Dear Doctor:

Thank you for your interest in applying for staff membership and privileges. Please indicate on the enclosed Application whether you will be applying at Chandler Regional Medical Center or Mercy Gilbert Medical Center, or both. The following are pre-requisites for Medical Staff appointment.

(1) Current unrestricted license to practice medicine in Arizona and a current unrestricted DEA.

(2) Actively engaged in a clinical practice at least 6 of the past 12 months (residency/fellowship or private practice).

(3) Actively practiced in a hospital for at least two of the past five years (full-time clinical residency/fellowship is equivalent).

(4) Be board certified, or be eligible to enter the certification examination system in accordance with the training and/or experience requirements defined by the applicable certifying board. The certifying board must be one of the following:

- Member board of the American Board of Medical Specialties (ABMS)
- Member board of the American Osteopathic Association (AOA)
- the American Board of Podiatric Surgery (ABPS)
- the American Board of Oral & Maxillofacial Surgery (ABOMS
- Certification by the Royal College of Physicians and Surgeons of Canada will be accepted in the following circumstances:

(a) the applicable ABMS specialty board recognizes the Canadian post-graduate training as equivalent to the ACGME post-graduate training (i.e. the ABMS specialty board accepts Canadian trained physicians for entrance into the ABMS certification exam process) and, relying on that,

(b) the Medical Staff Department has approved acceptance of Canadian Boards for department members. Such board status (eligible or certified) must be in the primary specialty for which privileges are sought (subspecialty certification requirements will be determined at the department level).

The applicant must achieve Board Certification within seven (7) years of completion of residency/fellowship training. However, a department chairman, the Credentials Committee and/or Medical Executive Committee may, in certain situations, recommend that a practitioner be granted privileges in a specialty other than the specialty in which he is certified if the practitioner otherwise meets the criteria for staff appointment and the training and/or experience criteria for the privileges requested. Please be aware that these are the minimum qualifications for staff appointment and individual departments may have more stringent requirements (Board certification requirements within less than 7 years of completion of residency/fellowship; i.e., Anesthesia 4 years, Cardiovascular 5 years, Emergency Medicine 3 years, Surgery 5 years).

(5) Professional liability insurance in the minimum amount of $1,000,000/$3,000,000 with a carrier acceptable to the Board of Directors (i.e. financial rating: AM Best - B+ or better and Standard and Poors - BBB or better).

(6) Residence and office location sufficiently close to the hospital(s) to provide continuous patient care.

If you do not meet the qualifications, you will be so advised and given the opportunity to provide additional information.

Enclosed you will find:

- Application form
- Conditions of Appointment and Release of Liability form
- Medicare Attestation form
- Delineation of Clinical Privileges form (CRMC and/or MGMC) – ***will be mailed if downloading app from site***
- Criminal Background Check Authorization Form - ***will be mailed if downloading app from site***
- Network Usage Form
- CME Log form
- TB Skin Test Form
- Confidential Malpractice Claims Form (to be completed if there are ANY claims/Board Actions)
- Application Fee Invoice
- Conflict of Interest Statement - ***will be mailed if downloading app from site***

Please complete and return all forms to the Credentials Office at MGMC. (This location credentials for both CRMC & MGMC.) Processing of your application cannot begin until all information has been received. A return envelope is provided for your convenience. Your application will be deemed incomplete if the application or any of the requested documents are not returned within 90 days and will be considered automatic withdrawal.

Also included is a CD with the Medical Staff Bylaws, Rules and Regulations, Credentials Manual and Professional Practice Evaluation Policy. Please review and familiarize yourself with this information.

***PLEASE PROVIDE CURRENT COPIES OF YOUR AZ LICENSE, DEA, INSURANCE, ANY/ ALL MEDICAL SCHOOL CERTIFICATES, BOARD CERTIFICATION CERTIFICATE, CURRICULUM VITAE**
***ALSO – A CURRENT COLOR PHOTO (must be digital head shot – passport photo accepted – pdf or jpg also accepted) MUST ACCOMPANY THIS APPLICATION –**
YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THESE ITEMS

You will be contacted if any additional information is required to complete your file. Following verification of the application information, your application will be forwarded to the appropriate Medical Staff Clinical Department for review and recommendation by the Chair. If the Department Chair recommends approval, your application will be forwarded to the Credentials Committee and/or Credentials Chair for review and recommendation prior to final action by the Medical Executive Committee and the Community Board.

PLEASE NOTE: As you complete your application, answer all questions carefully and to the best of your knowledge. Any questions which are answered and found to be incomplete or inaccurate upon committee review may delay your application and/or require an interview. If the application is not returned within 90 days of the above date, it will be considered automatic withdrawal of application.

If you have any questions or I can be of further assistance, please feel free to contact me at (480) 728-7160.

Sincerely,

Leilani Wilson, CPCS
Supervisor, Credentials Verification Office

Enclosures

Mercy Gilbert Medical Center
Credentials Verification Office/Medical Staff Services
3555 Val Vista Drive
Gilbert, AZ 85296
Tel (480) 728-7160 Fax (602) 798-9753

INITIAL APPLICATION
FOR
MEDICAL STAFF APPOINTMENT

Select Facilities Desired: **CHANDLER REGIONAL** ☐ **MERCY GILBERT** ☐

IDENTIFY PRIMARY FACILITY:_____

(PLEASE INDICATE SPECIALTY AREA IN WHICH YOU ARE REQUESTING PRIVILEGES)

ANESTHESIA
- ☐ Anesthesia
- ☐ Cardiothoracic Anesthesia
- ☐ Pain Management

CARDIOVASCULAR
- ☐ Cardiology
- ☐ CV / Thoracic Surgery
- ☐ Vascular Surgery

EMERGENCY MEDICINE
- ☐ Emergency Medicine
- ☐ Urgent Care (includes FP & IM who are Urgent Care)

MEDICINE/FAMILY PRACTICE
- ☐ Allergy and Immunology
- ☐ Critical Care
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Family Practice – Admit
- ☐ Family Practice – Non-Admit
- ☐ Gastroenterology
- ☐ Infectious Disease
- ☐ Internal Medicine – Admit
- ☐ Internal Medicine – Non-Admit
- ☐ Nephrology
- ☐ Neurology
- ☐ Oncology/Hematology
- ☐ Physical Medicine and Rehab
- ☐ Psychiatry
- ☐ Pulmonary Disease
- ☐ Rheumatology

OBSTETRICS AND GYNECOLOGY
- ☐ Gynecology
- ☐ Gynecology / Oncology
- ☐ Infertility-Reproductive-Endocrine
- ☐ Maternal-Fetal Med
- ☐ OB/GYN

PEDIATRICS
- ☐ Neonatal-Perinatal Medicine
- ☐ Pediatrics
- ☐ Pediatric Cardiology
- ☐ Pediatric Endocrinology
- ☐ Pediatric / Hematology/Oncology
- ☐ Pediatric Neurology

RADIOLOGY
- ☐ Radiology
- ☐ Radiation Oncology

SURGERY
- ☐ Colon & Rectal Surgery
- ☐ Dentistry
- ☐ Dermatology Surgery
- ☐ General Surgery
- ☐ Hand Surgery
- ☐ Neurological Surgery
- ☐ Ophthalmology
- ☐ Oral / Maxillofacial Surgery
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatric Dentistry
- ☐ Pediatric Surgery
- ☐ Plastic/Reconstructive Surgery
- ☐ Podiatry
- ☐ Urology
- ☐ Wound Healing

All areas of the application must be completed. Reference to Curriculum Vitae is not acceptable.

Do <u>NOT</u> leave any blank spaces: correct incorrect information, complete missing information.
If not applicable, mark "N/A"

PLEASE PRINT OR TYPE

I. PERSONAL DATA

UPIN#_____ Social Security #_____NPI#_____

Business Email:_____ Personal Email: _____

Pager**:** _____ Cell Phone: _____ Gender: _____

Name:_____ Degree_____

List other names you have used: _____

Date of Birth:_____ Place of Birth: _____ Citizenship: _____

Name of Spouse: _____

Foreign Language: _____ Speak:_____ Write:_____

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Home Fax: _____

Office Address: (If more than one, list each office and address)

Primary:_____Office Phone: _____

City, State, Zip: _____Office Fax: _____

Office Manager**:**_____Phone #: _____

Secondary_____Office Phone: _____

City, State, Zip: _____Office Fax: _____

Office Manager**:**_____ Phone #: _____

Mailing Address: (if different than the office street address)_____

City, State, Zip: _____

Affiliated with: _____

Covering Physicians: _____

Corporate Name/Group Practice Name: _____

The answers to the following questions must account for all time periods from medical education to the present. Attach a supplement page if additional space is needed.

II. MEDICAL EDUCATION

(List all medical, osteopathic, dental or podiatric schools attended. Send copy of degree.)

College or University: _____

From: _____ To:_____ Degree Earned: _____

III. ECFMG

Please attach copy of ECFMG Certificate

ECFMG Certification # _____ Date Issued _____ NA _____

IV. POSTGRADUATE TRAINING

List every residency and fellowship ever begun or completed

Internship:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____ Program Director: _____

From :_____ To:_____ Specialty: _____

Residency: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____ Program Director: _____

From: _____ To: _____ Specialty: _____

Fellowship _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____ Fax: _____ Program Director: _____

From :_____ To:_____ Specialty: _____

*PLEASE LIST ANY FURTHER TRAINING WITH ADDRESS AND DATES OF ATTENDANCE ON AN ADDITIONAL PIECE OF PAPER**

V. MILITARY SERVICE

Have you served or are you currently serving in the United States Military? (Include DD214 if applicable) Yes □ No □

From: _____/____/_____ To: _____/____/_____ Type of Discharge: _____ Branch:_____

VI. EMPLOYED FACULTY POSITIONS

Does not include faculty appointment or staff membership (i.e. Hospitals, Medical Schools, etc.)

Institution: _____ From: ____/____/____ To:____/____/____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Contact Person: _____

Department/Positions: _____

VII. PRIVATE PRACTICE/EMPLOYMENT

List in chronological order your work history since completion of your postgraduate education.

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

Group Name:_____Contact Person**:** _____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Specialty:_____ **Dates of Employment: From** ____/____/____ **To** ____/____/____

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

Group Name:_____Contact Person**:** _____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Specialty:_____ **Dates of Employment: From** ____/____/____ **To** ____/____/____

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

Group Name:_____Contact Person**:** _____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Specialty:_____ **Dates of Employment: From** ____/____/____ **To**

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

Group Name:_____Contact Person**:** _____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Specialty:_____ **Dates of Employment: From** ____/____/____ **To** ____/____/____

List any gaps in time of three (3) consecutive months or more:

From _____/_____ to _____/_____ Reason: _____

From _____/_____ to _____/_____ Reason: _____

PLEASE PROVIDE NAME, ADDRESS, PHONE/FAX OF PERSON WHO CAN VERIFY TIME GAP ABOVE.

VIII. CONTINUING MEDICAL EDUCATION (CME)

Please submit documentation of CME hours obtained related to privileges requested**.**

Number of continuing medical educational hours awarded to you during the past two calendar years: _____

Percentage of CME in your specialty: _____%

Please complete and submit the attached CME Log or an itemized listing of CME for the past two years.

IX. STAFF MEMBERSHIPS

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

PRIMARY HOSPITAL AFFILIATION (the facility you utilized the most)**:**_____

Address: _____ Phone:_____

City: _____ State:_____ Zip Code: _____ Fax: _____

Dates of Staff Membership: From: ____/____/____ To: ____/____/____

STATE OF ARIZONA HOSPITAL STAFF MEMBERSHIPS

Hospital	Status	Appt Date	Date Resigned (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OUT OF STATE STAFF MEMBERSHIPS

Hospital: _____

Address: _____City: _____ State: _____ Zip Code: _____

Date(s) of Staff Membership: From ____/____/____ To ____/____/____

Hospital: _____

Address: _____City: _____ State: _____ Zip Code: _____

Date(s) of Staff Membership: From ____/____/____ To ____/____/____

Hospital: _____

Address: _____City: _____ State: _____ Zip Code: _____

Date(s) of Staff Membership: From ____/____/____ To ____/____/____

Hospital: _____

Address: _____City: _____ State: _____ Zip Code: _____

Date(s) of Staff Membership: From ____/____/____ To ____/____/____

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 relating 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

X. 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

XI. BOARD CERTIFICATION

Send copy of letter of eligibility of certificate

Name of Board: _____

☐ Certified ☐ Not Certified If not certified, indicate current status:_____

Date Certified: _____ Date Recertified: _____ Certification #:_____

Name of Board: _____

☐ Certified ☐ Not Certified If not certified, indicate current status:_____

--

Date Certified: _____ Date Recertified: _____ Certification #:_____

Subspecialty Board: _____

☐ Certified ☐ Not Certified If not certified, indicate current status:_____

Date Certified: _____ Date Recertified: _____ Certification #:_____

Subspecialty Board: _____

☐ Certified ☐ Not Certified If not certified, indicate current status:_____

Date Certified: _____ Date Recertified: _____ Certification #:_____

1. Have you ever been examined by any specialty board, but failed to pass the examination? ☐ No ☐ Yes
   If "Yes," please provide a full explanation of the details on a separate sheet and attach.

2. If not certified, have you applied to take the certification examination? ☐ No ☐ Yes

3. If "Yes," have you been accepted to take the certification examination? ☐ No ☐ Yes
   Please provide copy of acceptance letter.

XII. OTHER PERTINENT 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 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 any felony or any misdemeanor relating to the practice of your profession, other health care-related matters, third-party reimbursement, violence, or controlled substances? ☐ No ☐ Yes

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

XIII. LICENSE

List **ALL** states in which you are licensed, have applied or are currently applying for licensure or registration. Attach a separate sheet if additional space is necessary. If you are no longer licensed or if a license was not issued, please explain.

State	License #	Date Issued	Expiration Date
AZ	_____	_____	____/ ____/ ____
_____	_____	_____	____/ ____/ ____
_____	_____	_____	____/ ____/ ____
_____	_____	_____	____/ ____/ ____

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

XIV. DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (DEA)

DEA #: _____Issued Date:_____ Expiration Date: _____

Please attach current copy of DEA certificate.

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

XV. PROFESSIONAL LIABILITY INSURANCE

FUTURE: Attach a copy of certificate of insurance or policy summary covering your FUTURE practice (if applicable):

Name of Carrier: _____ Policy #: _____

Address: _____ City: _____ AZ: _____ Zip Code: _____

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

CURRENT: Attach copy of certificate of insurance or policy summary covering your CURRENT practice.

Name of Carrier: _____ Policy #: _____

Address: _____ City: _____ AZ: _____ Zip Code: _____

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

PAST: Attach copy of certificate of insurance or policy summary covering your PAST practice.

Name of Carrier: _____ Policy #: _____

Address: _____ City: _____ AZ: _____ Zip Code: _____

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

Please list any other malpractice insurance carriers on an additional piece of paper

Do you have "tail coverage" ? ☐ 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 professional liability suits? ☐ No ☐ Yes

If you answered yes to questions 7, 8, or 9, complete the enclosed confidential supplemental malpractice information sheet; Make copies as necessary - one for <u>EACH</u> claim, complaint, suit, settlement, or arbitration.
<u>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</u>.

**** 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.***

XVI. REFERENCES

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.
(REFERENCES SHOULD BE IN YOUR SPECIALTY AND NOT AN ASSOCIATE)

Acceptable References: Chief of Residency, Training Program Director, Department Chair, Service Chief, or other Practitioners in the same specialty.

1. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

2. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

3. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

4. Name: _____ Specialty: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone: _____ Fax: _____

CORRECT ADDRESSES, PHONE/FAX, MUST BE PROVIDED FOR ALL REFERENCES GIVEN

XVII. 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 dependant 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:_____

   _____

XVIII. TB SKIN TEST

The Arizona Department of Health Services (DHS) and Chandler Regional/Mercy Gilbert Medical Center(s) Infection Control Committee requires each medical staff member 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;

(b) A report of a negative chest x-ray; or

(c) If the medical staff/allied health staff member has had a positive Mantoux skin test, another physician's written statement that he or she is free from infectious pulmonary tuberculosis and completion of the enclosed Annual Tuberculosis Questionnaire (found on the accompanying page).

If a medical staff or allied health member signs this attestation and cannot provide evidence, DHS has indicated that it will report the physician to AMB/BOMEX 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 report of a negative chest X-ray; or

☐ Although I had a positive Mantoux skin test, I have another physician's statement that I 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 WITH RETURN OF APPLICATION, INCLUDING ANNUAL TB QUESTIONNAIRE IF APPLICABLE.**

CHANDLER REGIONAL MEDICAL CENTER / MERCY GILBERT MEDICAL CENTER

ANNUAL TUBERCULOSIS QUESTIONNAIRE

FOR THE INDIVIDUAL WITH A POSITIVE TB SKIN

A11 Chandler Regional and Mercy Gilbert Medical Center(s) practitioners with positive tuberculin skin tests must complete and sign the following questionnaire annually. 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	_____	_____

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

> "Health care workers (HCWs) 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."

Therefore, if you are experiencing any of the above symptoms you should contact Employee Wellness, CRMC Employee Wellness at x87035 or MGMC Employee Wellness at x88395, and your physician, as you may be manifesting symptoms of tuberculosis.

Comments: _____

_____

_____ _____

Print Name Signature

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

_____ _____

Department Date

_____

LHP Signature and Date

Revised: 2/11

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 Chandler Regional Medical Center/Mercy Gilbert Medical Center application and attest to their accuracy.

_____ _____

Signature Date

_____

Print Name

CHANDLER REGIONALMEDICALCENTER
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 By-Laws 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 By-Laws 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**_____

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

CONTINUING MEDICAL EDUCATION

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.

DATES	COURSES	NUMBER OF HOURS

TOTAL NUMBER OF HOURS _____

CHANDLER REGIONAL MEDICAL CENTER/GILBERT MERCY MEDICAL CENTER

INVOICE

NOTICE OF APPLICATION FEE(S)

Please submit an application fee of **$350.00** for membership to **ONE** facility. For **BOTH** facilities (Chandler Regional & Mercy Gilbert), please submit an application fee of **$450.00.**

Please make check payable to:

CHANDLER REGIONAL MEDICAL CENTER

In the amount of **$350.00** for **one** facility
OR
$450.00 for **both** facilities
(CRH & MGMC)

Please include your check when you return your completed Application Questionnaire to the Credentials Verification Office. Once payment has been received, processing of your application will begin. **The application fee is non-refundable.** Thank you.

CREDENTIALS VERIFICATION OFFICE

NOTE:

This form

MUST

be filled out for

EACH

Malpractice Claim /ALL BOMEX Open Investigations

(Please Provide Supporting Information)

This is a requirement by the Credentials Committee – Thank you.

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

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

OR

I DO NOT agree to release of photograph:

_____ _____

Signature Date

MEMORANDUM

Date
May 17, 2010

To
Chandler Regional and Mercy Gilbert Medical Staff

From
Jeanette Hendrickson, Director Medical Staff Services

Subject
Credentialing Process Management

Dignity Health has consolidated our Physician Credentialing system. This memo is to inform you that in the event you are on staff at more than one facility, your demographic based information may be co-managed by these facilities. The listing below indicates the information categories that could be co-managed:

- ***Providers:*** Name, DOB, SSN, NPI, email
- ***Addresses & Group Associations:*** Address Type (e.g. Primary, Alternate, Mailing, Home), Street 1 & 2, City, State, Zip, Phone, Fax, email, Group(s)
- ***Affiliations:*** Affiliation/Employer Institution name, Category, Dates of Affil / Employ
- ***Education:*** Educational Institution Name, Program (e.g. Med. School, Nursing, Residency), Graduation Date, Dept/Spec
- ***Insurance:*** Policy#, Begin & Expire dates, Carrier, Status, Limits, Type (Occurrence, Claims Made, Tail, Super)
- ***Licenses:*** Certificate #, Issued & Expire dates, State, Status, Schedules
- ***Specialties / Boards:*** Specialty: Specialty, Type, Status, Tax. Board: Board, Status, Dates, Expires
- ***Actions:*** Sources: OIG, NPDB, Providers' applications. NPDB Action/Omission codes (2), description memos, dates, reporting institution. NPDB - compliant data structure
- ***Plans:*** Payer name, dates, ID
- ***Institutions:*** Institution name, address, phone, fax, URL, email.
- ***Malpractice Claims:*** Sources: NPDB, Insurance verification, Providers' applications NPDB compliant data structure, description memos, dates, reporting institution, claim amounts, Court name & Case #, # parties sued
- ***OIG:*** Sweep Date, # possible matches, proof of providers' inclusion in sweeps.

All co-managed information is of a demographic nature, provided by you or resourced from public information sources such as NPDB or OIG.

Please contact your medical staff offices should you have any questions or concerns.

Physician/Practice Information	**Medical Staff Services Office**
Practice Name: _____ Physician Name: _____ Street:_____ City: _____ State: _____ Zip: _____ Email: _____ Telephone:_____	Facility Name: Chandler Regional/Mercy Gilbert Medical Centers Contact name: Leilani Wilson, Credentials Supervisor Email: leilani.wilson@chw.edu Telephone: (480) 728-7160

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 Catholic Healthcare West's ("**CHW**") 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 CHW 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 CHW 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 of physician identified above)

Date: _____

Approved: 
(*signature of medical services contact identified above*)

Date: