

APPLICATION FOR ALLIED HEALTH PRIVILEGES

Northeast Florida Healthcare Organizations

Revision Date: 09/2016

Personal

NAME (Last, First, Middle):		Professional Discipline:	
AKA or Maiden Name			
DOB:	SS#:	NPI #:	Medicaid #
Birth City, State, Country:			
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No - If answer is NO, please give Alien Registration #:			
Languages spoken (in addition to English):			
Home Address: Street:		Apt#:	City, State, Zip:
Home Phone #:	Cell Phone #:	Pager #:	
E-Mail Address: (Please list the email where you would like hospital correspondence to go)			
Optional	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Race:	<input type="checkbox"/> Single <input type="checkbox"/> Married - Spouse Name:

Practice Information

Supervising Physician(s)/Dentist(s):		Start Date:	Tax ID #:				
Legal Practice Name:		Business/Office Manager:					
Primary Practice Address/Contact Info:							
Street & Suite #: _____		Primary Office Phone #: _____					
_____		Primary Office Fax #: _____					
City, State, Zip: _____		After Hours/Answering Service #: _____					
Is this where Credentialing information should be sent? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no please complete below)							
Address to send Credentialing Information:		Credentialing Specialist Information:					
Street & Suite #: _____		Name: _____					
_____		Phone: _____ Fax: _____					
City, State, Zip: _____		E-mail: _____					
Primary Office Hours:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Additional Office Addresses

Secondary Practice Address:	Additional Practice Address:
Street & Suite #: _____	Street & Suite #: _____
City, State, Zip: _____	City, State, Zip: _____
Secondary Office Phone #: _____	Additional Office Phone #: _____
Secondary Office Fax #: _____	Additional Office Fax #: _____
After Hours/Answering Service #: _____	After Hours/Answering Service #: _____

Professional Licenses (Please list all licenses ever held)

State	License #	Type (RN, ARNP, PA, etc.)	Effective Date	Expiration Date	Currently practice under this license?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Prescriber Certificate (Physician Assistants only) (Please list all certificates ever held)

Issuing Body State	Certificate #	Effective Date	Expiration Date	Currently prescribe under this certificate?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Specialty Certification(s)

Certifying Board	Specialty Certified In	Original Issue Date	Expiration Date	Do you practice this specialty?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

If not certified, are you actively involved in the certifying process? Yes No
 If yes, please document status in process (e.g. copy of letter of acceptance to sit for exam).
 Scheduled Date of Exam: _____

If not certified, have you ever taken and failed a certification exam? Yes No
 Please explain: _____

Professional Liability Insurance

Please list current carrier and previous carrier(s) if you have been covered by current carrier less than five (5) years

Current Carrier Information:		
Carrier Name: _____	Policy #: _____	
Address: _____	Phone #: _____	
Type Policy: <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Per Claim Limits: \$	Retroactive Date:
	Aggregate Limits: \$	Expiration Date:
Previous Carrier Information:		
Carrier Name: _____	Policy #: _____	
Address: _____	Phone #: _____	
Type Policy: <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	Per Claim Limits: \$	Retroactive Date:
	Aggregate Limits: \$	Expiration Date:

Education/Training Attach additional pages as needed

1. Undergraduate Education	
School Name: _____	Phone #: _____
Address: _____	FAX #: _____
City, State, Zip: _____	Email: _____
Country: _____	Contact: _____
Dates Attended: From _____ To _____ Degree Received: _____	
2. Graduate Education:	
School Name: _____	Phone #: _____
Address: _____	FAX #: _____
City, State, Zip: _____	Email: _____
Country: _____	Contact: _____
Dates Attended: From _____ To _____ Degree Received: _____	
3. Other Professional Education/Training:	
School Name: _____	Phone #: _____
Address: _____	FAX #: _____
City, State, Zip: _____	Email: _____
Country: _____	Contact: _____
Dates Attended: From _____ To _____ Degree/Certification Received: _____	

Faculty/Teaching Appointments/ Military Service and Gaps in Work History

Please list any other activities/affiliations not listed under Education/Training, Professional Staff Appointments

Faculty/Teaching Appointments	
School Name: _____	Phone #: _____
Address: _____	FAX #: _____
City, State, Zip: _____	Email: _____
Your position: _____	From _____ To _____
School Name: _____	Phone #: _____
Address: _____	FAX #: _____
City, State, Zip: _____	Email: _____
Your position: _____	From _____ To _____
Military Service/Other Employment	
Facility: _____	Contact: _____
Address: _____	Phone#: _____ FAX#: _____
City, State, Zip: _____	Email: _____
Title/Activity: _____	From: _____ To: _____
Gaps in work history (Ex: Personal Leave, etc.)	
From: _____ To: _____	Explanation: _____
From: _____ To: _____	Explanation: _____

There should be **no unexplained gaps** from date of completion of graduate school to the present - Attach pages as needed.

Professional Staff Appointments/Privileges/Employment History

Please note **PAST** and **PRESENT** Affiliations, including Employment (Attach additional pages as needed.)

Hospital/Company Name and Address and Contact Information (for verification purposes)	
Facility: _____	Supervising Physician: _____
Address: _____	Contact: _____
City, State, Zip: _____	Phone#: _____
From: _____ To: _____ <input type="checkbox"/> Employee <input type="checkbox"/> AHP	FAX#: _____
Specialty: _____	Email: _____
Facility: _____	Supervising Physician: _____
Address: _____	Contact: _____
City, State, Zip: _____	Phone#: _____
From: _____ To: _____ <input type="checkbox"/> Employee <input type="checkbox"/> AHP	FAX#: _____
Specialty: _____	Email: _____
Facility: _____	Supervising Physician: _____
Address: _____	Contact: _____
City, State, Zip: _____	Phone#: _____
From: _____ To: _____ <input type="checkbox"/> Employee <input type="checkbox"/> AHP	FAX#: _____
Specialty: _____	Email: _____
Facility: _____	Supervising Physician: _____
Address: _____	Contact: _____
City, State, Zip: _____	Phone#: _____
From: _____ To: _____ <input type="checkbox"/> Employee <input type="checkbox"/> AHP	FAX#: _____
Specialty: _____	Email: _____

Peer References

PEERS SHOULD:

- Have **CURRENT** knowledge (**last 6-12 months**) of your professional performance, clinical judgment and clinical/technical skills
- Include **1 Physician/Dentist** (*not to include supervising physicians/dentists*)
- **2 Peer References** (*e.g. having the same credentials as you*)
- Not be related to you by family or marriage or a former program director.

Please include Practitioner Name, Address and Phone/Fax # (for contact purposes)	
Peer Name/Title: _____	Peer's Specialty: _____
Practice Name: _____	Office Phone #: _____
Practice Address: _____	Office Fax #: _____
_____	Email: _____
Peer Name/Title: _____	Peer's Specialty: _____
Practice Name: _____	Office Phone #: _____
Practice Address: _____	Office FAX #: _____
_____	Email: _____
Peer Name/Title: _____	Peer's Specialty: _____
Practice Name: _____	Office Phone #: _____
Practice Address: _____	Office FAX #: _____
_____	Email: _____

Health Status

Are you able to perform the requested privileges in a safe and competent manner? (If response is NO or special accommodations are necessary, please explain separately.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you presently use illegal drugs? (If response is YES, please explain separately.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Disciplinary Actions

1. Has any action ever been undertaken, whether it remains pending or has been completed , involving but not limited to denial, revocation, suspension, obligation(s), reduction, limitation, probation, non-renewal, involuntary or voluntary relinquishment or withdrawal in connection with: (a) Your membership status, clinical privileges at any hospital, IPA, HMO, PHO, PPO, managed care organization, or institution? (b) Your membership or fellowship in any local, state, regional, national or international professional organization? (c) Your license to practice any profession in any jurisdiction? (d) Your Drug Enforcement Administration or other controlled substances registration? (e) Your specialty board certification and/or professional school faculty position or membership?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been charged with, convicted of, pled <i>nolo contendere</i> to, or paid a fine for (or are you currently being investigated for or do you currently have charges pending for) a criminal offense (excluding minor traffic violations), including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever been the subject of a civil or criminal complaint or administrative action (or been notified in writing that you are being investigated as the possible subject of a civil, criminal or administrative action) regarding sexual misconduct, child abuse (or other crime involving children), violence (including domestic) or elder or vulnerable adult abuse (or other crime involving the elderly or vulnerable adults)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your professional liability insurance carrier ever excluded you from performing any specific privileges within your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever had any judgments entered against you or settlements made on your behalf in any of your professional liability claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you on notice of any medical malpractice claims pending against you (including a Notice of Intent to initiate litigation for medical malpractice) or have you ever been named as a defendant in a professional liability action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: If the answer to any of the above questions is YES, please explain:
