



**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



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. Last name First name Middle name 2. Title
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





**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*

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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**

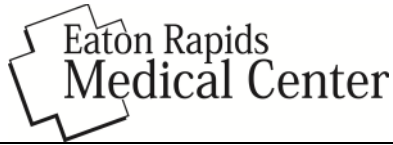
1. Area of Certification \_\_\_\_\_

2. Date certified \_\_\_\_\_ 3. Expiration date \_\_\_\_\_

4. Date recertified \_\_\_\_\_ 5. Expiration date \_\_\_\_\_

6. Certifying Board \_\_\_\_\_

7. Address \_\_\_\_\_  
*Number and street City State Zip Code*



### 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 \_\_\_\_\_



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 \_\_\_\_\_



### 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)*



**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): \_\_\_\_\_

\_\_\_\_\_

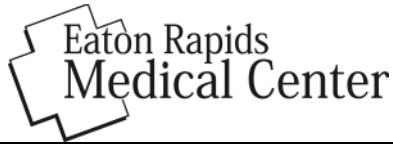
\_\_\_\_\_

Name of insurance carrier: \_\_\_\_\_

Address of insurance carrier: \_\_\_\_\_

Telephone number of insurance carrier: \_\_\_\_\_ Policy No. \_\_\_\_\_





**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 \_\_\_\_\_



**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 \_\_\_\_\_



**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: \_\_\_\_\_