



## 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
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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

## Practice Information

### Primary Practice Location Information

Practice / Corporation/ Group Name	Telephone	Fax
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Practice Group Tax ID	Answering Service	Practice Email Address (if applicable)
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Office Address	City	State	Zip Code
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Office Manager	Office Manager Telephone	Office Manager Email Address
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Covering Physicians: \_\_\_\_\_

### Alternate Practice Location Information

Practice / Corporation/ Group Name	Telephone	Fax
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Practice Group Tax ID	Answering Service	Practice Email Address (if applicable)
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Office Address	City	State	Zip Code
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Office Manager	Office Manager Telephone	Office Manager Email Address
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### Credentialing Location Information

Office Address	City	State	Zip Code
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Telephone	Fax	Email Address
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Office Manager	Office Manager Telephone	Office Manager Email Address
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## 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

Institution	Dates Attended:	From	To
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Address	Telephone	Fax
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City	Degree Conferred	Education Type
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State	Zip Code	Country (if non-U.S.)
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**Medical Education Information (cont'd)**

\_\_\_\_\_ Dates Attended: \_\_\_\_\_ from \_\_\_\_\_ To \_\_\_\_\_  
 Institution

\_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address

\_\_\_\_\_ Degree Conferred \_\_\_\_\_ Education Type \_\_\_\_\_  
 City

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

**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.*

\_\_\_\_\_ Dates \_\_\_\_\_ / \_\_\_\_\_  
 Institution Attended: From To

\_\_\_\_\_ Training  Yes  No  
 Education Type Area of Training Completed:

If not successfully completed, please explain: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country (if non-U.S.) \_\_\_\_\_  
 Address

\_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
 Program Director

**Post Graduate Training Information**

\_\_\_\_\_ Dates \_\_\_\_\_ / \_\_\_\_\_  
 Institution Attended: From To

\_\_\_\_\_ Training  Yes  No  
 Education Type Area of Training Completed:

If not successfully completed, please explain: \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country (if non-U.S.) \_\_\_\_\_  
 Address

\_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
 Program Director

**Post Graduate Training Information (cont'd)**

Institution \_\_\_\_\_ Dates Attended: \_\_\_\_\_ / \_\_\_\_\_  
 From \_\_\_\_\_ To \_\_\_\_\_

Education Type \_\_\_\_\_ Area of Training \_\_\_\_\_ Training  Yes  No  
 Completed:

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  Yes  No  
 Completed:

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 \_\_\_\_\_



**Affiliation Information**

Hospital / Healthcare Institution Name \_\_\_\_\_ Appt. Dates: \_\_\_\_\_ / \_\_\_\_\_  
 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 **previous ten (10) years**. 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 \_\_\_\_\_





### 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

### 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.**

**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 occurred? \_\_\_\_\_

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



## 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: \_\_\_\_\_

\_\_\_\_\_

**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**

## 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
Physician 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)*

Date: \_\_\_\_\_

Approved: \_\_\_\_\_  
*(medical services contact signature)*

Date: \_\_\_\_\_

**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

**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



**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.

Verification of Application. 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.

Authorization of Release. 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: \_\_\_\_\_

**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)*

**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 SVal Vista  
 Gilbert, AZ 85297

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