

APPLICATION FOR RENEWAL OF ALLIED HEALTH PRIVILEGES

Northeast Florida Healthcare Organizations

Revision Date: 08/2016

Personal

NAME: (Last , First, Middle)		Professional Discipline:
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: <input type="checkbox"/> Single <input type="checkbox"/> Married - Spouse Name:		

Practice Information

Supervising Physician(s)/Dentist(s):	
Do you work for more than one group? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please complete additional supervising physicians below)	
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: _____

Additional Practice Addresses

Address: _____	
Secondary Office Phone #: _____	Secondary Office Fax #: _____
Contact Name: _____	After Hours/Answering Service #: _____
Address: _____	
Secondary Office Phone #: _____	Secondary Office Fax #: _____
Contact Name: _____	After Hours/Answering Service #: _____

Additional Supervising Physician(s)/Group(s)

Supervising Physician: _____	Supervising Physician: _____
Legal Practice Name: _____	Legal Practice Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Office Phone #: _____	Office Phone #: _____
Office Fax #: _____	Office Fax #: _____
Contact: _____	Contact: _____

Current Professional Staff Appointments/Privileges (Please mark all facilities where you currently hold privileges)

Facility Name	Supervising Physician	Clinical area/department where you most actively work?	At which facility are you most active?	Info for manager/supervisor(s) in clinical area/department in which you spend the majority of your time at each hospital at which you practice. We will contact them.
Baptist Medical Center-Jax			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
Wolfson Children's Hospital			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
Baptist Medical Center-Beaches			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
Baptist Medical Center-Nassau			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
Baptist Medical Center-South			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
Brooks Rehab Hospital			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
UF Health Jacksonville			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
St. Vincent's Riverside			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
St. Vincent's Southside			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____
St. Vincent's Clay County			<input type="checkbox"/>	Name: _____ Phone: _____ Fax: _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Baptist Medical Center-Jacksonville/Wolfson Children's Hosp | <input type="checkbox"/> Baptist Medical Center – Southside | <input type="checkbox"/> St. Vincent's Riverside |
| <input type="checkbox"/> Baptist Medical Center – Beaches | <input type="checkbox"/> Brooks | <input type="checkbox"/> St. Vincent's Southside |
| <input type="checkbox"/> Baptist Medical Center - Nassau | <input type="checkbox"/> UF Health Jacksonville | <input type="checkbox"/> St. Vincent's Clay County |
| <input type="checkbox"/> Other _____ | | |

Additional Facilities where you hold privileges:

Facility: _____	Facility: _____
Address: _____	Address: _____
Supervising Physician: _____	Supervising Physician: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Peer Reference - One (1) peer references (e.g. having the same credentials as you), who has CURRENT knowledge of your professional performance, clinical judgment and clinical/technical skills. This individual may not be related to you by family or marriage, or a recently initiated, pending or current professional partnership/financial association.

Peer Reference Name and Address (In order for us to contact this reference, please provide the following information)

Practitioner's Name: _____	Phone: _____
Address: _____	Fax: _____
Practitioner's Specialty _____	Email: _____

Malpractice Insurance

Carrier Name: _____	Policy #: _____	Phone #: _____
Type Policy: <input type="checkbox"/> Claims Made <input type="checkbox"/> 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?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
If not certified, are you actively involved in the certifying process?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Please explain: _____				

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.)	<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	* 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: (a) Your membership status, clinical privileges at any hospital, IPA, HMO, PHO, PPO, managed care organization, or institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Your membership or fellowship in any local, state, regional, national or international professional organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Your license to practice any profession in any jurisdiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Your Drug Enforcement Administration or other controlled substances registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(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
2. Have you 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has your professional liability insurance coverage been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has your professional liability insurance carrier excluded you from performing any specific privileges within your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you 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	<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 been named as a defendant in a professional liability action?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

