CRESCENT VIEW SURGERY CENTER
Practitioner Application

Please type or print clearly. *Do not leave blank spaces – if response is not applicable, write "N/A." Provide all required attachments. We cannot process incomplete applications.*

Personal Data.

First Name: _____ Middle Name: _____ Last Name: _____

Maiden Name: _____ M/F: _____ Check One: ☐ MD ☐DO ☐DMD ☐DDS ☐DPM ☐Other: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____/_____/_____

Professional Data

Primary office address is considered your official mailing address unless specified otherwise. Provide any additional information on a separate piece of paper and attach to the application.

Practitioner Start Date: _____

Primary Office Information Type of Practice: ☐ Solo ☐ Group Is this practice incorporated? Yes ☐ No ☐

Primary Specialty_____ Secondary Specialty (if applicable): _____

Practice Name: _____ Tax ID. No: _____

Practice Name as it appears on your Federal W-9 Form if different from above:

_____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone Number: (_____) _____

Fax Number: _____ Answering Service: (_____) _____

Billing Address: _____ Tax ID. No: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone Number: (_____) _____

Fax Number: _____ Answering Service: (_____) _____

Partners: Names of Associates

_____ _____ _____

_____ _____ _____

Additional Office Information Type of Practice: ☐ Solo ☐ Group Is this practice incorporated? Yes ☐ No ☐

Practice Name: _____ Tax ID. No: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Telephone Number: (_____) _____ Fax Number: (_____) _____

Billing Address: _____ Tax ID. No: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____) _____ Fax Number: (_____) _____

Email

Please list your home and/or office email below (Optional). Is this your preferred method of communication? Yes ☐ No ☐

Home Email: _____@_____._____

Office Email: _____@_____._____

Please type or print clearly. *Do not leave blank spaces – if response is not applicable, write "N/A." A response of "see attached" or "see CV" is not acceptable unless (1) the referenced area is clearly identified, dated, and signed by the practitioner, and (2) the attachment or CV format lists both "from" and "to" dates.*

Education *Provide complete information/address.*

If more than one Internship, Residency or Fellowship was begun and/or completed, provide information on a separate sheet and attach to this application.

Professional: _____ Start Date: ____/____/____ Date of Graduation: ____/____/____

Complete Address: _____

City: _____ State: _____ Zip Code:_____

Degree (circle): MD DO MBBS DDS DMD DPM

Dates Attended:

Internship: _____ Type: _____ From: ___/___/___ To: ___/___/___

Complete Address: _____

City: _____ State: _____ Zip Code: _____

Dates Attended:

Residency: _____ Type: _____ From: ___/___/___ To: ___/___/___

Complete Address: _____

City: _____ State: _____ Zip Code: _____

Dates Attended:

Fellowship: _____ Type: _____ From: ___/___/___ To: ___/___/___

Complete Address: _____

City: _____ State: _____ Zip Code: _____

If medical school or other professional school was not in the United States, Canada or Puerto Rico, provide a copy of your ECFMG certificate and the following information: Date exam was taken: ___/___/___ Where exam was taken: _____

Board Certification

Required Attachments: A copy of your current Board Certification certificate. If you are not Board Certified, evidence of completion of residency program in the field for which you are applying is required.

Names of specialty boards by which you are certified:	**Date Certified:**	**Expiration Date: (if applicable)**
_____	_____/_____/_____	_____/_____/_____
_____	_____/_____/_____	_____/_____/_____
_____	_____/_____/_____	_____/_____/_____

Re-certified? (Check N/A if re-certification not offered/required)	If Yes, Date Re-certified	Expiration Date	Board Qualified?
☐Y ☐N ☐N/A	____/____/____	____/____/____	☐Y ☐N

Licensure *List license(s) held in state(s) where currently practicing. Required Attachment: A copy of current license(s)/certificate(s).*

State	**License Number**	**Expiration Date**
Louisiana	_____	_____/_____/_____
_____	_____	_____/_____/_____
_____	_____	_____/_____/_____

License History: Have you ever held a license in any other than the states listed above (including during training)?

☐Yes ☐No If the answer is yes, provide license information below:

State	**License Number**	**Expiration Date**
_____	_____	_____/_____/_____
_____	_____	_____/_____/_____

Medicare Number: _____ **Medicaid Number:** _____ **UPIN:** _____

NPI # _____

Federal DEA Number(s) _____ _____/_____/_____

_____ _____/_____/_____

State Controlled Substance Numbers (if applicable) _____ _____/_____/_____

Please type or print clearly. *Do not leave blank spaces – if response is not applicable, write "N/A."*

Insurance

Required Attachment: A copy of the declaration or face sheet for your current policy(ies) that includes <u>your name</u>.

Malpractice Carrier:_____ Policy Number: _____

Expiration Date: ____/____/____ Claim Limit: _____ Aggregate Limit: _____

Malpractice Carrier: _____ Policy Number: _____

Expiration Date: ____/____/____ Claim Limit: _____ Aggregate Limit: _____

List or attach all malpractice insurance carriers and types of coverage for the past ten (10) years: _____

_____

_____

Medical Staff Appointment

Specify privileges and status at <u>primary</u> facility. Please complete or attach a list of all hospitals for which you have admitting privileges.

Name of Hospital	Specialty/Privileges	Status *(Active, Courtesy, Consulting, Provisional, Temporary, Applying)*
Primary Hospital:		
Secondary Hospital:		
Additional Hospital:		

Peer References

Please list three professional references in your specialty, <u>not</u> including relatives, current partners, or associates in practice, who we may contact for references.

Peer Name	Address	Phone and Fax Numbers
		( ) _____ /_____ ( ) _____ /_____
		( ) _____ /_____ ( ) _____ /_____
		( ) _____ /_____ ( ) _____ /_____

Continuing Education

Please complete section or attach continuing education information earned since completion of training.

CME Activity	Date(s) Completed	Total Credit(s)/Unit(s)

Work History

List chronologically all professional activities since completion of post-graduate training. Explain any gaps 6 months or greater. Please type or print clearly. *A response of "see attached" or "see CV" is not acceptable unless (1) the referenced area is clearly identified, dated, and signed by the practitioner, and (2) the attachment or CV format lists both "from" and "to" dates.* ***NOTE: Please indicate both MONTH and YEAR.***

<u>Activity:</u>	**<u>Location:</u>**	**<u>Dates (From/To):</u>**
_____	_____	_____ / _____ **to** _____ / _____
_____	_____	_____ / _____ **to** _____ / _____
_____	_____	_____ / _____ **to** _____ / _____
_____	_____	_____ / _____ **to** _____ / _____
_____	_____	_____ / _____ **to** _____ / _____

Practice History *Please read and answer the following questions carefully. All "yes" answers require a detailed explanation, signed and dated by the practitioner.*

1. Have any of the following been, or are currently in the process of being voluntarily **or** involuntarily relinquished, not renewed, denied, revoked, suspended, reduced, limited, placed on probation, disciplined/formally reprimanded or asked to resign? *If yes, provide detailed explanation.*

   a. Medical license in any state ..... Yes ☐ No ☐
   b. Internship, residency or fellowship programs ..... Yes ☐ No ☐
   c. Other professional registration/license ..... Yes ☐ No ☐
   d. Federal DEA or other controlled substance registration ..... Yes ☐ No ☐
   e. Academic appointment ..... Yes ☐ No ☐
   f. Membership on any hospital medical staff ..... Yes ☐ No ☐
   g. Clinical privileges ..... Yes ☐ No ☐
   h. Prerogatives/rights to see patients on any HMO, PPO, or other healthcare entity medical panel ..... Yes ☐ No ☐
   i. Military and/or any other medical institutional/employment affiliation or status ..... Yes ☐ No ☐
   j. Professional society membership ..... Yes ☐ No ☐
   k. Professional office ..... Yes ☐ No ☐
   l. Has Medicare, Medicaid or any PRO or PSRO authority initiated any investigations or actions against you (such as fines, sanctions or dismissal from the program) for any reason ..... Yes ☐ No ☐
   m. Any other type of professional sanction ..... Yes ☐ No ☐
   n. Professional liability insurance ..... Yes ☐ No ☐

2. a. Have there been any criminal charges brought against you? ..... Yes ☐ No ☐
   If "yes," provide complete details, including court reports and final actions.
   b. Have you ever been the object of an administrative, civil or criminal complaint or investigation regarding sexual conduct? ..... Yes ☐ No ☐
   If "yes," provide detailed explanation in an attachment.

3. Have you resigned from a hospital staff or medical institution while under investigation related to professional competence or conduct? ..... Yes ☐ No ☐

4. Has a hospital or managed care program notified you that you have a quality of care or utilization problem? ..... Yes ☐ No ☐

5. Have you ever had, or are you currently aware, of having any physical, mental, or emotional condition or chemical dependency/substance abuse problem which may interfere with your ability to care for patients in any way with or without accommodation? ..... Yes ☐ No ☐

6. Date of last physical exam: _____ Date of last TB skin test: _____

   _____ Positive _____ Negative

7. Are you now abusing, or have you been treated for abusing chemical substances or alcohol? ..... Yes ☐ No ☐

8. Have you completed, or are you now participating in an impaired physicians program? (Provide full details) ..... Yes ☐ No ☐

9. Have there been or are there currently pending, any professional liability claims or suits, settlements, judgments or arbitration proceedings involving your professional medical practice? ..... Yes ☐ No ☐

   (Important Note: Complete a claim history form for each claim/malpractice activity.)

10. To your knowledge, has any information pertaining to you been reported to the National Practitioner Data Bank? ..... No ☐

    ☐Yes, claim payment only ☐Yes, other (provide complete details)

I confirm that this practitioner is competent to perform the privileges requested.

Confirmed by: _____ Date: _____
Medical Director

INCOMPLETE RESPONSES WILL BE RETURNED FOR REQUIRED EXPLANATION / DOCUMENTATION

Attestation/Release

I acknowledge that I have the burden of producing adequate information for a proper evaluation of my competence, character, ethics and other qualifications, and to resolve any doubts about such qualifications.

By applying for appointment to Crescent View Surgery Center, I:

a. Signify my willingness to appear for interviews in regard to my application. Upon request by Crescent View Surgery Center, I agree to submit to a medical examination and to take a drug-screening test.
b. Authorize Crescent View Surgery Center to consult with members of medical staffs of hospitals, hospital administrators, and other health care entities or officials with which I have been associated, state agencies that regulate or license physicians/other health professionals, HCFA, specialty practice Boards, past and present liability insurance carriers, as well as any national data bank or any others who may have information bearing on my competence, my ethical qualifications, or on any other matter pertaining to this application or Crescent View Surgery Center's standards whatsoever. I hereby waive any right to receive notice from any such third party before releasing such information to Crescent View Surgery Center and that a fax or copy of this release may be used as authorization for third parties to release information to Crescent View Surgery Center.
c. Agree to provide, and consent to Crescent View Surgery Center's inspection of, all records and documents that may be deemed material by Crescent View Surgery Center either for evaluation of professional qualifications and competence to carry out the practice activities requested, including my moral and ethical qualifications for membership, or for peer review, quality management or utilization management after admission; I understand that Crescent View Surgery Center will treat information received as confidential.
d. Agree to hold harmless and indemnify all representatives of Crescent View Surgery Center for their acts performed in connection with evaluating me and my credentials, and with any subsequent peer review, quality management or utilization management matter, except those acts performed with actual malice or bad faith.
e. Release from any liability all individuals and organizations that provide information to Crescent View Surgery Center, in good faith and without malice, concerning either my competence, ethics, character, cost efficiency experience, and other qualifications for medical staff appointment and/or clinical privileges, or any subsequent peer review, quality management or utilization management matter, including information which otherwise would be privileged or confidential. I hereby consent to the release of such information.
f. Understand that I am required to notify Crescent View Surgery Center if I am indicted, and that I may be suspended from clinical privileges at their discretion until allegations are resolved.
g. Understand that I am required to notify Crescent View Surgery Center if there is any change related to any question contained in this application and will provide updates of documents/licenses requested as part of this application as they are renewed or changed.
h. Understand that I may only perform practice activities in any setting in which I can reasonably be considered competent by training or demonstrated competence per privileges granted by Crescent View Surgery Center. I have not requested privileges for any procedures for which I am not certified or qualified.
i. Agree to provide and/or authorize Crescent View Surgery Center to request and secure all individual quality and cost information which may be privileged and confidential from sources such as participating hospitals, participating health plan or insurers, or any other organization or agency.
j. Agree to comply with all restrictions, requirements and rules related to any self-referrals and/or dependent or adjunct providers.

I agree that all of the foregoing provisions regarding Crescent View Surgery Center shall apply equally to all of its agents and designees.

I acknowledge that this application does not constitute an employment contract. A photocopy of this document shall serve as the original.

I hereby authorize and request that my signature be electronically affixed to all of my dictation according to the Electronic Signature Policy. I acknowledge that complete patient identifying information must be provided as specified in the Medical Record Documentation Guidelines, and that my electronic signature cannot be affixed if there are blanks, gaps, contradictory statements, or other items in the report that require physician attention.

I acknowledge that application to Crescent View Surgery Center and meeting qualifications does not ensure acceptance to Crescent View Surgery Center and that Crescent View Surgery Center will require me to sign an Agreement to provide services. I hereby further acknowledge that Crescent View Surgery Center has no obligation to offer privileges, and that Crescent View Surgery Center will make determinations as to each Crescent View Surgery Center member's participation in each health care arrangement on a case-by-case basis based on criteria developed by the Medical Advisory / Governing Board or its delegated committee. I also acknowledge that Crescent View Surgery Center membership is granted for a limited term, and that I will be required to reapply for membership at the end of each term.

In making this application for appointment to Crescent View Surgery Center, I acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation 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 whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the Crescent View Surgery Center. I further agree to abide by such center and staff rules and regulations as may be from time to time enacted.

I hereby certify that the information provided in this application and attachments is correct and complete. I understand that any misstatement or omission from this application constitutes cause for possible denial of privileges at, or summary dismissal from Crescent View Surgery Center Medical Staff. I further understand that my participation in Crescent View Surgery Center can only begin when the credentialing process has been completed and only if my privileges have been approved by the governing body.

Signature: _____ Print: _____

Date: _____

Return completed application and all required attachments to:

Credentials Department
Crescent View Surgery Center
3434 Houma Blvd Ste 300
Metairie LA 70006

Crescent View Surgery Center

Professional Liability Claim History

COMPLETE A SEPARATE FORM FOR EACH CLAIM

(Please copy this page if additional sheets are needed)

PROFESSIONAL LIABILITY DETAILS
Patient Name/Case Number:
Date of occurrence:
Date claim/suit filed:
Nature of the claim: (Please provide a brief explanation)
Alleged Injury/Allegations listed in the complaint:
Claim status: ☐Pending ☐Closed - Date closed:
If closed, indicate method of closing: ☐Dismissal ☐Settled ☐Judgment
Amount of settlement or judgment: $
Name and address of malpractice insurance carrier involved:

DATE: _____ PRACTITIONER SIGNATURE:_____

PRINTED NAME: _____