APPLICATION FOR REAPPOINTMENT

Northeast Florida Healthcare Organizations **Revision Date: 01/2017**

Personal

NAME: (Last , First, Middle)		**Professional Degree:** ☐MD ☐DO ☐DPM ☐DDS ☐DMD
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 – you may list more than one)		
Optional: ☐Single ☐Married - Spouse Name:		

Practice

☐**Primary Care:** *(Family Practitioners, Internists or Pediatricians who deliver primary healthcare services. Internists and Pediatricians who practice a subspecialty may classify themselves in either category.)*

☐**Specialist** -- **Please list your specialty here**:

Practice Type:

☐ Multi-physician group

☐ Solo Practice – Physician(s) who will provide practice coverage: _____

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? ☐ Yes ☐ No (if no please complete below)

Address to send Credentialing Information:	**Credentialing Specialist Information:**
Street & Suite #:_____	Name: _____
City, State, Zip: _____	Phone:_____ Fax: _____
	E-mail: _____

Additional Practice Addresses

Street & Suite #:_____ Secondary Office Phone #: _____

City, State, Zip:_____ Secondary Office Fax #: _____

Contact Name:_____ After Hours/Answering Service #: _____

Street & Suite #:_____ Secondary Office Phone #: _____

City, State, Zip:_____ Secondary Office Fax #: _____

Contact Name:_____ After Hours/Answering Service #: _____

Professional (Medical/Dental)Staff Appointments/Privileges

Current Staff Category (Please mark all facilities where you currently hold privileges)					**Requesting Status Change?**	**Requested Staff Status Change** (Must have active status at one Citywide facility)			
Facility Name	**Active**	**Courtesy**	**Provisional**	**Other**		**Active**	**Courtesy**	**Provisional**	**Other**
Baptist Medical Center-Jax					☐No ☐Yes				
Wolfson Children's Hospital					☐No ☐Yes				
Baptist Medical Center-Beaches					☐No ☐Yes				
Baptist Medical Center-Nassau					☐No ☐Yes				
Baptist Medical Center-South					☐No ☐Yes				
Brooks Rehab Hospital					☐No ☐Yes				
UF Health Jacksonville					☐No ☐Yes				
St. Vincent's Riverside					☐No ☐Yes				
St. Vincent's Southside					☐No ☐Yes				
St. Vincent's Clay County					☐No ☐Yes				

In the event of a DISASTER, to which ONE hospital would you most likely respond:

☐ Baptist Medical Center-Jacksonville/Wolfson Children's Hosp
☐ Baptist Medical Center – Beaches
☐ Baptist Medical Center - Nassau
☐ Other _____
☐ Baptist Medical Center – Southside
☐ Brooks
☐ UF Health Jacksonville
☐ St. Vincent's Riverside
☐ St. Vincent's Southside
☐ St. Vincent's Clay County

Additional Facilities where you hold privileges:

Facility:_____ Phone: _____
Address:_____ Fax: _____
☐ Active/Attending ☐ Courtesy ☐ Provisional ☐ Other:_____ Contact: _____

Facility:_____ Phone: _____
Address:_____ Fax: _____
☐Active/Attending ☐Courtesy ☐Provisional ☐Other:_____ Contact: _____

Facility:_____ Phone: _____
Address:_____ Fax: _____
☐ Active/Attending ☐Courtesy ☐Provisional ☐Other:_____ Contact: _____

Malpractice Insurance

Carrier Name:_____ Policy #:_____ Phone #: _____		
Type Policy: ☐Claims Made ☐Occurrence	Per Claim Limits: $	Retroactive Date:
	Aggregate Limits: $	Expiration Date:

Specialty/Subspecialty Board Certification(s) *(Since your last (re)appointment)*

Certifying Board	Specialty Certified In	Original Issue Date	Expiration Date	Do you practice this specialty?
				☐ Yes ☐ No
				☐ Yes ☐ 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 taken and failed a certification exam since your last (re)appointment? ☐ Yes ☐ No
Please explain: _____

Professional Fellowship/ Training *(Since your last (re)appointment)*

Post-Graduate Training: ☐ Residency ☐ Fellowship ☐ Other: _____

School Name: _____ Program Director: _____

Address: _____ Phone #: _____

City, State, Zip: _____ FAX #: _____

Program Name: _____ Email: _____

Dates Attended: _____ (MM/YY) To _____ (MM/YY) Specialty: _____

Health Status	**** Last 2 Years***	
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.)*	☐Yes ☐No	
Do you presently use illegal drugs? *(If response is YES, please explain separately.)*	☐Yes ☐No	

Disciplinary Actions	**** Last 2 Years***	***Any History***
1. Has any action 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:	☐Yes ☐No	☐Yes ☐No
(a) Your membership status, clinical privileges at any hospital, IPA, HMO, PHO, PPO, managed care organization, or institution?	☐Yes ☐No	☐Yes ☐No
(b) Your membership or fellowship in any local, state, regional, national or international professional organization?	☐Yes ☐No	☐Yes ☐No
(c) Your license to practice any profession in any jurisdiction?	☐Yes ☐No	☐Yes ☐No
(d) Your Drug Enforcement Administration or other controlled substances registration?	☐Yes ☐No	☐Yes ☐No
(e) Your specialty board certification and/or professional school faculty position or membership?	☐Yes ☐No	☐Yes ☐No
2. Have you been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program?	☐Yes ☐No	☐Yes ☐No
3. Have you been charged with, convicted of, pled *nolo contendere* 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?	☐Yes ☐No	☐Yes ☐No
4. Have you 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)?	☐Yes ☐No	☐Yes ☐No
5. Have you been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?	☐Yes ☐No	☐Yes ☐No
6. Has your professional liability insurance coverage been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?	☐Yes ☐No	☐Yes ☐No
7. Has your professional liability insurance carrier excluded you from performing any specific privileges within your specialty?	☐Yes ☐No	☐Yes ☐No
8. Have you had any judgments entered against you or settlements made on your behalf in any of your professional liability claims?	☐Yes ☐No	☐Yes ☐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 been named as a defendant in a professional liability action?	☐Yes ☐No	☐Yes ☐No

* **IMPORTANT: If the answer to any of the above questions is <u>YES, IN THE LAST TWO YEARS</u>, please explain separately.**

Attestation

I hereby affirm that the information furnished by me in connection with this application is correct and complete to the best of my knowledge and is furnished in good faith.

I agree to notify each healthcare entity to which I am applying for appointment and privileges, should there be any changes in licensure, professional liability coverage (including judgments or settlements made on my behalf), DEA certification, and physical or mental health status, in accordance with each entity's required reporting timeframes.

I hereby certify that I have successfully completed the hours of continuing education required for my most recent Florida licensure/licensure renewal, and that I continue to be in compliance with the State of Florida requirements for continuing education. I agree to provide proof of attendance and program content upon request. I understand that I am subject to random audit by a Hospital to confirm compliance with continuing education requirements.

Additionally, I affirm that during the past two years, a majority of my continuing education credits were related to my specialty.

_____	_____	_____
Signature of Applicant	Typed Name of Applicant	Date