Eaton Rapids Medical Center

INSTRUCTIONS FOR COMPLETION OF APPLICATION FOR SPECIFIED SERVICE AUTHORITY ALLIED HEALTH PROFESSIONAL

Please read the following instructions prior to completing the Application. Applications are not considered complete until all supporting documentation has been received and verified.

1) Type or legibly print all information.
2) Provide answers to all questions. If the question is not applicable, write "NA".
3) Attach current copies of the following documents:
   a) Professional liability insurance declaration sheet
   b) Diploma or education certificate
   c) Professional license
   d) Professional Certification certificate
   e) Completed Request for Specified Service Authority
   f) PPD status validation within previous 12 months
   g) Influenza vaccination
   h) ACLS certification (if required on your privilege form)
   i) DEA Certificate (if applicable)
      i) Delegation of Prescriptive Authority for Controlled Substances to Advanced Practice Practitioners
   j) Curriculum Vitae
4) Identification
   a) Current Driver's license
   b) Recent in Color Photo of yourself
5) Your signature is required on:
   a) Application (Attestation, Release of Information)
   b) Request for Specified Service Authority
   c) Approval for Medical Staff Appointment
   d) Competency Check List
   e) Bylaws and Rules Acknowledgement Statement
   f) Risk Management Handbook Acknowledgement Statement
   g) CHAMPUS Statement: (Medicare Acknowledgement)
   h) Corporate Compliance Confidentiality Agreement
   i) Conflict of Interest Disclosure Statement
   j) Practitioner Performance Measures/Associated Expectations
   k) Restraint/Seclusion Acknowledge Statement
   l) Behavioral Standards
   m) Signature Page
6) Signature of your sponsoring physician is required on:
   a) Application (Sponsor Statement)
   b) Request for Specified Service Authority
7) Application Fee of $50 (check to be made payable to *ERMC Medical Staff Services*)
8) Return application and requested documents to:

Medical Staff Coordinator
Eaton Rapids Medical Center
1500 S. Main Street
Eaton Rapids, MI 48827
(517) 663-9446 Fax (517) 663-9450
medicalstaff@ermchealth.org

Eaton Rapids Medical Center

APPLICATION FOR SPECIFIED SERVICE AUTHORITY
ALLIED HEALTH PROFESSIONAL

Scope of Specified Service Authority Requested (check all that apply)

____ Certified Registered Nurse Anesthetist
____ Clinical Psychologist
____ Licensed Practice Nurse
____ Nurse Practitioner
____ Physician's Assistant
____ Registered Nurse
____ Social Worker
____ Surgical Assistant
____ Medical Assistant
____ Other: _____

PERSONAL INFORMATION

1. _____ 2. Title _____
Last name *First name* *Middle name*

3. Social Security Number_____ 4. ___Male ___Female

5. Maiden/other legal name(s) used _____

6. Home address _____
Number and street *City* *State* *Zip Code*

7. Home phone_____

8. Home Fax_____ E-mail _____

9. Date of birth_____ 10. Birthplace _____

11. Citizenship_____

12. Contact in case of emergency_____

13. Home phone_____ 14. Work phone_____

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PRACTICE INFORMATION

1. Corporation Name_____

2. Office Address _____
   Number and street City State Zip Code

3. Mailing Address_____
   Number and street City State Zip Code

4. Phone _____Ext._____ 5. Fax _____

6. Date started at Practice _____ 7. E-mail address_____
   Month/year

8. Office Phone_____ 9. CAQH Number _____

10. Office Manager_____

11. NPI Number (nurse practitioners, physician assistants, CRNAs, psychologists) _____

LICENSURE

1. Are you currently licensed/registered? ____Yes ____No.

2. If yes, what type? ____Full license ____Limited license

3. Michigan professional license/registration number_____

4. Expiration date_____

5. Federal Controlled Substance Regulation Certificate (DEA) number_____

6. Expiration Date_____

7. Licenses held in other states:

   State_____ License Number _____

   Issue Date _____Expiration Date _____

   ****

   State_____ License Number _____

   Issue Date _____Expiration Date _____

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EDUCATION/TRAINING

Colleges, universities, or other schools attended since high school
(If attended more than two, please attach separate sheet)

1. Name of School _____

2. Address _____
Number and street *City* *State* *Zip Code*

3. Phone_____ 4. Fax_____ 5. Contact Person _____

6. Dates: from_____ to _____ 7. Degree _____
month/year *month/year*

****

1. Name of School _____

2. Address _____
Number and street *City* *State* *Zip Code*

3. Phone_____ 4. Fax_____ 5. Contact Person _____

6. Dates: from_____ to _____ 7. Degree _____
month/year *month/year*

CERTIFICATION

1. Area of Certification _____

2. Date certified _____ 3. Expiration date_____

4. Date recertified _____ 5. Expiration date_____

6. Certifying Board _____

7. Address _____
Number and street *City* *State* *Zip Code*

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HOSPITAL AFFILIATIONS

List all hospitals at which you have held staff membership and/or specified service authority.

1. Hospital Name _____

   Address _____
   Number and street *City* *State* *Zip Code*

   Phone_____ Ext_____ Fax _____

   Department_____ Dates_____ to _____
   month/year *month/year*

2. Hospital Name _____

   Address_____
   Number and Street *City* *State* *Zip Code*

   Phone_____ Ext_____ Fax_____

   Department_____ Dates_____ to_____
   month/year *month/year*

HISTORY OF PROFESSIONAL PRACTICE

List all previous professional employment experience since obtaining degree. List most recent experience first. (Please use additional sheets as needed)

1. Employer _____

   Address _____
   Number and street *City* *State* *Zip Code*

   Phone_____ Fax_____ Contact Person _____

   Dates_____ to_____ Title _____
   month/year *month/year*

   What functions did you perform? _____

   Reason for leaving_____

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2. Employer _____

Address _____
Number and Street *City* *State* *Zip Code*

Phone_____ Fax_____ Contact Person _____

Dates_____ to_____ Title _____
month/year *month/year*

What functions did you perform? _____

Reason for leaving_____

3. Employer _____

Address _____
Number and Street *City* *State* *Zip Code*

Phone_____ Fax_____ Contact Person _____

Dates_____ to_____ Title _____
month/year *month/year*

What functions did you perform? _____

Reason for leaving _____

UNACCOUNTED INTERVALS

List all unaccounted intervals in your practice history since completion of training.

_____ Dates_____ to_____

_____ Dates_____ to_____

_____ Dates_____ to_____

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DISCIPLINARY ACTIONS

1. Has your state license/registration certificate to practice ever been limited, suspended or revoked, either voluntarily or involuntarily? _____Yes _____No _____ not applicable

2. Has your state or federal drug registration/license ever been limited, suspended or revoked, either voluntarily or involuntarily? _____Yes _____No _____not applicable

3. Have you ever been convicted of a felony? _____Yes _____No

4. Have any legal actions been filed against you? _____Yes _____No

5. Have any disciplinary actions or investigations by any state licensing board or professional organization ever been initiated against you? ____Yes ____No

If you answer yes to any of the above questions, please explain on a separate sheet and attach.

PROFESSIONAL LIABILITY INSURANCE

1. Name of current liability insurance carrier _____

2. Limits of coverage_____ Effective date_____ Exp. Date _____
(Note: Minimum $200,000/$600,000 limits required; attach a copy of your current policy declaration sheet)

3. Are you covered under your physician's/employer's insurance policy? ____Yes ____No

4. Do you carry your own policy? _____Yes _____No

5. Have judgments or settlements ever been made by an insurance company under an insurance policy, risk retention group, self-insurance plan, or otherwise, in settlement (or partial settlement) of, or in satisfaction of, judgment in a malpractice action/claim on your behalf? _____ Yes _____No

6. Do you have any pending claims? _____Yes _____No
(If you answered "yes" to questions 5 or 6, please explain on the attached supplemental claims form)

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SUPPLEMENTAL CLAIMS FORM **(Copy page and attach for additional claims/suits)**

Name of patient (plaintiff): _____

☐ Claim ☐ Suit Date of incident: _____

Year claim or suit was filed: _____ Year claim or suit was settled: _____

Nature of allegations: _____

_____

_____

Status: ☐ Pending ☐ Dismissed ☐ Settled, amount $_____

☐ Jury decision (describe):_____

_____

_____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____ Policy No. _____

Name of patient (plaintiff): _____

☐ Claim ☐ Suit Date of incident: _____

Year claim or suit was filed: _____ Year claim or suit was settled: _____

Nature of allegations: _____

_____

_____

Status: ☐ Pending ☐ Dismissed ☐ Settled, amount $_____

☐ Jury decision (describe): _____

_____

_____

Name of insurance carrier: _____

Address of insurance carrier: _____

Telephone number of insurance carrier: _____ Policy No. _____

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HEALTH STATUS

1. Do you have a current physical or mental condition, including substance abuse, which might impair or limit your ability to provide services for which you have applied? _____Yes _____No

2. Are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients? ____Yes ____No

If you answer yes to any of the above questions, please explain on a separate sheet and attach.

REFERENCES

List 4 persons who can attest to your professional ability, i.e., persons who have worked extensively with you or have been responsible for professional observation of your work. **Please note:**

At least 1 reference must be from a practitioner with the same legal credentials as you.

The other 3 references must be practitioners with either the same legal credentials or a physician (MD, DO, DPM, DDS).

1. Name_____ Title _____

   E-mail_____

2. Name_____ Title _____

   E-mail_____

3. Name_____ _____ Title _____

   E-mail_____

4. Name _____ Title_____

   E-mail _____

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CONTINUING EDUCATION DATA

Please submit a listing of Continuing Education courses attended—where, when, and the number of hours of CE credits obtained—on a separate sheet or copies of CE documents that are related to the specified service authority you hold.

OR

Sign the statement below:

I hereby certify that I have completed CE 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 Allied Health Professional Staff.

_____ _____

Signature *Date*

SPONSOR STATEMENT

This section to be completed by physician employer/contractor/sponsor

I accept full responsibility for this individual's performance at Eaton Rapids Medical Center (ERMC) with respect to patients under my supervision, for proper conduct within ERMC, and for the observance of the Professional Staff Bylaws, and all Rules and Policies of ERMC and the Professional Staff.

Sponsor's Signature_____ Date _____

Print Name_____

Eaton Rapids Medical Center

ATTESTATION & RELEASE OF INFORMATION

I do hereby request Specified Service Authority as an Allied Health Professional as noted. I attest by affixing my signature in the space provided below that the information provided on this Application is true and complete to the best of my knowledge, and that omission or falsification of information may be cause for automatic and immediate rejection of this application for AHP membership and specified service authority or termination of any AHP membership or specified service authority granted before discovery of the misrepresentation, misstatement, or omission.

I, the undersigned, do hereby authorize Eaton Rapids Medical Center to consult with other hospitals or employers with whom I have been associated and with others who may have information bearing on my competence, character, and ethical qualifications.

I further consent to the inspection by Eaton Rapids Medical Center of all records and documents which may be pertinent to an evaluation of my professional, moral, and ethical qualifications and competence to provide services within the scope of service authority requested.

I do hereby release from any liability all representatives of Eaton Rapids Medical Center and its Professional Staff for their acts performed in good faith and without malice in connection with evaluating me and my credentials and release from any liability all individuals and organizations in connection with providing information to Eaton Rapids Medical Center in good faith and without malice concerning my competence, ethics, character, professional liability coverage, and other qualifications for specified service authority, including otherwise privileged or confidential information.

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

Applicant's Signature: _____ Date: _____

Print Name: _____