

* * * Notice to Applicant * * *

Our goal is to process your application quickly and get all information verified within 60 days of receipt.

Incomplete applications will not be processed and may be returned to the sender.

Here are things you can do to help in processing your application:

1. Provide the name, **current** addresses, telephone numbers and fax numbers for your training program director and the current program director, if different; all past and present hospital affiliations (medical staff office), with dates of affiliation, etc. **Please be accurate with dates.**
2. Include names and complete addresses for **all** professional liability coverage for the past five (5) years, including any self-insured trusts, and details of **all** malpractice claims, settlements or judgements, closed or pending, including the amounts of any settlements during the past ten (10) years. (Attachment G)
3. Submit a recent photo of yourself with your application. Also submit a copy of your current Driver's License.
4. Provide three (3) professional references as indicated on the application with current, complete addresses, telephone and fax numbers for each one. **Avoid references with obvious conflict of interest issues. Please contact the individuals listed on your application and ask them to provide a prompt reply to our requests for verification**
5. Provide a list of all cases performed in residency OR if out of training for two (2) or more years, provide a list of cases performed during the past two years at your most recent active hospital (with complications, if applicable). **The privileges request form will indicate the minimum number of cases needed.** Review the privileges you are requesting and submit all information necessary to document training, experience and current competency according to the criteria when applicable (as noted on privilege form or attached criteria).
6. **Incomplete and/or incorrect information** on the application may cause delays in the credentialing process, and may result in a denial of your application. **"See CV"** or **"See previous application"** is unacceptable on an application for medical staff membership and privilege. **Write legibly.**
7. Review your entire application for accuracy and completeness, making sure **all** questions are answered appropriately. Check the dates you have provided for any "gaps" of time, i.e., vacation, leave of absence, relocating, etc. If gaps exist, provide a written explanation. **Any misstatement or omission of information will be considered falsification and may be grounds for the rejection of your application and the refusal to consider any future applications.** Remember that **you are responsible** for providing **all** information necessary to process your application for membership and privileges.
8. The application fees for Texas Health Harris Methodist Hospital Southlake are:
Physician Initial application - \$200
Physician Reapplication - \$100 Active Staff
Physician Reapplication - \$150 Courtesy/Consulting Status
Physician Reapplication - \$500 Courtesy with less than 6 cases per year
Allied Health Initial application - \$150
Allied Health Reappointment - \$75
9. **Medical Staff Bylaws/Rules & Regulations** are located on the web site: www.texashealthsouthlake.com under Medical Staff Services. Review the Physician Compliance Module, Physician Policies and Orientation Manual.
10. Please provide copies of all supporting documentation; Sign and return all of the Department addendums; Provide two (2) years CME's or CEU's necessary for licensure; Include a current copy (within the last 12 months) of your PPD test results/chest X-Ray results, etc. You may be asked to provide additional information as needed.
11. **ALLIED HEALTH REFERENCES:** Name two members **of your same discipline and one physician** who have personal knowledge of your current professional abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from THSL and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time. **None of the individuals should be related to you by family or recently initiated or impending professional partnership/financial association and each should currently have a hospital affiliation.**

Attachment H

HOSPITAL ADDENDUM

**TO THE TEXAS DEPARTMENT OF INSURANCE (TDI)
STANDARDIZED CREDENTIALING APPLICATION**

(Attach recent wallet size photo)

SECTION ONE - PERSONAL INFORMATION

Last Name:	First Name:	Middle Name:
Mobile/Cellular Phone Number:	Pager Number (Required):	Answering Service Number:
Marital Status: ____S ____M	Name of Spouse:	E-mail address (Required):

SECTION TWO - EDUCATION INFORMATION

Did you complete all your internship/residency/fellowship training programs? Yes No
If no, please explain. If additional space is needed, please supply the information as an attachment.

SECTION THREE – PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

Current Type of Policy: Occurrence Claims-Made

- Has your insurance carrier ever refused to renew your policy, placed limitations on your scope of coverage, excluded any specific area of practice from your coverage or terminated your coverage? Yes No
- Has your present professional liability insurance carrier excluded any specific area of practice from your coverage? Yes No
- Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty? Yes No

If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.

4. Have you EVER had any malpractice actions that are pending, settled, arbitrated, mediated, dismissed or litigated? Yes No

If you have answered yes to question 4, please complete and submit Attachment G of the TDI Application for each claim.

SECTION FOUR – PROFESSIONAL WORK HISTORY

THE TDI APPLICATION REQUESTS WORK HISTORY FOR ONLY THE PAST FIVE (5) YEARS. PLEASE PROVIDE ALL PROFESSIONAL WORK HISTORY SINCE YOUR COMPLETION OF TRAINING, INCLUDING CLINICS, MEDICAL CENTERS, SOLO PRACTICES, SELF-EMPLOYMENT, EMPLOYMENT OR ANY PRACTICE FROM WHICH YOU RECEIVED AN INCOME BEYOND WHAT YOU DOCUMENTED IN THE TDI APPLICATION IN THE SPACE PROVIDED BELOW. IF ADDITIONAL SPACE IS NEEDED, PLEASE SUPPLY THE INFORMATION AS AN ATTACHMENT. **SEE CV OR PREVIOUS APPLICATION IS UNACCEPTABLE.**

Name and Nature of Affiliation:		Dates of Affiliation:			
		From: / / To: / /			
Title or Position With Affiliation:					
Complete Address:		City:	State:	Zip:	Phone () Fax ()
Reason for Discontinuance if No Longer Affiliated:					
Name and Nature of Affiliation:		Dates of Affiliation:			
		From: / / To: / /			
Title or Position With Affiliation:					
Complete Address:		City:	State:	Zip:	Phone () Fax ()
Reason for Discontinuance if No Longer Affiliated:					
Name and Nature of Affiliation:		Dates of Affiliation:			
		From: / / To: / /			
Title or Position With Affiliation:					
Complete Address:		City:	State:	Zip:	Phone () Fax ()
Reason for Discontinuance if No Longer Affiliated:					
THE TDI APPLICATION REQUESTS AN EXPLANATION FOR ANY TIME GAPS GREATER THAN SIX MONTHS. EXPLAIN BELOW ALL TIME GAPS IN WORK HISTORY 30 DAYS OR GREATER INCLUDING ANY GAP IN ANY INTERSHIP/RESIDENCY/FELLOWSHIP TRAINING OR DURING ANY TEACHING APPOINTMENT. IF ADDITIONAL SPACE IS NEEDED, PLEASE SUPPLY THE INFORMATION AS AN ATTACHMENT.					

SECTION FIVE – HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

1. Have you ever withdrawn an application for medical staff membership or clinical privileges or failed to seek reappointment or renewal of medical staff membership or privileges? Yes No
2. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your medical practice changed at any hospital or other healthcare institution within the last two years? Yes No
3. Have your clinical privileges or Medical Staff membership at any hospital or other healthcare institution ever been voluntarily or involuntarily limited, reduced, excluded, denied, suspended, revoked, restricted, surrendered, relinquished, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have investigations or proceedings toward any of those ends been instituted or recommended by any hospital or other healthcare entity, medical staff or committee, or governing board? Yes No
4. Do you or a member of your immediate family maintain ownership (direct or indirect), or receive compensation from any company or entity providing healthcare services (e.g. clinical labs, hospitals, or diagnostic testing centers) where you could benefit financially from patient referrals (excluding syndications and/or retirement plans)? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

SECTION SIX – ADDITIONAL INFORMATION

1. Have any investigations or disciplinary action ever been initiated or are there now pending challenges against you by any state licensure board? Yes No
2. Has your license to practice ever been involuntarily or voluntarily denied, limited, suspended, revoked, relinquished or surrendered or have you ever been subject to any disciplinary actions, by a state licensing board? Yes No
3. Have you ever been required to obtain additional education or training, proctoring, supervision, or consultation as a result of peer review of quality assurance/improvement or utilization review activities by any type of healthcare entity? Yes No
4. Have you ever been disciplined, excluded from, suspended, reprimanded, sanctioned, censured, investigated, disqualified, declared an ineligible person or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other private, federal or state governmental health care plans or programs, or are there any such actions pending? Yes No
5. Have you ever been convicted of, pled guilty to, pled nolo contendere to, or formally charged with a felony or misdemeanor (including DUI) other than minor traffic violations? Yes No
6. Have you ever been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever been subject to civil money penalties under the Medicare or Medicaid program? Yes No
7. Have your Federal DEA and/or Controlled Substances Certificate(s), registrations or authorization(s) in any state, ever been denied, limited, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished, or are any such challenges currently pending? Yes No
If so, which registration number and state?
8. If not board certified, have you ever taken the exam given by any specialty board, but failed to pass? Yes No
9. Has your membership in any medical/professional society or association been voluntarily or involuntarily challenged, denied, limited, suspended, revoked or relinquished, or are there any actions currently pending that would affect your membership in any medical/professional society? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

SECTION SEVEN – HEALTH STATUS

1. Have you been diagnosed with or in the past received treatment for a physical, mental, chemical dependency or emotional condition which could impair your current ability to provide patient care or fulfil the essential functions of medical staff membership or participation in any healthcare institution? Yes No
2. Are you currently under a monitoring or rehabilitation contract/agreement for any health condition including substance abuse or mental illness, or disruptive behaviour that could impair your current ability to provide patient care or fulfil the essential functions of medical staff membership or participation in any healthcare entity? Yes No
3. Tuberculin (PPD) Test Results:
Date of Last PPD Test (MM/DD/YYYY):
Results of Tuberculin (PPD) Test? ____Positive ____Negative If positive, was x-ray taken: Yes No
4. If results of PPD test were positive, have you experienced any of the following symptoms: persistent cough of more than two months, coughing up blood, recurrent night sweats, unexplained weight loss and/or fever? Yes No
5. Are you unable to have a PPD test due to an allergic (anaphylactic) reaction or medical condition? Yes No

If the answer to any of the above questions is yes, please provide detailed information.

SECTION EIGHT – CONTINUING MEDICAL EDUCATION

1. Have you met the minimum continuing medical education requirements for renewal of your license in the past two years? Yes No
2. Please list below or attach a list of the CME credits attained relative to your specialty during the past two years. Also attach a copy of certificates, logs or other documentation of attendance at programs listed. Yes No

<i>Program Title</i>	<i>Dates Attended</i>	<i>Credit</i>
<i>Hours/Category</i>		

APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this application and addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing.

APPLICANT'S SIGNATURE

_____ DATE _____

APPLICANT'S PRINTED NAME _____