes	No
12. Have you ever been charged with or convicted of any crime related to your clinical practice, including Medicare or Medicaid related crimes: have you ever been subjected to civil money penalties under the Medicare or Medicaid program; have you ever been suspended from participation in medical or Medicaid?	Yes	No
13. Have you ever been voluntarily or involuntarily terminated or forced to resign, or resigned 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
14. Have you ever voluntarily accepted any of the above sanctions or restrictions under threat of same or voluntarily resigned under threat of same?	Yes	No
15. 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 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 Allied Health Professionals. 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 the 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 Allied Health Professionals, 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 _____

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 and Pharmacy for reference.

_____
Practitioner's Name Printed

_____
Office Address

_____
City, State, Zip Code

_____
DEA Number

_____
Dictation Number

_____
UPIN Number/ NPI Number

_____
Practitioner's Signature

_____
Practitioner's Initials

_____
Date

CC. Medical Records
Business Department
Health Information Office

AUTHORIZATION AND RELEASE OF LIABILITY

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 medial 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 had made available to me a copy of Specialty Hospital At Monmouth Medical Staff By-laws, The Rules and Regulations, and the Hospital By-laws, as amended from time to time, in all regards.

All information submitted by me in this application is true to the best of my knowledge and belief

_____ _____

Date Signature of Practitioner

_____

Printed Name of Practitioner

ACUTECARE HEALTH SYSTEM

Specialty Hospital at Monmouth *Specialty Hospital at Kimball*

Physician Medicare Acknowledgment Statement

Medicare payments to hospitals are based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patients' 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.

By signing, I acknowledge that I have read and understood the contents of this notice.

Date (Do not type or stamp, must be handwritten)	UPIN or NPI (If applicable, e.g., A12345 or 2345678901)
Attending Physician's Signature (Do not type or stamp, must be handwritten)	Attending Physician's Name (Please print)

Specialty Hospital at Monmouth/Kimball
MEDICAL STAFF APPLICATION
AUTHORIZATION FOR RELEASE OF DOCUMENTS
BY
SPECIALITY HOSPITAL AT MONMOUTH/KIMBALL

I hereby authorize and consent to the release by the Specialty Hospital At Monmouth Administrative Office of such information and/or documents as may be necessary for the Specialty Hospital At Monmouth to use in the processing of this medical staff application.

Such release of information may include, but shall not be limited to the following documents

- Copy of License (certificate) to Practice Medicine in the State of NJ
- Copy of DEA permit
- Copy of Malpractice Insurance Coverage

Date

Signature of Practitioner

Printed Name of Practitioner

ADDENDUM TO APPLICATION FOR CONTINUED MEMBERSHIP / CLINICAL PRIVILEGES

Practitioner Name: _____

Credentialing Contact Name: _____

Email: _____ Phone: _____ Fax: _____

Practitioner NPI:	

Tax ID:	

Medicare:	Medicaid:

HEALTH STATUS

Date of Latest Tuberculin (PPD) Test: (MM/DD/YY) _____

Results: _____ *Negative* _____ *Positive*

X-rays Taken ___ Yes _____ No : *Results:* _____

Conflict of Interest
Annual Compliance Acknowledgement

I have read the Conflict of Interest Policy and understand its contents. By executing this certificate, I hereby acknowledge my obligation and agreement to abide by the policy and procedure as set forth in the Conflict of Interest Policy. I further certify that to the best of my knowledge and belief and subject to the exceptions, if any, listed below, I have complied with the Conflict of Interest Policy.

_____
Name (Please Print)

_____ _____
Signature Date

The following matters, if any, are the sole exceptions to the above statements:

_____

_____

_____

HEALTH SCREENING ATTESTATION

The Joint Commission (TJC) requires hospital organizations to screen for exposure and/or immunity to infectious diseases that licensed independent practitioners (physicians), hospital staff, students/trainees, and volunteers may come in contact with.

TB Screening:

Please note: Prior receipt of BCG vaccine is not a contraindication for a tuberculin skin (TST) A recent BCG may cause a false-positive TST Usually less than 10mm). Reactivity of TST due to BCG vaccination typically wanes 5 years after receiving the vaccine.

I have a positive TST history with a negative chest radiograph (latent TB) OR have completed therapy for active pulmonary TB in the past. I currently do not have signs/symptoms compatible with active TB.
(Note: a follow-up chest radiograph is only indicated if symptomatic).

☐ Yes ☐ No

I have a negative TST within the last 13 months

☐ Yes ☐ No

****** Attach a copy of recent PPD Screening results**

I am exempt from documented skin testing results due to the Permissible exclusion checked below:

- ☐ Documentation of previously reported positive reaction to a tuberculin testing
- ☐ Documentation of previously or presently adequately treated TB disease
- ☐ Documentation has been completed for adequate preventative therapy

Vaccine Preventable Diseases. Please check one of the Following:

To the best of my knowledge, I have immunity to chickenpox/ varicella, measles, mumps, and rubella through history of disease and /or vaccination.

☐ Yes ☐ No *If No:* please *check* which viral diseases you do not have known immunity

- ☐ chickenpox/varicella
- ☐ measles
- ☐ mumps
- ☐ rubella

I attest that the above information is correct.

_____ Date: _____
Signature

Practitioner Name (Printed): _____

ACHS
AcuteCare Health System, LLC

Dan Czermak
President

Howard Lebowitz, PhD
Chief Medical Officer

Violeta Peters, RN MA
Chief Executive Officer

CONTINUING MEDICAL EDUCATION ATTESTATION

Instead of providing copies of your program certificates or copies of what you provide the NJ Board of Medical Examiners for license renewal, you have opted to provide an attestation regarding your Continuing Medical Education credits for reappointment.

Please sign and date the bottom of the attestation statement that follows.

ATTESTATION STATEMENT

I attest I have earned the required amount of CME credits over the past 24 months. The CME's earned are related to my area of practice. I understand there could be a random audit and that I can provide proof of attendance and program content if requested.

_____ _____

Signature Date

Print Name:_____

cme.attestation

ALLIED HEALTH PROFESSIONAL DELINEATION OF PRIVILEGES

APPLICANT'S NAME:_____ DATE:_____

This is my: ☐ Initial Application ☐ Re-appointment Application ☐ I am modifying my privileges

Professional Category *(circle)*: Nurse Clinician Nurse Practitioner Physician Assistant

Name of Sponsoring Physician:

NO ADMITTING PRIVILEGES – THE PRIVILEGES LISTED BELOW ARE MEANT TO ASSIST AND NOT TO REPLACE THE PHYSICIAN'S RESPONSIBILITIES.

SPECIFIC TASKS/PROCEDURES	ACTION REQUIRED						
	PRIVILEGES REQUESTED		PRIVILEGES APPROVED		PRIVILEGES DENIED		COMMENTS
Check box of requested privileges	MEC REC		Board App	MEC REC	Board App	MEC REC	Board App
BASIC PROCEDURES							
☐ Obtain patient histories and perform physical exams							
☐ Patient Rounds							
☐ Develop and implement a treatment plan							
☐ Monitor the effectiveness of therapeutic interventions							
☐ Complete progress notes							
☐ Documentation in medical record, dictate, write H&P and discharge summaries, with authentication by physician signature.							
☐ Instruct/teach patients							
☐ Remove sutures/drains							
☐ Venipuncture as appropriate to documented education/training or licensure.							
☐ Irrigation/packing wounds							
☐ Debride and care for superficial wounds including sharps removal of necrotic tissue only							
☐ Make appropriate referrals							
OPTIONAL PROCEDURES *(must specify)* **Each procedure listed below will require written documentation of training and experience.**							
☐							
☐							
☐							
☐							

I certify that I am competent to perform the above procedures by virtue of my education, training, and experience.

_____ _____

Applicant's Signature Sponsoring Physician's Signature

APPROVED:

_____ _____

Medical Executive Committee Date

_____ _____

Board of Directors Date