Credentialing Application

Application is submitted by: (Please print your name exactly as it appears on your social security card.)

Name ____

Last First MI Suffix Title

Please indicate the entity (ies) to which you are applying:

☐ Dignity Health Chandler Regional Medical Center
☐ Dignity Health East Valley Rehabilitation Hospital
☐ Dignity Health Mercy Gilbert Medical Center
☐ Dignity Health St Joseph's Hospital & Medical Center
☐ Dignity Health St Joseph's Westgate Medical Center

Instructions

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, use page 16 or attach additional sheets and reference the question being answered. Mark all non-applicable sections with N/A. Please do not use abbreviations when completing the application.

Checklist

Current copies of the following documents must be submitted with this application:

- **All** training certificates – Medical School, Internship, Residency and Fellowship (as applicable)
- Board certification (certificate, status letter) or proof of eligibility
- Copy of Driver's License and/or Passport
- Current Curriculum Vitae (CV) – **month and year format**
- Current color photo - passport picture preferably (may send electronically - pdf or jpg)
- Current Professional Liability Insurance Coverage - malpractice certificate
- Copy of Current TB **&** Flu record & attestation
- DEA certificate
- Documentation of any claims, investigations, disciplinary actions (as applicable)
- ECFMG – (as applicable)
- Life Support Certificates (ACLS/BLS etc) Please review DOP's for your specialty
- Military release certificate (DD214) – (as applicable)
- **Entity-Specific Checklist**
- **Procedure Logs** from the last (24) months in correlation with the privileges you are requesting or a personal letter of reference from a current program director, department chair, sponsor or supervisor who can attest to your current clinical competency within the last 2 years, plus procedure log or op notes for any special procedures you are requesting (criteria found on delineation of privileges)

Appointments are considered without regard to race, color, creed, religion, age, sex, national origin, sexual orientation, marital status, veteran status, the presence of non-job related physical or mental disability, genetic information, status with regard to public assistance membership or activity in a local commission, the types of procedures that they provide, or the types of patients that they serve.

All Information Must Be Printed In Black Ink, Typed or Electronically Generated

Identifying Information

General Information

Please enter basic information about yourself

Name ______ ______ ______ ______ ______
Last | First | MI | Suffix | Title (e.g. MD, DDS, APN)

Please enter any other names you have used/been known by:

Name ______ ______ ______ ______ ______
Last | First | MI | Suffix | Date Used From - To

Name ______ ______ ______ ______ ______
Last | First | MI | Suffix | Date Used From - To

Gender: ☐ Male ☐ Female ______ Social Security# ______ Birth Date ______ Birth Place (City, State, Country)

______ Ethnicity (Optional) ______ Marital Status ______ Spouse's Name (if applicable)

______ Home Address ______ City ______ State ______ Zip Code ______ Country

______ Home Phone ______ Cell Phone Number ______ Personal/Home Email Address

Healthcare Related Numbers

______ AZ Medicaid # ______ NPI ______ Taxonomy Code

Military Service Information

Military Reserves: ☐ Yes ☐ No ______ Military Service Branch ______ Date of Entry ______ Date of Separation (include DD214 if applicable)

Languages

______ Language 1 ______ Fluency ______ Language 2 ______ Fluency

______ Language 3 ______ Fluency ______ Language 4 ______ Fluency

Provider Specific Contact Information

Please enter information where you can be best reached

______ Telephone ______ Cell Phone Number ______ Fax ______ Answering Service

______ Pager ______ Email Address

Dignity Health

Practice Information

Primary Practice Location Information

Practice / Corporation/ Group Name ______ Telephone ______ Fax ______

Practice Group Tax ID ______ Answering Service ______ Practice Email Address (if applicable) ______

Office Address ______ City ______ State ______ Zip Code ______

Office Manager ______ Office Manager Telephone ______ Office Manager Email Address ______

Covering Physicians: ______

Alternate Practice Location Information

Practice / Corporation/ Group Name ______ Telephone ______ Fax ______

Practice Group Tax ID ______ Answering Service ______ Practice Email Address (if applicable) ______

Office Address ______ City ______ State ______ Zip Code ______

Office Manager ______ Office Manager Telephone ______ Office Manager Email Address ______

Credentialing Location Information

Office Address ______ City ______ State ______ Zip Code ______

Telephone ______ Fax ______ Email Address ______

Office Manager ______ Office Manager Telephone ______ Office Manager Email Address ______

Dignity Health

Specialties and Boards Information

Primary Practice Specialty

Specialty: ______________________________ Board:____

☐ Board Certified ☐ Not Board Certified If not certified, indicate current status:__________________

Date Certified: ___________ Date Recertified: _____________ Expiration Date: ______________Cert#:__________

☐ Lifetime Certified

Subspecialty: ___________________________ Board:____

☐ Board Certified ☐ Not Board Certified If not certified, indicate current status:___________________

Date Certified: ___________ Date Recertified: _____________ Expiration Date: ______________Cert#:___________

☐ Lifetime Certified

Subspecialty: ___________________________ Board:____

☐ Board Certified ☐ Not Board Certified If not certified, indicate current status:_____________________

Date Certified: ___________ Date Recertified: _____________ Expiration Date: ______________Cert#:____________

☐ Lifetime Certified

Subspecialty: ___________________________ Board:____

☐ Board Certified ☐ Not Board Certified If not certified, indicate current status:_____________________

Date Certified: ___________ Date Recertified: _____________ Expiration Date: ______________Cert#:_____________

☐ Lifetime Certified

Education/Training Information

The answers to the following questions must account for all time periods from medical education to the present. If additional space is needed, please copy this section of the application.

Medical Education Information

____ Dates Attended:______________ ________________

Institution From To

____ __________________ ________________

Address Telephone Fax

____ __________________ ________________

City Degree Conferred Education Type

________________________ ___________________ ______________________________________

State Zip Code Country (if non-U.S.)

Dignity Health

Medical Education Information (cont'd)

Dates Attended: ______ ______

Institution — from — To

Address — Telephone — Fax

City — Degree Conferred — Education Type

State — Zip Code — Country (if non-U.S.)

Post Graduate Training Information

List every internship, residency and fellowship ever begun or completed. If additional space is needed, please copy this section of the application.

Institution — Dates Attended: ______ / ______ From — To

Education Type — Area of Training — Training Completed: ☐ Yes ☐ No

If not successfully completed, please explain: ______

Address — City — State — Zip Code — Country (if non-U.S

Program Director — Telephone — Fax — Email

Post Graduate Training Information

Institution — Dates Attended: ______ / ______ From — To

Education Type — Area of Training — Training Completed: ☐ Yes ☐ No

If not successfully completed, please explain: ______

Address — City — State — Zip Code — Country (if non-U.S

Program Director — Telephone — Fax — Email

Dignity Health

Post Graduate Training Information (cont'd)

Institution ______ Dates Attended: ______ From / ______ To

Education Type ______ Area of Training ______ Training Completed: ☐ Yes ☐ No

If not successfully completed, please explain: ______

Address ______ City ______ State ______ Zip Code ______ Country (if non-U.S

Program Director ______ Telephone ______ Fax ______ Email ______

Post Graduate Training Information

Institution ______ Dates Attended: ______ From / ______ To

Education Type ______ Area of Training ______ Training Completed: ☐ Yes ☐ No

If not successfully completed, please explain: ______

Address ______ City ______ State ______ Zip Code ______ Country (if non-U.S

Program Director ______ Telephone ______ Fax ______ Email ______

ECFMG Information

ECFMG Number (if applicable) ______ Issue Date ______

Employed Faculty Practice Information

Employed Faculty Positions

Institution ______ Employment Dates: ______ From / ______ To

Address ______ City ______ State ______ Zip Code ______

Department/Positions: ______ Contact Person: ______

Employed Faculty Positions (cont'd)

Institution — Employment Dates: From / To

Address — City — State — Zip Code

Department/Positions: — Contact Person:

Employed Faculty Positions

Institution — Employment Dates: From / To

Address — City — State — Zip Code

Department/Positions: — Contact Person:

Practice History Information

*List in chronological order your work history for the previous **ten (10) years**. If additional space is needed, please copy this section of the application.*

Practice Information

Future Employment: ☐ **Current Employment:** ☐ **Past Employment:** ☐

Practice / Corporation / Group Name — Type

Address — Practice Dates: From / To

City — State — Zip Code — Telephone — Fax

Contact Person: — Email

Practice Information

Future Employment: ☐ **Current Employment:** ☐ **Past Employment:** ☐

Practice / Corporation / Group Name — Type

Address — Practice Dates: From / To

City — State — Zip Code — Telephone — Fax

Contact Person: — Email

Practice Information (cont'd)

Future Employment: ☐ **Current Employment:** ☐ **Past Employment:** ☐

Practice / Corporation / Group Name ______ Type ______

Address ______ Practice Dates: ______ / ______ (From / To)

City ______ State ______ Zip Code ______ Telephone ______ Fax ______

Contact Person: ______ Email ______

Healthcare Affiliations Information

List ALL hospitals to which you have or have applied for privileges ***during the previous 10 years****. If you are no longer affiliated with any hospital or withdrew your application, provide a full explanation on separate page). If additional space is needed, please copy this section of the application.*

Affiliation Information

Hospital / Healthcare Institution Name ______ Appt. Dates: ______ / ______ (From / To)

Address ______ Affiliation Type ______ Current Status ______

City ______ State ______ Zip Code ______ Telephone ______ Fax ______ Department ______

Affiliation Information

Hospital / Healthcare Institution Name ______ Appt. Dates: ______ / ______ (From / To)

Address ______ Affiliation Type ______ Current Status ______

City ______ State ______ Zip Code ______ Telephone ______ Fax ______ Department ______

Affiliation Information

Hospital / Healthcare Institution Name ______ Appt. Dates: ______ / ______ (From / To)

Address ______ Affiliation Type ______ Current Status ______

City ______ State ______ Zip Code ______ Telephone ______ Fax ______ Department ______

Dignity Health

Affiliation Information

____ Appt. Dates: __________ / __________
Hospital / Healthcare Institution Name From To

Address | Affiliation Type | Current Status

City | State | Zip Code | Telephone | Fax | Department

Time Gaps

List any gaps equal to or greater than 90 days (3 months).

You must account for all time gaps that occurred during the ***<u>previous ten (10) years</u>****. Time gaps equal to or greater than 90 days (3 months) must be accounted for by you and verified in writing by someone other than yourself.*

Gap Information

From _____/_____ to _____/_____ Reason: ____

Contact Person | Email Address | Fax

Home Address | City | State | Zip Code | Country

Gap Information

From _____/_____ to _____/_____ Reason: ____

Contact Person | Email Address | Fax

Home Address | City | State | Zip Code | Country

Gap Information

From _____/_____ to _____/_____ Reason: ____

Contact Person | Email Address | Fax

Home Address | City | State | Zip Code | Country

Dignity Health

Licensure and Certification Information

Licensure Information

Please list all current and past licensures and specify the type, i.e., MD, DO, DDS, etc. If additional space is needed, please copy this section of the application.

Licensure Type ______ Original Issue Date ______ Expiration Date ______

State ______ Number ______ Status ______

Licensure Type ______ Original Issue Date ______ Expiration Date ______

State ______ Number ______ Status ______

Licensure Information (cont'd)

Licensure Type ______ Original Issue Date ______ Expiration Date ______

State ______ Number ______ Status ______

Licensure Type ______ Original Issue Date ______ Expiration Date ______

State ______ Number ______ Status ______

DEA Registration Information

Federal DEA Registration Number ______ State ______ Issue Date ______ Expiration Date ______

Other Certification Information

Please check all certifications that apply and attach a copy of your current certificate.

CERTIFICATION	YES	NO	ISSUE DATE	EXPIRATION DATE
ACLS				
ATLS				
NRP				
PALS				
BLS				
NALS				
ALSO				

Dignity Health

Continuing Medical Education

Continuing Medical Education (CME)

Every calendar year, each person holding an active medical license to practice medicine in this State shall complete twenty (20) hours of the continued medical education required by A.R.S. 32-1434. Please list below or attach a complete list of Continuing Medical Education Programs attended during the past two (2) years. Make sure you include those hours that are ***specifically related to the clinical privileges you are requesting.***

☐ Not applicable, I completed training within the past year.

DATES	COURSES	NUMBER OF HOURS

TOTAL NUMBER OF HOURS ____________________________

Dignity Health

Peer Reference Information

List **FOUR** physicians who have personal knowledge of your current clinical competence, ethical character, health status, and ability to work cooperatively with others and who will provide **specific written comments on these** matters upon request.

(TWO OF THE FOUR REFERENCES SHOULD BE IN YOUR SPECIALTY AND NOT AN ASSOCIATE)

PLEASE NOTE:

- If the reference has not worked with you within the past 2 years, you will be required to provide another reference.
- References may not be from a family member and please do not list associates from the practice you will be joining.
- References must be local if you have been in Arizona for more than 6 months.

Acceptable References: Chief of Residency, Program Director, Department Chair, Service Chief, or other Practitioners in the same specialty.
If office location is within a large organization, i.e. university, hospital, please include name of the reference's Department in address.

Professional Peer Reference

Name Specialty

Address

City State Zip Code Telephone Fax

Email

Professional Peer Reference

Name Specialty

Address

City State Zip Code Telephone Fax

Email

Professional Peer Reference

Name Specialty

Address

City State Zip Code Telephone Fax

Email

Professional Peer Reference

Name Specialty

Address

City State Zip Code Telephone Fax

Email

Professional Liability Insurance

*Please list current professional liability insurance information. You must provide information on all professional policies under which you may be covered. List ALL policies under which you have been insured for the **previous ten (10) years.** Please attach copies of current and past certificates of insurance.*

Insurance Carrier for Practice in Arizona

Name of Policy Holder: ____ Policy #: ____________________________

Name of Insurance Carrier (Not Agent):____

Address: ___________________________________ City: ________________ State: ______ Zip Code: _____________

Inception Date: _____/ _____/ _____ Expiration Date: _____/ _____/ _____ Occ/Agg: __________ / __________

CURRENT: *Attach copy of professional liability insurance certificate or covering your CURRENT practice.*

Name of Carrier: ____ Policy #: ____________________________

Address: ___________________________________ City: ________________ State: ______ Zip Code: _____________

Inception Date: _____/ _____/ _____ Expiration Date: _____/ _____/ _____ Occ/Agg: __________ / __________

PAST: *Attach copy of professional liability insurance covering your PAST practice*

Name of Carrier: ____ Policy #: ____________________________

Address: ___________________________________ City: ________________ State: ______ Zip Code: _____________

Inception Date: _____/ _____/ _____ Expiration Date: _____/ _____/ _____ Occ/Agg: __________ / __________

PAST: *Attach copy of professional liability insurance covering your PAST practice*

Name of Carrier: ____ Policy #: ____________________________

Address: ___________________________________ City: ________________ State: ______ Zip Code: _____________

Inception Date: _____/ _____/ _____ Expiration Date: _____/ _____/ _____ Occ/Agg: __________ / __________

PAST: *Attach copy of professional liability insurance covering your PAST practice*

Name of Carrier: ____ Policy #: ____________________________

Address: ___________________________________ City: ________________ State: ______ Zip Code: _____________

Inception Date: _____/ _____/ _____ Expiration Date: _____/ _____/ _____ Occ/Agg: __________ / __________

*** Please list additional malpractice insurance carriers on an additional piece of paper***

Do you have “tail coverage”? ☐ No ☐ Yes

Dignity Health

Other Professional History Information

If the answer to any of the following questions is "Yes," please provide a full explanation of the details on a separate sheet and attach.

1. Has your employment, medical staff appointment or clinical privileges, or status as a participating provider in a managed care organization, ever been relinquished, withdrawn, suspended, diminished, revoked, denied, not renewed, or subject to probationary or Other conditions at any hospital, health care facility or managed care organization, whether voluntarily or involuntarily?
   ☐ No ☐ Yes

2. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or participating provider status in a managed care organization, or resigned before a decision was made by a governing board?
   ☐ No ☐ Yes

3. Have you ever been the subject of an investigation at any hospital, health care facility, or managed care organization?
   ☐ No ☐ Yes

4. Have you ever been the subject of focused individual monitoring related to your clinical competence or professional conduct at any hospital, health care facility, or managed care organization?
   ☐ No ☐ Yes

5. Are there presently any proceedings or investigations taking place at any hospital, health care facility, or managed care organization relating to your clinical competence or professional conduct?
   ☐ No ☐ Yes

If the answer to any of the following questions is "Yes," please provide a full explanation of the details on a separate sheet ***and attach.***

1. Has your participation in any HMO, PPO, PHO or other provider networks or managed care organizations changed for reasons related to clinical competence or professional conduct?
   ☐ No ☐ Yes

2. Has your participation in any federal, state, or private health insurance program changed (for example, Medicare, Medicaid)?
   ☐ No ☐ Yes

3. To your knowledge have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?
   ☐ No ☐ Yes

4. Have you ever been convicted of a felony?
   ☐ No ☐ Yes

5. Have you ever been convicted of a misdemeanor?
   ☐ No ☐ Yes

6. Have you ever been named as a defendant in a criminal proceeding?
   ☐ No ☐ Yes

If the answer to any of the following questions is "Yes," please provide a full explanation of the details on a separate sheet and attach.

1. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, suspended, revoked, terminated, or restricted?
   ☐ No ☐ Yes

2. Have you ever been asked to surrender your license in any state?
☐ No ☐ Yes

3. Have you ever been reprimanded or otherwise sanctioned by, or had conditions placed on your license by any licensure agency?
☐ No ☐ Yes

4. Have any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or voluntary relinquishment of such licensure been initiated against you?
☐ No ☐ Yes

5. Are you currently enrolled/participating in a substance abuse program?
☐ No ☐ Yes

If Yes, please provide a full explanation of the details on a separate sheet and attach

Has your DEA registration or state controlled substance license ever been investigated, relinquished, limited, denied, suspended or revoked, or have any conditions been placed on them?
☐ No ☐ Yes

If the answer to any of the following questions is "Yes," please provide a full explanation of the details on a separate sheet and attach.

1. Have you ever practiced medicine without professional liability insurance?
☐ No ☐ Yes

2. Has your professional liability insurance coverage ever been terminated by action of the insurance company?
☐ No ☐ Yes

3. Have you ever been denied professional liability insurance coverage?
☐ No ☐ Yes

4. Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?
☐ No ☐ Yes

5. Has any insurance company ever imposed a surcharge or additional premium upon you because of your claims history?
☐ No ☐ Yes

6. Have any professional liability suits* ever been filed against you?
☐ No ☐ Yes

7. Are any professional liability suits* against you presently pending?
☐ No ☐ Yes

8. Have any judgments been made against you, or have there been any settlements involving you, in any professional liability suits?
☐ No ☐ Yes

If you answered yes to questions 7 or 8, complete the enclosed confidential supplemental malpractice information sheet; Make copies as necessary - one for EACH claim, complaint, suit, settlement, or arbitration.

Also, enclose a copy of the complaint, your answer or response to the complaint and a brief narrative description of the events surrounding the case and your level involvement/participation.

*** Please include suits against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.**

Dignity Health

CONFIDENTIAL INFORMATION SHEET

For Information Pertaining To Malpractice Litigation
And Professional Complaints

For each lawsuit or complaint, please furnish the following information and attach a **copy of the complaint including your response to the complaint and level of participation**. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form.

Name(s) of plaintiff(s) or complainant(s): ______________________________

Month/Year of Incident? ______________________________

Where incident ccurred?______________________________

Describe the nature of Incident? (Complaint, Allegation):______________________________

____

____

Provide a narrative description of your participation/level of care:______________________________

____

____

Outcome of Incident?

☐Pending ☐Dismissed ☐Dropped ☐Settled, Amount?______________

☐Verdict for you, Amount? ___________ ☐Verdict for plaintiff, Amount? ______________

Represented by Legal Counsel for this claim/malpractice lawsuit?

☐No ☐Yes If yes, give the name and address of counsel.

Name:______________________________

Address:______________________________

Telephone Number:______________________________

Insurance Company that provided coverage for this claim:

Name:______________________________

Address:______________________________

Telephone Number:______________________ Policy Number: ______________

____

Signature Date

____

Printed Name Phone Number

Dignity Health

ABILITY TO EXERCISE PRIVILEGES

Are you able to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of appointment, including, but not limited to, emergency service coverage and committee service?
☐ No ☐ Yes

HEALTH STATUS

1. Do you have a chronic or recurring illness, mental or physical disability that may affect your ability to perform privileges requested?
   ☐ No ☐ Yes

   If Yes, Please Explain:____

   ____

2. Are you currently or have you in the past been dependent on or treated for alcohol or drugs?
   ☐ No ☐ Yes

   If Yes, Please Explain:____

   ____

3. Are you currently taking medication or undergoing treatment or therapy that is likely to affect your ability to perform privileges requested?
   ☐ No ☐ Yes

   If Yes, Please Explain:____

   ____

Dignity Health

TB SKIN TEST, FLU VACCINATION & OTHER IMMUNIZATIONS

The Arizona Department of Health Services (DHS) and Dignity Health(s) Infection Control Committee(s) require each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis **annually.** This evidence of freedom from infectious pulmonary tuberculosis can be established by:

(a) A report of **negative Mantoux skin test** or a **negative Quantiferon Gold blood test;**
(b) A report of a **negative chest x-ray**; or
(c) Although I had a **positive Mantoux skin test**, I have another **physician's written statement** that I am free from infectious pulmonary tuberculosis and have completed the enclosed Annual Tuberculosis Questionnaire (found on the accompanying page).

DHS will accept a medical staff or allied health member's attestation that he or she is free from infectious pulmonary tuberculosis and if able to provide one of the types of evidence listed above, should it be requested. **If a medical staff or allied health/ancillary member signs this attestation and cannot provide evidence, DHS has indicated that it will report the physician to AMB/OBEX or the appropriate licensing board.**

I attest that I was evaluated for infectious pulmonary tuberculosis in _______ / _______ /______

I have attached the following evidence to demonstrate that I am free from infectious pulmonary tuberculosis:

☐ A report of a negative Mantoux skin test;

☐ A negative Quantiferon Gold blood test;

☐ A report of a negative chest X-ray; or

☐ Although I had a **positive Mantoux skin test**, I have another physician's statement that I am free from infectious pulmonary tuberculosis and have enclosed a completed Annual Tuberculosis Questionnaire.

**** MUST INCLUDE COPY OF TB TEST, CHEST X-RAY OR PHYSICIAN'S STATEMENT (if applicable) WITH RETURN OF APPLICATION, INCLUDING ANNUAL TB QUESTIONNAIRE IF APPLICABLE.**

Current Annual Flu Vaccination ☐ Month/year administered___________ **Location:** ________________________
(where did you get the vaccination? Hospital? Clinic? PCP?)

Decline Flu Vaccination ☐ If decline, check one: ☐ Medical Contraindication ☐ Religion

If you decline the Annual Flu Vaccination, you should check the declination box and sign this form (legibly) as a declination. You may be contacted to ensure that you intend to wear a mask during flu season.

I attest to the above statements as true and accurate:

______________________________ **Print** Name legibly

______________________________ Date

______________________________ **Signature**

Dignity Health

TUBERCULOSIS QUESTIONNAIRE

FOR THE INDIVIDUAL WITH A POSITIVE TB SKIN TEST

All Dignity Health Medical Center(s) practitioners with positive tuberculin skin tests must complete and sign the following questionnaire on an annual or semi-annual basis. Please check "yes" or "no" next to each symptom. If you check "yes", then describe the symptom including date of onset at the bottom of this page.

SYMPTOM	YES	NO
Unexplained weight loss	__________	__________
Easily fatigued	__________	__________
Loss of appetite	__________	__________
Hemoptysis (coughing up blood)	__________	__________
Productive, prolonged cough (over 3 weeks duration)	__________	__________
Fever, chills	__________	__________
Night sweats	__________	__________
Chest Pain	__________	__________

The current recommendations from the Center for Disease Prevention and Control (CDC) regarding annual chest x-rays for the individual with a positive TB skin test is as follows:

"Health care workers (HCW's) with positive PPD tests should have a chest radiograph as part of the initial evaluation of their PPD test; if negative, repeat chest radiographs are not needed unless symptoms develop that may be due to TB".

Comments: ____

____

______________________________ ______________________________

Print Name Signature

I understand by typing in my name, this will be considered an electronic signature.

______________________________ ______________________________

Date

____

LHP Signature and Date

CONSENT TO RELEASE OF PHOTOGRAPH

I am voluntarily providing a photograph of myself to Chandler Regional Medical Center and Mercy Gilbert Medical Center (the "Hospitals"). I agree that the Hospitals may use my photograph as follows: in newsletters announcing Physician of the Month, in "Ask the Expert" columns if I authored the column, in connection with my profile on the Hospitals' websites, and, if I am named Physician of the Month, in posters relating to that announcement. I also agree that the Hospitals may use my photograph in other materials marketing the services offered by the Hospitals.

I agree that I will not have the right to inspect or approve the materials in which my picture appears, and I agree that I will have no right to be paid for the use of my photograph. I understand that if my photograph is used in any web-based materials, it may be downloaded by any computer user and the Hospitals will be unable to prevent that. I agree not to hold the Hospitals responsible for use by any other party.

____ _______________________________________

Signature Date

____

Print Name

OR

I DO NOT agree to release of photograph:

____ _______________________________________

Signature Date

☐ Dignity Health Chandler Regional Medical Center
☐ Dignity Health East Valley Rehabilitation Hospital
☐ Dignity Health Mercy Gilbert Medical Center
☐ Dignity Health St Joseph's Hospital & Medical Center
☐ Dignity Health St Joseph's Westgate Medical Center

RE: ______________________________________
Please print complete name

Dear Practitioner,

We are requesting your signature below so that we may scan it into our Credentialing Database for the pharmacy to view online.

Please do not hesitate to contact the Credentials Office for any questions you may have. Thank you for your assistance in regards to this request.

X____

Signature required

Physician/Practice Information	**Medical Staff Services Office**
Practice Name: ________________________________	Facility Name: Circle all that apply below
Phycian Name: ________________________________	Dignity Health: CRMC, EVRH, MGMC, SJHMC, WGMC
Street:________________________________	Contact name: ________________________________
City: ________________ State: _____ Zip: ________	Email: ________________________________
Email: ________________________________	Telephone:________________________________
Telephone:________________________________	

110.1.050 Exhibit A

Memorandum of Understanding

Independent Physician

The undersigned physician (hereinafter referred to as "**you**" or "**your**") wishes to have access to and use of the undersigned medical facility ("**Medical Facility**") and **Dignity Health** network, which may include, as applicable, Intranet, Extranet, or audio/video/PDA/telecommunication devices, desktops and laptops (the "**Network**"). By granting you such access, you may be able to view or copy confidential or privileged patient-related information that is electronically stored and made available to health care professionals.

As a condition of receiving access to the Network, you acknowledge and agree as follows:

1. Information that you seek through the Network shall be limited solely to that of patients who are being cared for by both you and the Medical Facility.
2. You shall limit your use of the information obtained from the Network (the "**Information**") solely to providing health care services to the patient to whom it relates. Where specifically permitted by the Medical Facility, you and your business associate, as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), may also use the Information for obtaining payment for your services and for certain health care operations as permitted under HIPAA. You shall not use the Information for any other purpose nor disclose Information relating to a particular patient to any third party without the written authorization of said patient.
3. You agree to undertake a reasonable degree of care to protect the Information considering its confidential and privileged nature, which care shall not, in any event, be less than that required by law and by Network Usage Policy for Providers Not Employed by Dignity Health policy ("NUPP"), a copy of which is attached.
4. You have read and understand the NUPP, and agree that, in addition to the requirements herein, the NUPP also governs your access to and use of the Network. Any revisions to the NUPP, which may be necessary from time to time, will be readily available to you on the Network for your review.
5. Your Network user ID and password is unique to you and at no time shall you share with or otherwise disclose either of them to any other individual in your office or elsewhere. You agree to immediately report to Medical Facility the disclosure or loss of your user ID or password, or its inappropriate use.
6. If you or your medical practice is a covered entity under HIPAA, you acknowledge you are separately and solely responsible for protecting any protected health information while it is being viewed or if copied or downloaded using your User ID and password.
7. For the purpose of Medical Facility's compliance with HIPAA, and security and integrity of the Network and the information therein, the Medical Facility and Dignity Health will electronically monitor, record and audit your Network activity. Nevertheless, you should not and cannot rely on such monitoring, recording, or auditing to electronically prohibit inappropriate use of your user ID or password by either you or another individual.

ACCEPTED AND AGREED TO:

By:________________________________ *(signature)*

Approved:________________________________ (medical services contact signature)

Date: ________________________________

Date: ________________________________

Dignity Health

APPLICANT'S APPLICATION STATEMENT

I understand that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I also agree to provide the Hospital with any additional information that the Hospital or one of its authorized representatives may request. **MY FAILURE TO PROVIDE ANY REQUESTED INFORMATION WILL CAUSE MY APPLICATION TO BE INCOMPLETE AND WILL PREVENT IT FROM BEING PROCESSED.**

If appointed to the Medical Staff, I understand and agree that I will participate in the emergency call rotation, if required by my department, and will treat all patients referred to me regardless of ability to pay.

I have read, reviewed and answered all questions on the Dignity Health application and attest to their accuracy.

____ _____________________________

Signature Date

____

Print Name

Dignity Health

MEDICARE/TRICARE ATTESTATION STATEMENT

NOTICE TO PRACTITIONERS

"Medicare, and/or other federally funded program payments to healthcare entities are based on patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws"

****

I acknowledge that I have read the above statement.

____ _____________________________________

Signature Date

____

Print Name

CHANDLER REGIONAL MEDICAL CENTER
MERCY GILBERT MEDICAL CENTER
CONDITIONS OF APPOINTMENT/REAPPOINTMENT AND RELEASE OF LIABILITY

By applying for appointment/reappointment to the Medical Staff of Chandler Regional and/or Mercy Gilbert Medical Centers, I hereby:

- ► **signify my willingness to appear for interviews in regard to my application;**
- ► **authorize the Hospital, Medical Staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others;**
- ► **consent to the inspection by the Hospital, Medical Staff and their representatives of all documents that may be material to an evaluation of my qualifications and competence to carry out the privileges requested, and consent to the full unconditional release of such information from other hospitals or organizations;**
- ► **consent to the sharing between CRMC and MGMC and their Medical Staff departments and committees of all information, including confidential information, bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others;**
- ► **release from liability all representatives of the Hospital and Medical Staff for their acts performed in connection with the evaluation of my application, credentials and qualifications;**
- ► **release from liability any and all individuals and organizations who provide information to the Hospital or the Medical Staff concerning my professional competence, professional ethics, character, physical and mental health status, release of malpractice claims history and coverage, as well as other qualifications/criteria for Staff appointment and clinical privileges;**
- ► **authorize and consent to Hospital representatives providing to other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care any information relevant to such matters that the Hospital may have and release Hospital representatives from liability for so doing;**
- ► **acknowledge that I have received, or have access to, the Bylaws of the Medical Staff and any other manuals and policies relevant to the appointment and reappointment process and to clinical practice in general at the Hospital, and agree to be bound by the terms thereof in all matters relating to medical staff membership and clinical privileges and to the consideration of my application for appointment/reappointment to the Medical Staff and for clinical privileges;**
- ► **acknowledge that the provisions of said Medical Staff Bylaws relating to confidentiality and release from liability are express conditions to my application for, and acceptance of, appointment to the Medical Staff and the continuation of such appointment and to my exercise of clinical privileges;**
- ► **pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for care of my patients to any practitioner not qualified to undertake that responsibility;**
- ► **acknowledge that I, as an applicant for appointment and privileges, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications, and that failure to sustain the burden of producing adequate information shall be deemed a voluntary withdrawal of my application;**
- ► **acknowledge that the misstatement or omission of material information on my application will result in my application being deemed incomplete and voluntarily withdrawn, pursuant to Section 3.6 of the Credentials Manual, in which event I will not be eligible to reapply for a period of three (3) years thereafter.**

ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE
TO MY BEST KNOWLEDGE AND BELIEF

Date______________________ **Signature**____

Name____
Please Print

Dignity Health.

DHAzCVO
RELEASE AND STATEMENT OF APPLICANT

Dignity Health Arizona Credentials Verification Office (DHAzCVO) and all Healthcare Entities receiving this information will treat all information submitted in this application as confidential and protected under Arizona state statutes. I understand and acknowledge that, as an applicant to those healthcare entities indicated in this application, it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications including my current licensure, relevant training and/or experience, current competence, health status, character and ethics can be based. I hereby pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for the care of my patients to any practitioner not qualified to undertake that responsibility. I further understand and acknowledge that the DHAzCVO, acting as agent for the healthcare entities, will verify the information in this application. I further understand that healthcare entities may also independently investigate my qualifications. By submitting this application, I agree to such verification and to the information exchange activities of the DHAzCVO and the healthcare entities. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations, and code of conduct of the healthcare entities and their medical staffs and agree to be bound by them. I understand and acknowledge that completing this application does not entitle me to membership or privileges at any of the healthcare entities and that DHAzCVO shall have no responsibility or liability with respect to healthcare entities' membership decisions. I further understand and agree that DHAzCVO is solely responsible for the information which it provides to healthcare entities and that healthcare entities shall have no responsibility or liability for the completeness or accuracy of this information insofar as it was provided by and/or verified by DHAzCVO.

<u>Verification of Application</u>. I hereby authorize all individuals, institutions, and entities, (past, present, and future) including all professional liability insurers with whom I have had or currently have professional liability insurance (including past and present claims history), who have knowledge concerning my qualifications and other information requested in this application to consult with, and release relevant information and/or records to the healthcare entities, their medical staffs and agents, specifically including but not limited to DHAzCVO. I further authorize the use of the pictures provided by me for internal/ external purposes.

<u>Authorization of Release.</u> I understand and agree that the authorizations given by me herein shall be irrevocable for a period of twenty-four (24) months. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me in this application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial of appointment or for summary dismissal from the healthcare entities. I further release from liability and from any restrictions as to confidentiality and/or privacy, all representatives of DHAzCVO, the hospitals, healthcare entities, their boards and medical staffs, and further release all medical schools, licensing boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in connection with the gathering and exchange of information as consented to above.

I agree to update this application while it is being processed, should there be any change in the information provided that could affect this application or its outcome.

I hereby agree that the exclusive remedy for any decision or recommendation made pertaining to this application for appointment or in any other peer review proceeding shall be to seek review of the correctness of the decision or recommendation, that no claim for alleged monetary damages will be brought on account thereof, and that no action at law or inequity will be brought until after all appeal rights available under the healthcare entities' medical staff bylaws/contracts have been exercised and completed.

I agree to notify DHAzCVO and the healthcare entities within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me. I further agree to notify DHAzCVO and the healthcare entities thirty (30) days prior to any change in malpractice insurance coverage.

Name:____
(Please Print)
Date:__________________ Signature:____________________________________

Dignity Health

Dignity Health

MEDICAL STAFF CONFLICT OF INTEREST STATEMENT

Medical Staff Member's Name: ________________________________Department:_________________________

Medical Staff Officer, Department or Committee Title, if any: ____

This statement is filed for (check one):

☐ Credentialing purposes (new or renewal)

☐ Annual or New Officer, Department Chief or Committee Chair
☐ Update

MUST COMPLETE FULLY

Key Definitions

"**Material financial interest**" means

- An employment, consulting, royalty, licensing, equipment or space lease, services arrangement or other financial relationship
- An ownership interest
- An interest that contributes more than 5% to a member's annual income or the annual income of a family member
- A position as a director, trustee, managing partner, officer or key employee, whether paid or unpaid

"***Family member***" means a spouse or domestic partner, children and their spouses, grandchildren and their spouses, parents and their spouses, grandparents and their spouses, brothers and sisters and their spouses, nieces and nephews and their spouses, parents –in-law and their spouses. Children include natural and adopted children. Spouses include domestic partners.

"***Ownership***" includes ownership through sole proprietorships, stock, stock options, partnership or limited partnership shares, and limited liability company memberships.

"**Personal interests**" mean those interests that arise out of a member's personal activities or the activities of a family member.

Disclosures of Material Financial and Personal Interests

A. Ownership.

Do you (or does a family member) have an ownership interest in any company that provides goods or services to the Hospital, or otherwise does business with the Hospital?

☐ No ☐ Yes, as follows:

Name of Person (self or family member)	Name of Company	Percent of Ownership	Type of Services Provided by the Company
1.			
2.			
3.			

(Use additional sheets as necessary)

Dignity Health.

B. Compensation Arrangements.

Do you (or does a family member) have an employment, consulting or other financial arrangement (including, without limitation, an office or space lease, royalty or licensing agreement, or sponsored research agreement) with a company that provides goods and services to the Hospital or otherwise does business with the Hospital?

☐ No ☐ Yes, as follows:

Name of Person (self or family member)	Name of Company	Describe the Compensation Arrangement	Dollar Value of Compensation
1.			
2.			
3.			

(Use additional sheets as necessary)

C. Business Positions.

Are you (or is a family member) an officer, director, trustee, managing partner, officer or key employee of a company that provides goods and services to the Hospital or otherwise does business with the Hospital?

☐ No ☐ Yes, as follows:

Name of Person (self or family member)	Name of Company	Business Position or Title	Dollar Value of Compensation (include meeting stipends and travel reimbursement)
1.			
2.			
3.			

(Use additional sheets as necessary)

I certify that the information hereby submitted is accurate and complete as of the date stated below, and that I shall promptly provide written notice to the Medical Staff of any changes to the information, after such date.

____

Date Signature of Medical Staff Member

DIGNITY HEALTH ARIZONA CVO (DHAzCVO)

☐ Dignity Health Chandler Regional Medical Center (CRMC)
☐ Dignity Health East Valley Rehabilitation Hospital (EVRH)
☐ Dignity Health Mercy Gilbert Medical Center (MGMC)
☐ Dignity Health St Joseph's Hospital & Medical Center (SJHMC)
☐ Dignity Health St Joseph's Westgate Medical Center (WGMC)

INVOICE

NOTICE OF APPLICATION FEE(S)

PHYSICIANS (Initial Application Fees):	ALLIED/ANCILLARY STAFF (Initial Apps):
CRMC or MGMC (1 facility) - $350 CRMC & MGMC (2 facilities) - $450 SJHMC/WGMC &/or EVRH (1 or 2 facilities) - $285 CRMC/MGMC & SJHMC/WGMC &/or EVRH (3-4 facilities) - $685.00	CRMC or MGMC (1 facility) - $100 CRMC & MGMC (2 facilities) - $150 SJHMC/WGMC &/or EVRH (1 or 2 facilities) - $285 CRMC/MGMC & SJHMC/WGMC &/or EVRH (3-4 facilities) - $435.00

METHODS OF PAYMENT:

ON-LINE: Copy and paste link below into your url; choose appropriate Option for payment category as outlined above.

DHAzCVO Application Fees: http://bit.ly/1T1QrJn

CHECKS: Please make check payable to: **CHANDLER REGIONAL MEDICAL CENTER.** Please include your check when you return your completed Application to the Dignity Health AZ Credentials Verification Office.

Mail Checks to:

Mercy Gilbert Medical Center
Attn: Lupe Mendoza, Manager, DHAzCVO
3555 S Val Vista
Gilbert, AZ 85297

NOTE: Once payment has been received, processing of your application will begin. **The application fee is non-refundable.** Thank you.