Eaton Rapids Medical Center

CREDENTIALING APPLICATION FOR APPOINTMENT

MEMBERSHIP AND PRIVILEGES ARE NOT GUARANTEED SIMPLY BY SUBMITTING THIS APPLICATION.

EATON RAPIDS MEDICAL CENTER CREDENTIALING APPLICATION

SECTION A – INSTRUCTIONS

1. Please type or legibly print all information and sign the designation page and the applicant's consent and release in Section N.

2. If more space is needed, attach additional sheets and make reference to the question being answered.

3. **Incomplete applications may be returned and will delay processing time. Provide answers to all questions, if appropriate response is none or N/A, state "none" or "N/A"**

4. Please ATTACH CURRENT COPIES of the following documents to this application:
   - ___ CV or Resume
   - ___ Federal Controlled Substance License (DEA), if applicable
   - ___ Michigan Controlled Substance License
   - ___ Michigan Physician/Dental/Podiatric License to Practice Medicine
   - ___ Professional Liability Insurance Certificate of Coverage from Insurance Carrier
   - ___ ECFMG Certificate (if Foreign Medical Graduate) and/or applicable USMLE Certificate
   - ___ Medical School Diploma
   - ___ Certificate of Internship/Residency and/or Fellowship **as applicable**
   - ___ Residency and/or Fellowship Training Logs
   - ___ Board Certification or Board eligibility Letter
   - ___ PPD Status Validation within previous 12 months
   - __ Influenza Vaccine & COVID Vaccine
   - ___ Privilege Form
   - ___ Current Driver's License
   - __ Recent Color Photo of yourself

5. Credentialing Application Fee (make check payable to ERMC Medical Staff) $100.00

6. **Anticipated Start Date:** _____

SECTION B - PERSONAL INFORMATION - if appropriate response is none or N/A, state "none" or "N/A"

1. _____ 2. Degree_____
Last Name First Name Middle Initial

3. Date of Birth _____ 4. Birthplace _____ 5. Ethnicity (optional) _____

6. Social Security Number _____ 7. (Optional) _____ Male _____ Female

8. Other Legal Name(s) Used _____

9. Home Address _____
Number and Street City State Zip Code

10. Home Phone _____ 11. Cell Phone _____

12. Email Address _____ 13. Preferred method of contact: _____

14. All current and prior city and states of residence _____

15. Citizenship _____

16. If not a citizen of the United States, please indicate the status of your VISA at the present time. _____

17. Languages spoken _____

18. Emergency Contact Name _____ 19. Emergency Contact Phone _____

SECTION C – PROFESSIONAL DATA - if appropriate response is none or N/A, state "none" or "N/A"

1. Practice Specialty _____

2. Practice Subspecialty _____

3. Since Medical School, list all licenses: (**If additional space is needed, please attach list**)

State _____ License Number _____ Expiration Date _____

State _____ License Number _____ Expiration Date _____

4. DEA Registration # _____ Expiration Date _____

5. NPI # _____ 6. NPI # ORGANIZATION: _____

7. CAQH # _____

PRIMARY PRACTICE INFORMATION

1. Practice Name _____

2. Local Practice Address _____
Number and Street City State Zip Code

3. General Phone _____ Ext._____ Fax _____

Office Manager/Contact _____ **Phone** _____

Email _____

SECTION D – EDUCATIONAL DATA - if appropriate response is none or N/A, state "none" or "N/A"

MEDICAL/DENTAL/PODIATRIC EDUCATION (If attended more than one, attach a separate sheet.)

College/University _____ Phone _____ Fax _____

Address _____
Number and Street City State Zip Code

Degree _____ Date(s) From _____ to _____ Year Graduated _____
(mm/dd/yyyy) (mm/dd/yyyy)

INTERNSHIP/TRANSITIONAL PROGRAMS

Describe below all internships that you have begun or completed. If more than **one internship**, please supply the same information on a separate sheet and attach. Please provide **complete** addresses.

Type of Internship/Preceptorship _____

Program Director _____ ❑ MD ❑ DO Institution _____

Phone _____ Fax _____ Email _____

Address _____
Number and Street City State Zip Code

Date(s) from _____ to _____ Program Completed? ☐ Yes ☐ No
(mm/dd/yyyy) (mm/dd/yyyy)

RESIDENCIES/FELLOWSHIPS

List in chronological order below all residencies/fellowships which you have begun or completed. If more that four residencies/fellowships, please supply the same information on a separate sheet and attach. Please provide **complete** addresses.

***Please Note: Your specialty program must be accredited by a body recognized by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association, The Commission on Dental Accreditation of the American Dental Association, or the American Podiatric Medical Association.**

1. Residency F Fellowship *Specialty _____

Program Director _____ ❑ MD ❑ DO Institution _____

Phone _____ Fax _____ Email _____

Address _____
Number and Street City State Zip Code Country

Date(s) from _____ to _____ Program Completed? Yes No (Please explain)
(mm/dd/yyyy) (mm/dd/yyyy)

2. Residency F Fellowship *Specialty _____

Program Director _____ ❑ MD ❑ DO Institution _____

Phone _____ Fax _____ Email _____

Address _____
Number and Street City State Zip Code Country

Date(s) from _____ to _____ Program Completed? ☐ Yes ☐ No (Please explain)
(mm/dd/yyyy) (mm/dd/yyyy)

3. Residency F Fellowship *Specialty _____

Program Director _____ ❑ MD ❑ DO Institution _____

Phone _____ Fax _____ Email _____

Address _____
Number and Street City State Zip Code Country

Date(s) from _____ to _____ Program Completed? ☐ Yes ☐ No (Please explain)
(mm/dd/yyyy) (mm/dd/yyyy)

4. Residency Fellowship *Specialty _____

Program Director _____ ❑ MD ❑ DO Institution _____

Phone _____ Fax _____ Email _____

Address _____
Number and Street City State Zip Code Country

Date(s) from _____ to _____ Program Completed? ☐ Yes ☐ No (Please explain)
(mm/dd/yyyy) (mm/dd/yyyy)

SECTION E – BOARD CERTIFICATION DATA - if appropriate response is none or N/A, state "none" or "N/A"

Name of Board/Certifying Entity	Specialty	Initial Certification Date	Expiration Date	Recertification Date	Expiration Date
1.					
2.					
3.					

Are you board eligible Yes No If yes, provide a copy of board eligible letter.

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

If yes, list board(s) and date(s): _____

If not certified, do you intend to apply? Yes Specify timeframe: _____

No Specify reason: _____

Have you ever taken and not passed a medical board examination? Yes ☐ No ☐

If yes, will you re-take? ☐ Yes ☐ No

SECTION F – HOSPITAL/INSTITUTION AFFILIATIONS - if response is none or N/A, state "none" or "N/A"

HOSPITAL/INSTITUTION STAFF MEMBERSHIPS

List the hospital(s) (**in chronological order**) at which you currently hold or have held staff membership and/or clinical privileges including your department assignments and staff category. If there are more than four, please supply the same information on a separate sheet and attach.

1. Hospital/Institution _____

   Address _____
   Number and Street City State Zip Code

   (**Medical Staff Services**): Phone _____ Fax _____ Email: _____

   Department _____ Chairperson _____

   Date(s) from _____ to _____ Admitting privileges: Yes No
   (mm/dd/yyyy) (mm/dd/yyyy)

   Category: _____ Reason for leaving: _____

2. Hospital/Institution _____

   Address _____
   Number and Street City State Zip Code

   (**Medical Staff Services**): Phone _____ Fax _____ Email: _____

   Department _____ Chairperson _____

   Date(s) from _____ to _____ Admitting privileges: ☐ Yes ☐ No
   (mm/dd/yyyy) (mm/dd/yyyy)

   Category: _____ Reason for leaving: _____

3. Hospital/Institution _____

   Address _____
   Number and Street City State Zip Code

   (**Medical Staff Services**): Phone _____ Fax _____ Email: _____

   Department _____ Chairperson _____

   Date(s) from _____ to _____ Admitting privileges: ☐ Yes ☐ No
   (mm/dd/yyyy) (mm/dd/yyyy)

   Category: _____ Reason for leaving: _____

4. Hospital/Institution _____

   Address _____
   Number and Street City State Zip Code

   (**Medical Staff Services**): Phone _____ Fax _____ Email: _____

   Department _____ Chairperson _____

   Date(s) from _____ to _____ Admitting privileges: ☐ Yes ☐ No
   (mm/dd/yyyy) (mm/dd/yyyy)

   Category: _____ Reason for leaving: _____

SECTION G – PROFESSIONAL WORK HISTORY - if appropriate response is none or N/A, state "none" or "N/A"

CHRONOLOGICAL PROFESSIONAL HISTORY

Please identify all professional employers, locum tenens, clinics, private or group practice, and/or military service, listing most recent first. Account for ALL intervals of time (including nonprofessional employers, etc) not included in Section F. List additional institutions on a separate sheet.

1. **Organization/Practice Name** _____ Phone _____ Fax _____

   Status: (Mark as applicable) Owner Employee Subcontractor Other

   Address _____
   Number and Street City State Zip Code

   Contact Person _____ Contact Email: _____

   Date(s) From _____ to _____ Reason for discontinuing affiliation _____
   (mm/dd/yyyy) (mm/dd/yyyy)

2. **Organization/Practice Name** _____ Phone _____ Fax _____

   Status: (Mark as applicable) Owner Employee Subcontractor Other

   Address _____
   Number and Street City State Zip Code

   Contact Person _____ Contact Email: _____

   Date(s) From _____ to _____ Reason for discontinuing affiliation _____
   (mm/dd/yyyy) (mm/dd/yyyy)

3. **Organization/Practice Name** _____ Phone _____ Fax _____

   Status: (Mark as applicable) Owner Employee Subcontractor Other

   Address _____
   Number and Street City State Zip Code

   Contact Person _____ Contact Email: _____

   Date(s) From _____ to _____ Reason for discontinuing affiliation _____
   (mm/dd/yyyy) (mm/dd/yyyy)

SECTION G – PROFESSIONAL WORK HISTORY (Con't) - if appropriate response is none or N/A, state "none" or "N/A"

UNACCOUNTED INTERVALS

1. Since medical school graduation are there any unaccounted intervals (one month or more)? Please list below:

_____ Date(s) From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

_____ Date(s) From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

_____ Date(s) From _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

SECTION H – PROFESSIONAL SANCTIONS – all questions must be answered

1. Please answer each of the questions. **If the answer to any of these questions is YES, please provide full details on a separate sheet, and attach.**

   A. Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, censored, reprimanded, placed on probation, not renewed, voluntarily or involuntarily relinquished while under investigation or in exchange for an investigation or action not being taken, or investigated?

Medical or other professional Registration/License in any state	☐ YES	☐ NO
DEA Registration	☐ YES	☐ NO
Academic Appointment	☐ YES	☐ NO
Membership of any hospital staff	☐ YES	☐ NO
Clinical Privileges	☐ YES	☐ NO
Prerogatives/rights on any medical staff	☐ YES	☐ NO
Other institutional affiliation or status	☐ YES	☐ NO
Professional organization/society membership, fellowship or board certification	☐ YES	☐ NO
Professional Office	☐ YES	☐ NO
Professional Liability Insurance	☐ YES	☐ NO
Private, State, or Federal health insurance programs For example, Medicare or Medicaid	☐ YES	☐ NO

   B. Have you ever been convicted of a felony or misdemeanor (excluding civil infraction traffic offenses) or is a felony charge currently pending against you? ☐ YES ☐ NO

   C. Has there been any disciplinary actions taken against you at any institution where you are currently or have been a member? ☐ YES ☐ NO

SECTION I – HEALTH STATUS – all questions must be answered

1. **If you answer YES to any of these questions, please provide a full explanation of the details on a separate sheet and attach**.

A. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform all elements of the clinical privileges for which you have applied without a direct threat to the health and safety of others? ☐ YES ☐ NO

NOTE: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in monitoring programs for alcohol, drug dependency, mental conditions, medical limitation of activity workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.

B. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients? ☐ YES ☐ NO

C Regarding chemical substances, have you or do you participate in any of the following *to the extent that your ability to competently and safely perform the essential functions of a practitioner* in your area of practice is or has been compromised?

- Use illegal drugs ☐ YES ☐ NO
- Consume alcohol ☐ YES ☐ NO
- Prescribe drugs for yourself ☐ YES ☐ NO
- Use chemical substances ☐ YES ☐ NO

D. Have you ever been treated for substance abuse? ☐ YES ☐ NO

SECTION J – PROFESSIONAL LIABILITY DATA

CURRENT:

1. Name of **current** carrier: _____ Dates from: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Address: _____
Number and Street City State Zip Code

Policy #: _____ Phone: _____ Fax: _____

2. Has your **current** professional liability insurance carrier excluded any specific procedures from your coverage? ☐ YES ☐ NO

If YES, list the procedures which have been excluded and provide a full explanation on a separate sheet including the name of the carrier, the date and specific information concerning any limitation.

3. Does your current PLI carrier cover you at all Institutions/affiliates to which you are applying? ☐ YES ☐ NO

PREVIOUS (**if appropriate response is none or N/A, state "none" or "N/A"**)

4. Name of all **previous** carriers and dates (if more than two please attach identical info on a separate sheet of paper)

Name of carrier: _____ Dates from: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Address: _____
Number and Street City State Zip Code

Policy #: _____ Phone: _____ Fax: _____

Name of carrier: _____ Dates from: _____ to _____
(mm/dd/yyyy) (mm/dd/yyyy)

Address: _____
Number and Street City State Zip Code

Policy #: _____ Phone: _____ Fax: _____

LEGAL ACTIONS

(All questions must be answered)

1. Have you ever been denied professional liability coverage or has your policy been cancelled or denied renewal? ☐ YES ☐ NO

   If you answered YES to question 1, please provide a full explanation of the details on a separate sheet and attach.

2. Within the past **5** years, have there been, or are there currently pending, any claims or Notice of Intent arising out of your care or supervision of care for a patient? (For this purpose, "claim" includes a lawsuit, arbitration, settlement or request for payment of damages). ☐ YES ☐ NO

   If you answered YES to question 2, please complete the information below. If additional space needed please attach a separate sheet with the same information below for each claim.

Name of Patient (Plaintiff): _____ Date of Occurrence mddyyyy):_____

Date Claim Filed (mmddyyyy):_____ Claim Settlement Date, if applicable mmddyyyy):_____

Claim Status: ❑ Claim ❑ Suit ❑ Open ❑ Closed

Insurance Carrier Name: _____ Insurance Carrier Phone: _____ Ext._____

Insurance Carrier Address: _____
Number and Street City State Zipcode

Policy Number: _____ Settlement Amount: _____

Resolution Method: ◯ None ◯ Arbitration ◯ Dismissed ◯ Judgment for Defendant

◯ Judgment for Plaintiff ◯ Mediation ◯ Settled

Description of Allegations: _____

_____ Were you the primary defendant? ☐ YES ☐ NO

Number of Co-defendants: _____ Your involvement in the case: _____

_____

Description of alleged injury to patient: _____

_____ Did the alleged injury result in death? ☐ YES ☐ NO

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐ YES ☐ NO

SECTION K – PEER REFERENCES – ALL LINES MUST BE COMPLETE

PEER REFERENCES (must be a practitioner, i.e., MD/DO/DPM/DDS, in same specialty as you)
None of the individuals may be related to you by family. Do NOT give names of your program directors as they will automatically be contacted unless you have been out of your program for over 24 months. Name four (4) individuals who have personal knowledge of your current clinical abilities in your specialty area, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through ***recent*** **(last 12-24 months)** observation of your professional practice over a reasonable period of time and at least one must have had organizational responsibility for your performance.

1. Name: _____ ☐ M.D. ☐ D.O. ☐ Other _____
   Medical Specialty: _____
   E-mail Address: _____

2. Name: _____ ☐ M.D. ☐ D.O. ☐ Other _____
   Medical Specialty: _____
   E-mail Address: _____

3. Name: _____ ☐ M.D. ☐ D.O. ☐ Other _____
   Medical Specialty: _____
   E-mail Address: _____

4. Name: _____ ☐ M.D. ☐ D.O. ☐ Other _____
   Medical Specialty: _____
   E-mail Address: _____

SECTION L – PRACTICE DEMOGRAPHICS - if appropriate response is none or N/A, state "none" or "N/A"

1. What, if any, limitations do you have on the age range of patients which you see? _____

2. Will you utilize/employ nurse practitioners, physician assistants, nurse midwives, physical therapists, occupational therapists, or other licensed professionals at this institution? ☐ YES ☐ NO
   If **YES**, please attach a list with names and specialties.

3. Are you accepting Medicare Patients? ☐ YES ☐ NO 4. Medicaid Patients? ☐ Yes ☐ NO

4. Will you be strictly a remote provider? ☐ Yes ☐ NO

SECTION M – CONTINUING MEDICAL EDUCATION DATA
(NOT APPLICABLE FOR CURRENT RESIDENTS/FELLOWS)

Please submit a listing of Continuing Medical Education (CME) courses attended – where, when, and the number of hours of CME credits obtained – on a separate sheet or copies of CME documents that are related to the clinical privileges you hold

OR ***Sign the statement below:***

I hereby certify that I have completed CME (Category I) credit related to my scope of practice. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical Staff.

_____ _____

Signature *Date*

SECTION N – APPLICANT'S CONSENT AND RELEASE (Must sign and date)

I, the undersigned, hereby apply for medical staff appointment, clinical privileges, and/or membership with the healthcare facility/organization(s) listed on the designation page. Copies of this application, including my signature below, are as valid as the original.

I understand and agree that as an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications and for resolving any doubts about my qualifications. I understand that my application will not be processed until it is deemed complete by the healthcare facility/organization. I have the responsibility to keep the application current by informing the healthcare facility/organization of any change in my professional liability insurance coverage, the filing of a lawsuit or other submission of a claim against me relating to my competency to practice my profession, any change in my medical staff status at another hospital, or any other material change or addition to the information provided in this application. I will provide the organization with updated current information regarding all questions on this application form as it becomes available. I will provide additional information that may be requested by the healthcare facility/organization or its authorized representatives. My failure to provide information requested, will prevent my application from being evaluated and acted upon.

I attest that the information included in this application is current, complete, accurate, true and fairly represents the current level of my qualifications for the clinical privileges requested. I understand that as a condition to making this application, any misrepresentation, misstatement, or omission from this application, whether intentional or not, may result in an automatic and immediate rejection of this application for appointment and clinical privileges or termination of any medical staff membership or clinical privileges granted before discovery of the misrepresentation, misstatement, or omission.

By applying for appointment and clinical privileges, I hereby:

- Agree to appear for an interview regarding my application if requested;
- Authorize the healthcare facility/organization and their representatives to consult with administrators and members of other healthcare facilities/organizations with which I am or have been associated, malpractice carriers, or anyone else who may have information bearing on my qualifications;
- Agree to provide a photo with signature – notarized – to assist in verifying my identity and agree to the distribution of such photo for additional credentialing verification purposes;
- Consent to the inspection by the healthcare facility/organization and their representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications to carry out the clinical privileges requested.
- Authorize the healthcare facility/organization and their representatives to provide other healthcare facilities/organizations, licensing boards, associations, and others concerned with provider performance and the quality and efficiency of patient care with any information about me relevant to such matters.
- Consent to the healthcare facility/organization and their authorized representatives to access my Michigan Care Immunization Registry (MCIR) records to verify my immunization history requirement purposes, as needed, during my medical staff appointment.
- Agree that I have disclosed in my application all criminal convictions and any felony charges brought or pending against me. I further authorize the healthcare facility/organization and its representatives to request, and any individual, company, firm, corporation or public agency, including law enforcement agencies, to divulge, any criminal records or information, verbal or written, pertaining to me, including information or data received from other sources.

I hereby release from liability to the fullest extent permitted by law all representatives of the healthcare facility/organization and its Medical/Professional Staff for their acts performed and statements made in good faith and without malice within its scope as a review entity. I hereby release from liability any and all third parties who in good faith, and without malice, provide information to the facility/organization concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior or any other matter that might have an effect on my competence, on patient care or on the orderly operation of any hospital or healthcare facility/organization.

I agree to:

- Abide by the bylaws, rules and policies of the healthcare facility/organization
- Abide by the medical staff bylaws, rules and policies and the rules and policies of the department and/or clinical service to which I am assigned
- Adhere to recognized principles governing the practice of medicine, participate in continuing education program which relate, at least in part, to the privileges granted to me by the healthcare facility/organization, and document such participation when requested to do so;
- Provide for care for my patients consistent with the standard of practice of my profession, accept committee assignments, accept administrative consulting assignments and participate in staffing emergency room service areas in my specialty on a reasonably agreed upon basis if requested to do so;
- Comply with applicable local, Michigan and federal law, including abstaining from the division of fees or remuneration for referrals under any guise whatsoever;
- Maintain a constructive interest and cooperate in advancing the healthcare facility/organization as a quality healthcare facility/organization; and;
- Seek consultation by physicians of appropriate clinical experience as needed or requested.

I acknowledge that medical staff appointment and clinical privileges at the healthcare facility/organization are not a right of every licensed professional who makes application for the same.

I understand that:

- My application will be evaluated in accordance with prescribed procedures defined in the medical staff bylaws and rules;
- All medical staff recommendations relative to my application are subject to the ultimate action of the healthcare facility/organization Board;
- If appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the healthcare facility/organization Board;
- Reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the healthcare facility/organization, acceptable performance of all responsibilities, as well as the other factors deemed relevant by the healthcare facility/organization. Reappointment and continued clinical privileges shall be granted only on formal application, according to medical staff bylaws and rules, and upon final approval of the healthcare facility/organization Board.
- I have received and had an opportunity to read a copy of the medical staff bylaws and rules of the healthcare facility/organization and such policies and directives as are applicable to appointees to the medical staff, and acknowledge I shall be bound by the terms thereof, any subsequent modifications or amendments thereof and any other established written policies of the healthcare facility/organization, which are consistent with the bylaws and rules, whether or not I am granted membership and privileges; and
- The provisions of the medical staff bylaws relating to confidentiality and release from liability are express conditions of my application for, and acceptance of, medical staff membership and the continuation of such membership and to my exercise of privileges.

_____

Print or Type Name

_____

Signature Date