

Shasta Community Health Center DENTAL 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 Dental License(s)
- DEA Certification
- Curriculum Vitae
- Board Certification (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:	Citizenship:	
Social Security #	Male:	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:	

Other Dental Interests in Practice, Research, etc:

Specialty:
Subspecialties:

DENTAL PROFESSIONAL EDUCATION

Dental 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

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/yy)	TO: (mm/yy)
Did you successfully complete the program? Yes 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? Yes 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? Yes No (Explain on separate sheet.)			

DENTAL LICENSURE

California State Dental 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 Dental graduates):	Date Issued:

ALL OTHER STATE DENTAL LICENSES

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

OTHER CERTIFICATIONS (E.G. 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 Dental Association
- a member board of the California Dental Association

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:

B. PREVIOUS 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/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/yy)	To: (mm/yy)	Reason for Leaving:

SUPPLEMENTAL PEER REFERENCES

List three professional references.

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.

1. Current Practice:	Contact Name:		Telephone Number: ()		
			Fax Number: ()		
Mailing Address:	City:	State:	ZIP:	From: (mm/yy)	To: (mm/yy)
2. Name of Practice/Employer:	Contact Name:		Telephone Number: ()		
			Fax Number: ()		
Mailing Address:	City:	State:	ZIP:	From: (mm/yy)	To: (mm/yy)
3. Name of Practice/Employer:	Contact Name:		Telephone Number: ()		
			Fax Number: ()		
Mailing Address:	City:	State:	ZIP:	From: (mm/yy)	To: (mm/yy)
4. Name of Practice/Employer	Contact Name:		Telephone Number: ()		
			Fax Number: ()		
Mailing Address:	City:	State:	ZIP:	From: (mm/yy)	To: (mm/yy)
5. Name of Practice/Employer	Contact Name:		Telephone Number: ()		
			Fax Number: ()		
Mailing Address:	City:	State:	ZIP:	From: (mm/yy)	To: (mm/yy)

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 Denti-Cal 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 dental staff, dental group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), Dental society, professional association, Dental 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 dental organization (e.g., hospital dental staff, medical group, independent practice association (IPA), dental plan, dental maintenance organization (HMO), preferred provider organization (PPO), dental society, professional association, dental school faculty position or other dental 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/yy)	To: (mm/yy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
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" and other Healthcare Organizations (e.g., hospital dental staffs, dental groups, independent practice associations (IPAs), dental plans, dental/health maintenance organizations (HMOs), preferred provider organizations (PPOs), other dental/health delivery system or entities, dental societies, professional associations, dental 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 "Dental/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 Dental 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 Dental/Healthcare Organization, which has resulted in the filing of a report to 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 Denti-Cal 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: _____

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 Dentist 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:	Age:	Location of Incident:
Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):			
Allegation:			
Liability Carrier When Incident Occurred:			
Additional Named Defendant(s):			

OPEN- If open, amount being sought:			
CLOSED- If closed, indicate method of closing:	Settlement	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

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization",¹ 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 Dentist 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)

Dentist Signature (Original Signature Required)

Date

² As used in the Information Release/Acknowledgments Section of the California Participating Dentist Application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified on page 1 of the California Dentist Application.