

## Shasta Community Health Center MEDICAL STAFF APPLICATION

### INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Current copies of the following documents must be submitted with this application:

- State Medical License(s)                      Face Sheet of Professional Liability Certification
- DEA Certification                                Curriculum Vitae
- Board Certification (if applicable)        ECFMG (if applicable)

### IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: (    ) -	Home Fax Number: (    ) -	
Birth Date:	Birth State:	Citizenship:
Social Security #    -    -	<input type="checkbox"/> Male:	<input type="checkbox"/> Female:

### PRACTICE INFORMATION:

Practice Name (if applicable):		
Primary Office Mailing Address:	City:	
	State:	ZIP:
Telephone Number: (    ) -	Fax Number: (    ) -	
Office Manager/Administrator:	Telephone Number: (    ) -	
	Fax Number: (    ) -	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

Secondary Office Mailing Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: (    )    -	
	Fax Number: (    )    -	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

NPI:	Medicare UPIN:	Medical UPIN:
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Other Medical Interests in Practice, Research, etc:

Specialty:

Subspecialties:

**MEDICAL/PROFESSIONAL EDUCATION**

Medical School:	Mailing Address:	Degree Received:	
City:	State:	ZIP:	Date of Graduation: /
Medical/Professional School:	Mailing Address:	Degree Received:	
City:	State:	ZIP:	Date of Graduation: /

POSTGRADUATE TRAINING AND EXPERIENCE

**INTERNSHIP/PGYI**

Institution:		
Mailing Address:		City:
State:	ZIP:	Program Director:
Type of Internship:		
Specialty:	From: /	To: /

**RESIDENCES/FELLOWSHIPS**

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Use separate sheet if necessary.

Institution:		Program Director:	
Mailing Address:	City:	State:	ZIP:
Type of Training (e.g. residency, etc.):	Specialty:	From: / (mm/yyyy)	TO: / (mm/yyyy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:	City:	State:	ZIP:
Type of Training:	Specialty:	From: /	To: /
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:	City:	State:	ZIP:
Type of Training:	Specialty:	From:	To:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:	City:	State:	ZIP:
Type of Training:	Specialty:	From:	To:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			

**MEDICAL LICENSURE**

California State Medical License Number:	Expiration Date: / /
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date: / /
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date: / /
ECFMG Number (applicable to foreign medical graduates):	Date Issued: / /

**ALL OTHER STATE MEDICAL LICENSES**

State:	License Number:	Expiration Date: / /	
State:	License Number:	Expiration Date: / /	
State:	License Number:	Expiration Date: / /	

**OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)**

Type:	Number:	Expiration Date: / /
Type:	Number:	Expiration Date: / /

**BOARD CERTIFICATION**

Include certification by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the medical board of California

a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Rectified	Expiration Date: (If any)

Have you applied for board certification other than those indicated above? Yes  No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for Certification on separate sheet.

**CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (a) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

**A. CURRENT AFFILIATIONS**

NAME, City, and State of Primary Admitting Hospital:	Department:
Status: (active, provisional, courtesy, temporary, etc.)	Appointment Date:
Name, City, and State of Secondary Admitting Hospital:	Department:
Status:	Appointment Date:
Name, City, and State of Other Institutions:	Department:
Status:	Appointment Date:

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care).

**B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS**

Name, City and State of Affiliation:		Department:
From: / (mm/yy)	To: / (mm/yy)	Reason for Leaving:
Name, City and State of Affiliation:		Department:
From: / (mm/yy)	To: / (mm/yy)	Reason for Leaving:
Name, City and State of Affiliation:		Department:
From: / (mm/yyyy)	To: / (mm/yyyy)	Reason for Leaving:
Name, City and State of Affiliation:		Department:
From: / (mm/yyyy)	To: / (mm/yyyy)	Reason for Leaving:
Name, City and State of Affiliation:		Department:
From: / (mm/yyyy)	To: / (mm/yyyy)	Reason for Leaving:

**SUPPLEMENTAL PEER REFERENCES**

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Title:	Telephone Number: ( )
Mailing Address:	City:	State:
		ZIP:
Name of Reference:	Title:	Telephone Number: ( )
Mailing Address:	City:	State:
		ZIP:
Name of Reference:	Title:	Telephone Number: ( )
Mailing Address:	City:	State:
		ZIP:

## WORK HISTORY

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice:	Contact Name:		Telephone Number: ( )		
			Fax Number: ( )		
Mailing Address:	City:	State:	ZIP:	From: /	To: /
Name of Practice/Employer:	Contact Name:		Telephone Number: ( ) -		
			Fax Number: ( ) -		
Mailing Address:	City:	State:	ZIP:	From: /	To: /
Name of Practice/Employer:	Contact Name:		Telephone Number: ( ) -		
			Fax Number: ( ) -		
Mailing Address:	City:	State:	ZIP:	From: /	To: /

## ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes," please provide full details on separate sheet.

- A. Has your license to practice medicine, Drug Enforcement Administration (DEA) Registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand-or is such action pending?  
 Yes    No
- B. Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for reasons relating to possible incompetence or improper professional conduct, by Medicare, Medicaid, or any public program-or is any such action pending?  
 Yes    No
- C. Have you ever been denied, for possible incompetence or improper professional conduct, clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) or have your clinical privileges, membership, participation or employment at any such organization ever been suspended, restricted, revoked or not renewed or is any such action pending?  
 Yes    No
- D. Have you ever surrendered clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct or in return for such an investigation not being conducted or is any such action pending?  
 Yes    No
- E. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, or not renewed-or is any such action pending?  
 Yes    No
- F. Have you been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board?  
 Yes    No

**HEALTH STATUS**

Are you able to perform all the services required by the applicable participating physician agreement, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?  Yes  No

**CONVICTIONS**

Have you ever been convicted of a felony?  Yes  No

If yes, please provide full details on a separate sheet.

**PROFESSIONAL LIABILITY**

Insurance Carrier:	Policy Number:		
Mailing Address:	City:	State:	ZIP:
Per claim amount: \$	Aggregate amount: \$	Expiration Date:	

Have any judgments been made against you, or settlements been agreed to, in professional liability cases, or are there any filed and served professional liability lawsuits against you pending?  Yes  No

Has your professional liability insurance ever been terminated or restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?  Yes  No

If yes to any of the above, please provide details per the attached claims information sheet. Please explain any surcharges to your professional liability coverage on a separate sheet.

Please list all of your professional liability carriers for the past ten years:

Name of Carrier:	Mailing Address:	From: / (mm/yyyy)	To: / (mm/yyyy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: / (mm/yyyy)	To: / (mm/yyyy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: / (mm/yyyy)	To: / (mm/yyyy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: / (mm/yyyy)	To: / (mm/yyyy)
Policy #	City:	State:	ZIP:

**INFORMATION RELEASE / ACKNOWLEDGEMENTS**

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications ("peer review information") by and between "this Healthcare Organization" <sup>1</sup> and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery system or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents-collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recertification application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessments, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing peer review information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

I also agree to notify this Healthcare Organization in writing, within five (5) days if receiving any written or oral notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; any adverse action by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public reproof, and any formal restriction, probation, suspension, revocation of licensure; any adverse action taken by any Healthcare Organization, which has resulted in the filing of section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; any revocation of DEA license; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

Print Name Here: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Stamped Signature is Not Acceptable)

Date: \_\_\_\_\_

\_\_\_\_\_

**This application was created and is endorsed by:**

- California Association of HMOs-(916)/552-2910)
- California Healthcare Association-(916)/552-7574)
- California Medical Association-(415/882-5166)
- IPA Association of California-(510/568-4722)
- Medical Quality Commission-(310/936-1100 x230)
- Unified Medical Group Association-(310/430-1191 x223)



## Medical Staff Application Addendum B Professional Liability Action Explanation

Please complete this form for each pending or settled professional liability action filed and served, or any payment made on behalf of you, the physician applicant. All questions must be answered completely. Please provide a separate sheet for each malpractice action. If additional sheets are required, please photocopy this page prior to completing.			
Date of Alleged Incident:		Date suit Filed:	
Patient Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Location of Incident:
Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):			
Allegation:			
Liability Carrier When Incident Occurred:			
Additional Named Defendant(s):			

<input type="checkbox"/> OPEN- If open, amount being sought:
<input type="checkbox"/> CLOSED- If closed, indicate method of closing: <input type="checkbox"/> Settlement <input type="checkbox"/> Judgement Date:
Amount of Settlement or Judgment:

**Summarize** the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1} condition and diagnosis at time of incident, 2} dates and description of treatment rendered, and 3} condition of patient subsequent to treatment. **Please print.**

### SUMMARY

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I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization",<sup>2</sup> its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. I further agree to notify this Healthcare Organization in a timely manner of any change to the information included in this form.

\_\_\_\_\_  
Name (please print or type)

\_\_\_\_\_  
Physician Signature (Original Signature Required)

\_\_\_\_\_  
Date

**Shasta Community Health Center**  
**Initial Request for Privileging**  
**APPLICANT MUST COMPLETE THIS PAGE**

Clinician Name: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

- Core Privileges - As per training and licensing
- Additional Request for Privileging (see attached)

- 
- Temporary Privileges granted pending Credentialing and Privileging Committee Review

\_\_\_\_\_  
Chief Medical Officer

\_\_\_\_\_  
Date

**Privileging Committee Recommendation:**

- Recommend approval of privileges as requested.
- Recommend approval with the following modifications/conditions:  
(Noted below)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_  
**Privileging Committee Chair**

\_\_\_\_\_  
**Chief Medical Officer**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

Shasta Community Health Center  
P.O. Box 992790  
1035 Placer Street  
Redding, CA 96001  
Phone: (530) 246-5710

This completed form is kept in the requesting clinician's credentialing packet.

# Shasta Community Health Center

Delineation of privileges

Initial Request

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Privileges include evaluation, the ability to perform a history and physical examination, form a differential diagnosis, order appropriate lab and radiological work, design treatment and provide necessary and appropriate follow-up care for medical and psychiatric problems. Privileges also include the ability to provide all forms of preventive health care, to obtain consultation with other medical providers, and to provide stabilization and basic life support services when indicated.

Special requests: each of the following privileges requires documentation of training and/or experience for the privilege requested.

I Procedure Requiring Privileging Applicant Complete Columns II & III (Check Privilege Request Only If You Are Requesting That Privilege Be Granted)	II Privilege Requested	III Number Performed Last 3 Years Total Number Performed	IV Approved With Proctor (Date)	V Approved Independent (Date)
ACLS (Advanced Cardiac Life Support)				
Banding Internal Hemorrhoids				
Breast Fine Needle Aspiration				
Cardiac Stress Testing				
Casting				
Circumcision				
Colposcopy with Biopsy				
Conscious Sedation				
Cryosurgery of the Cervix with biopsy				
Cryosurgery of the Cervix without biopsy				
Cryosurgery of Skin Lesion				
EKG Interpretation				
Endometrical Biopsy				
Excision of Lesions Trunk and Extremities				

# Shasta Community Health Center

Delineation of privileges

Initial Request

Name: \_\_\_\_\_ Date: \_\_\_\_\_

I Procedure Requiring Privileging Applicant Complete Columns II & III (Check Privilege Request Only If You Are Requesting That Privilege Be Granted)	II Privilege Requested	III Number Perform Last 3 Years Total Number Performed	IV Approved With Proctor (Date)	V Approved Independent (Date)
Excision of Lesions Face and Neck				
External Hemorrhoid Thrombectomy				
Foreign Body Removal from Eye				
Foreign Body Removal/Soft Tissue				
Fractures/Management of				
I & D Bartholin cyst				
I & D Ischio-rectal abscess				
I & D of soft tissue abscesses				
IUD * (Do we do this as a clinic)				
Joint Injection/Aspiration				
LEEP (Loop Electrode Excision of the Cervix)				
Lumbar Puncture				
Multiple or Complicated Wound Closure Number:> _____ Size: _____ cm.				
Nail Removal/extraction of matrix				
Paracentesis				
Punch Biopsy of the Skin				
Repair of Simple Lacerations				
Repair of Complex Lacerations				
Flexible /Sigmoidoscopy				
Trigger Point Injections/Soft Tissue				
Vasectomy				



# AUTHORIZED SIGNATURE VERIFICATION

Signatures of all clinicians are obtained for use in the Electronic Health Record. Signature will be scanned into the Electronic Health Record as your official signature of record. If possible please use a sharpie or a felt tip pen.

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Print Your Name

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Signature

**Original to Informatics Department  
Copy to Credentials file**