Dear Doctor:

Thank you for your interest in _____. Enclosed you will find an Application and hospital specific Addendum/Supplemental forms required for Medical Staff Membership. In addition, the following items must also accompany your request for membership/privileges in order for your request to be deemed complete for processing.

- ☐ Completed Application, *signed and dated (enclosed)*
- ☐ Hospital Specific Documents, *signed and dated (enclosed)*
- ☐ Clinical Privileges Request form, *signed and dated (enclosed)*
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of Medical Degree and Intern/Residency/Fellowship Certificates of
- ☐ Current copy of proof of liability coverage certificate(s) for companies that afforded cover for prior five years (must include dates of coverage and limits)
- ☐ Copy of Board Certification Certificate (if applicable)
- ☐ Copy of Medical License
- ☐ Copy of Federal, and State when applicable, Controlled Substance Certificate(s)
- ☐ Completed Health Screening Attestation, *signed and dated (enclosed)*
- ☐ Copy of recent PPD screening results
- ☐ Copy of Continuing Medical Education (CME) hours received prior two year period *(Must include Category I Course Name, Location, and Number of Credits Earned)*
- ☐ Copy of Government Issued Photo ID (i.e., State Drivers License, Passport)
- ☐ Copy of current Curriculum Vitae

Please return your completed application and supplemental forms along with the above listed attachments to:

_____

_____

_____

Again, thank you for your interest and if you have any questions please call _____.

AcuteCare Health System

☐ Specialty Hospital at Kimball ☐ Specialty Hospital at Monmouth

MEDICAL STAFF APPLICATION

IDENTIFYING INFORMATION		
LAST NAME FIRST NAME MI	BIRTHPLACE	DATE OF BIRTH
OFFICE ADDRESS CITY, STATE ZIP CODE		OFFICE TELEPHONE NUMBER ( )
HOME ADDRESS CITY, STATE ZIP CODE		HOME TELEPHONE NUMBER ( )
BEEPER/PAGER TELEPHONE NUMBER ( )	OFFICE FAX TELEPHONE NUMBER ( )	
IF GROUP, GROUP NAME:		
PARTNERS & ASSOCIATES:		
Credentialing Contact Person:		
Address if different from above:		
SOCIAL SECURITY NUMBER:	UPIN NUMBER/ NPI	
MEDICARE PROVIDER NUMBER:	MEDICAID PROVIDER NUMBER:	
CITIZENSHIP:	IF NOT U.S. CITIZEN, PLEASE GIVE ALIEN OR ADMIN. NUMBER:	
MARITAL STATUS (circle): M S W D	SPOUSE NAME, if applicable	
NAME AND TELEPHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY		
HEALTH PROFESSION (circle): PHYSICIAN DENTIST PODIATRIST		
COVERAGE ARRANGEMENT: (I have made arrangements for coverage of my patients in my absence) Yes No		
Name:		
Telephone Number:		
Beeper/Pager Number:		
YOUR CLINICAL FIELD:	YOUR SPECIALITY/SUBSPECIALTY:	

PRE-PROFESSIONAL INFORMATION	
College or University:	Degree Received:
Address (Street address, city, state, zip code)	Date of Graduation:

MEDICAL EDUCATION (Graduates of foreign medical schools must provide a copy of their ECFMG Certification or evidence of completion of a Fifth Pathway Program)	
School Attended	Degree Received:
Address (Street address, city, state, zip code)	Date of Graduation
ECFMG Number (If applicable)	Date Issued

Practitioner Name: ______________________________

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

Practitioner Name: _____

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

Practitioner Name: _____

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS		
BOARD CERTIFICATION (Evidence of board certification or application to take the board examination, if eligible, must be attached to this application)		
Certified by American Board (Name of Board):	Date Certified:	Date Expires:
Subspecialty Board Status (Name of Board):	Date Certified:	Date Expires:
If not Board Certified, Give Intentions and Status:		
Is Re-certification Required? Yes No If yes, your re-certification status:		Have you ever taken and failed a Board Exam? Yes No
PROFESSIONAL SOCIETIES		
American College of :	Date	
American College of:	Date	
Fellowship in Other Specialty Colleges		

LICENSURE (Attach a copy of your State License certificate)			
Licensee, Type Of License, Name of Board Issuing License:			
Name of State in Which License is Held	License Number	Date Issued /	Date Expires
Other License (Name of State)	License Number	Date Issued /	Date Expires
Other License (Name of State)	License Number	Date Issued /	Date Expires

DRUGS AND NARCOTIC REGISTRATIONS (Attach a copy of your Federal and State Controlled Substance Certificates, if applicable.		
Classes of Drugs/Medications used in your field:		
Classes of Drugs/Medications you are authorized to prescribe:		
DEA Registration Number	Expiration Date:	Limitations, if applicable
State Registration Number (DPS)	Expiration Date:	Limitations, if applicable

Practitioner Name: _____

PROFESSIONAL REFERENCES List three (3) practitioners, of which at least one must be a colleague in your specialty, who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others who will provide specific written comments on these matters upon request from Hospital authorities. The named individuals must have acquired the requisite knowledge through observation of your professional practices over a reasonable period of time, and are not formerly, currently, or about to become associated with you in practice.

Name	Phone: ( ) Fax : ( ) Email:
Address (Street address, city, state, zip code)	
Name	Phone: ( ) Fax : ( ) Email:
Address (Street address, city, state, zip code)	
Name	Phone: ( ) Fax : ( ) Email:
Address (Street address, city, state, zip code)	

PREVIOUS EXPERIENCE (Military Service, Private Practice, But excluding training and teaching)
List in Chronological Order

	Dates
	Dates
	Dates

LIABILITY INSURANCE COVERAGE (Please submit a copy of your Liability Insurance Coverage certificate that includes carrier name, amounts and dates of coverage with your application)

Current Carrier		Agent Name and Phone Number:
How long with Carrier?	Inclusive Dates	
PI Limits per Occurrence	PI Limits Aggregate	Policy #

INSURANCE HISTORY
Please provide the Name and Address of any carrier, other than your current carrier, that has provided professional liability coverage to you at any time during the proceeding five (5) years.

Name of Carrier	Inclusive Dates: Policy #:
Name of Carrier	Inclusive Dates: Policy #:
Name of Carrier	Inclusive Dates: Policy #:

Practitioner Name: _____

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.	
1. Have any professional liability claims been made against you?	Yes No
2. Has any judgment been entered against you in any professional liability case?	Yes No
3. Has any settlement been made in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment?	Yes No
4. Have you been denied professional liability insurance, has your policy been canceled, has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any professional liability carrier expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?	Yes No

HEALTH STATUS

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.	
1. Have you ever used any intoxicant, narcotic, or other psychoactive drug to the extent that it has interfered with your ability to perform professional duties?	Yes No
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 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 Yes No
6. Have you ever taken a leave of absence from you medical practice for any reason for 30 days or more? If yes, please provide inclusive date and reason for leave.	Yes No

PRACTICE HISTORY

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.	
1. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily surrendered, denied, suspended, revoked, limited or restricted?	Yes No
2. Is there any state in which you were previously licensed in which your 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

Practitioner Name: _____

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

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge and belief.
In making this application for appointment to the medical staff of this hospital, I acknowledge that I have received and read the Medical Staff Bylaws of the hospital and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and medical staff policies and rules and regulations as may be from time to time enacted.

_____ _____

Practitioner's Signature Date

AUTHORIZATION AND RELEASE OF LIABILITY

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

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

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

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:

_____

_____

_____

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)

LOW/NO VOLUME
PRACTITIONER
CURRENT COMPETENCY ATTESTATION
Peer Evaluation/ Professional Reference Questionnaire

I, _____ understand that to qualify for continued appointment and privileges on the Medical Staff of AcuteCare health System, I must provide evidence of current clinical competence. I understand it is my responsibility to ensure that this information is provided to the ACHS Medical Staff. Acceptable verification is the completion of this form by an appropriate peer with whom I have worked during the last 12 months and who is able to attest to the information requested below.

TO BE COMPLETED BY APPLICANT

I release all individuals and institutions from liability for statements and data provided in good faith with respect to their responses. I authorize the below information to be provided to Acute Care Health System.

_____ _____
Signature Date

TO BE COMPLETED BY PEER

Personal Information

Physician Being Evaluated _____ Years Known_____

I know this physician: ____ very well ____ casually ____ personally ___ professionally

My Medical Speciality:_____

I have had an opportunity to evaluate this Physician during the last 12 months: ____ Yes ____ No
If No, do you feel that you can still make reasonable comments and recommendations regarding this physician's ability to practice the attached requested privileges and current competencies? __Yes __No If yes,why?_____

This evaluation is based on the practitioner's performance in the following setting(s):

___ Inpatient Unit ___ Outpatient Unit ___ Ambulatory Facility ___Other:_____

Professional knowledge, skills and attitude
If you do not have adequate knowledge to answer a particular question, please indicate unable to evaluate (UE).

Please rate the following as Excellent (EX), Good, Average (AV), Below Average (BA) or Unable to evaluate (UE)

Medical Knowledge					
Basic medical/clinical knowledge	___ EX	___ Good	___Avg	___BA	___UE
Knowledge in specialty	___ EX	___ Good	___Avg	___BA	___UE
Technical and Clinical Skills	___ EX	___ Good	___Avg	___BA	___UE
Clinical Judgment					
Basic clinical judgment	___ EX	___ Good	___Avg	___BA	___UE
Availability and thoroughness of patient care	___ EX	___ Good	___Avg	___BA	___UE
Appropriate and timely use of consultants	___ EX	___ Good	___Avg	___BA	___UE
Quality/appropriateness of patient care outcomes	___ EX	___ Good	___Avg	___BA	___UE
Appropriateness of resource use (e.g., admissions, procedures, length of stay, tests)	___ EX	___ Good	___Avg	___BA	___UE
Clinical pertinence and completeness of medical Record documentation	___ EX	___ Good	___Avg	___BA	___UE
Communication skills					
Overall communication skills	___ EX	___ Good	___Avg	___BA	___UE
Verbal and written fluency in English	___ EX	___ Good	___Avg	___BA	___UE
Clarity/legibility of records	___ EX	___ Good	___Avg	___BA	___UE
Responsiveness to patient needs	___ EX	___ Good	___Avg	___BA	___UE
Interpersonal skills					
Ability to work with members of healthcare team	___ EX	___ Good	___Avg	___BA	___UE
Rapport with patients	___ EX	___ Good	___Avg	___BA	___UE
Rapport with families	___ EX	___ Good	___Avg	___BA	___UE
Rapport with hospital staff	___ EX	___ Good	___Avg	___BA	___UE
Professionalism					
Timely documentation of medical record	___ EX	___ Good	___Avg	___BA	___UE
Participation in medical staff organization activities (e.g., committees, leadership positions)	___ EX	___ Good	___Avg	___BA	___UE
Participation in continuing medical education	___ EX	___ Good	___Avg	___BA	___UE
Demonstration of ethical standards in treatment	___ EX	___ Good	___Avg	___BA	___UE
Maintenance of patient confidentiality	___ EX	___ Good	___Avg	___BA	___UE
Fulfillment of clinical emergency department call Responsibilities	___ EX	___ Good	___Avg	___BA	___UE

On review of the applicant's request for clinical privileges and criteria, as applicable, do you find the privileges requested to be appropriate and in keeping with your knowledge of the applicant's experience and clinical activity at your organization? ____ Yes ____ No

If No, please explain:_____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

_____

_____ _____

Signature Email

_____ _____

Telephone Number Date

LOW/NO VOLUME
PRACTITIONER
CURRENT COMPETENCY ATTESTATION
OPPE Facility Professional Reference Questionnaire

I, _____ understand that to qualify for continued appointment and privileges on the Medical Staff of AcuteCare health System, I must provide evidence of current clinical competence. I understand it is my responsibility to ensure that this information is provided to the ACHS Medical Staff. Acceptable verification is the completion of this form by an appropriate representative from another Joint Commission Accredited area hospital who is able to verify the needed information.

TO BE COMPLETED BY APPLICANT

I release all individuals and institutions from liability for statements and data (including my clinical activity and a copy of my delineation of privileges) provided in good faith with respect to their responses. I authorize the below information to be provided to Acute Care Health System.

_____ _____
Signature Date

TO BE COMPLETED BY HOSPITAL REPRESENTATIVE

I, _____ verify that the above-named physician has had the following patient activity at this facility during the past 12 month period, without any identified problems necessitating disciplinary actions or focused review. The practitioner's privileges are in good standing and have been deemed as currently competent to perform the privileges granted (attached current delineation of privileges).

Current Staff Category:_____ Specialty:_____

Initial Appointment Date:_____ Reappointed Through:_____

Number of Procedures:_____ Number of Consultations:_____

_____ Delineation of Privileges Forms Attached

_____ _____
Signature Title

_____ _____
Hospital Date

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:* _____

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, MD
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