General Staff Application

Position applying for ____Date __________

APPLICANTNAME ____
Last First Middle Maiden

BUSINESS ADDRESS ____Telephone (_____) ______-________
Street City State Zip

RESIDENCE ADDRESS ____Telephone (_____) ______-________
Street City State Zip

SOCIAL SECURITY DOB __________-______-______DATE OF BIRTH ____________________________
(To be used for identification purposes only)

EDUCATION

UNDERGRADUATE/Technical EDUCATION

____
School/College or University Address City State Zip

Dates of Enrollment to Degree ____/___/____ Degree _______________ Date of Graduation _____/_______/_______

GRADUATE EDUCATION ____
Graduate School Address City State Zip

Dates of Enrollment to Degree ____/___/____ Degree _______________ Date of Graduation _____/_______/_______

PROFESSIONAL EDUCATION ____
Institution Address City State Zip

Dates of Enrollment to Degree ____/___/____ Degree _______________ Date of Graduation _____/_______/_______

LICENSURE _______________ _______________ _______________ ________ / ______ / ______
State Date issued Number Expiration Date

_______________ _______________ _______________ ________ / ______ / ______
State Date issued Number Expiration Date

_______________ _______________ _______________ ________ / ______ / ______
State Date issued Number Expiration Date

PROFESSIONAL SPECIALIZATION CERTIFICATION

Are you certified by a professional board or association? ___ Yes ___ No If yes, please answers the following:

Name of Board or Association ____

Type of Certification ________________________________ Issued __ / __ / __ Expiration Date ____ / ____ /___
(Please attach a copy to application)

MILITARY SERVICE

Have you served in the Military? ___Yes ___No If yes, please answer the following:

____ _________________________________
Branch Rank

____ _________________________________
Dates Type of Discharge

CONTINUING EDUCATION

Please attach a list of the continuing education programs that you have attended or presented for the period since last license renewal.

CPR   Basic Life Support   Advanced Life Support   Instructor

OTHER CERTIFICATION ______________________________ ____________________
Type of certification   Date of Certification

******

1. Are you currently taking controlled substances by prescription or otherwise? ___ Yes___ No

"**Currently**" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two years.

"**Controlled Substances**" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed prescriber's direction, as well as those used illegally.

"**Ability to provide health care services**" is to be construed to include the following:

a. The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments; and
b. The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and
c. The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes" to question 1, please answer a and b below.

a. a. Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? ___Yes ___ No
b. Are you currently participating in a professionally supervised program that monitors you in order? To assure that you are not illegally utilizing the controlled substances? ___Yes ___ No

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? ___ Yes ___ No

"**Medical condition**" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIY I AIDS, tuberculosis, drug addiction and alcoholism.

If you answered “yes” to question 2, answer a and b below.

a. Are any limitations that may be related to your medical condition ameliorated? By current ongoing treatment or participation in a monitoring program? ___ Yes ___ No
b. Are any limitations that may be related to your medical condition overcome by? The manner in which you have chosen to provide health care services? ___ Yes ___ No

3. Have you ever been convicted of a crime (not including traffic violations)? ___ Yes ___ No

4. Have you ever been diagnosed as or have you ever been treated for pedophilia, exhibitionism, or voyeurism? ___ Yes ___ No

If you answered "Yes" to any of the above, please attach explanation and related documents.

______________________________ ____________________
Applicant Signature   Date

General Staff Application

Employment/Privileges History

Please list (most recent first) all places where you have practiced, had staff privileges or been employed. Also, please explain any periods of time not accounted for since graduation from professional educational program. Use additional page(s) if necessary. All time periods must be accounted for, including periods of unemployment and vacations between employments.

1. Place ____
Contact ____ Phone Number ___________________________

____
Address City County State Zip

Position/Title/Status ____________________________________ Dates: ___ / ___ / ___ to: ___ / ___ / ___

____
Reason for Leaving

2. Place ____
Contact ____ Phone Number ___________________________

____
Address City County State Zip

Position/Title/Status ____________________________________ Dates: ___ / ___ / ___ to: ___ / ___ / ___

____
Reason for Leaving

3. Place ____
Contact ____ Phone Number ___________________________

____
Address City County State Zip

Position/Title/Status ____________________________________ Dates: ___ / ___ / ___ to: ___ / ___ / ___

____
Reason for Leaving

4. Place ____
Contact ____ Phone Number ___________________________

____
Address City County State Zip

Position/Title/Status ____________________________________ Dates: ___ / ___ / ___ to: ___ / ___ / ___

____
Reason for Leaving

5. Place ____
Contact ____ Phone Number ___________________________

____
Address City County State Zip

Position/Title/Status ____________________________________ Dates: ___ / ___ / ___ to: ___ / ___ / ___

____
Reason for Leaving

General Staff Application

Professional and References

Please list the names, full mailing addresses, and phone numbers of three professional references.

Professional References (persons not related to you and with first-hand knowledge of your professional work).

1. Name ____Title _______________________________________
Employer ____
____
Address City State Zip

Phone Number _______________________________

2. Name ____Title _______________________________________
Employer ____
____
Address City State Zip

Phone Number _______________________________

3. Name ____Title _______________________________________
Employer ____
____
Address City State Zip

Phone Number _______________________________

General Staff Application

(THIS PAGE TO BE COMPLETED BY LICENSED AND/OR CERTIFIED STAFF ONLY)

APPLICANT NAME ____ TITLE ______________________________

SPECIALTY/TITLE ____

CONTROLLED SUBSTANCE REGISTRATION

DEA# _______________________ DPS# _______________________

EXP. DATE ___________________ EXP. DATE ___________________

___ Advanced Practice Nurse ___ Physician Assistant Prescriptive authority? ___ Yes ___ No

PROFESSIONAL MEMBERSHIP(S) ____
(PROFESSIONAL ASSOCIATION, SOCIETY OR ACADEMY)

TRAINING

Entity/Hospital Type of Program Dates

Address City State/ZIP

Entity/Hospital Type of Program Dates

Address City State/ZIP

Entity/Hospital Type of Program Dates

Address City State/ZIP

TEACHING

Institution Department Dates

APPOINTMENTS

Rank Dates of Affiliation

Institution Department Dates

Rank Dates of Affiliation

Institution Department

PRIVATE PRACTICE

Address City State ZIP Type Dates of Practice

Address City State ZIP Type Dates of Practice

Licensed/Certified Clinical Applicant: ____

HOSPITAL/ENTITY AFFILIATION
(List all past and present)

Address City State ZIP Type Dates of Affiliation

Address City State ZIP Type Dates of Affiliation

Address City State ZIP Type Dates of Affiliation

OTHER POSITION (S)

NAME Address City State ZIP

Type Dates of Affiliation

Note: STATE HOSPITAL/ENTITY AFFILIATION ON PRACTICE/EMPLOYMENT HISTORY
USE ATTACHED EMPLOYMENT/PRIVILEGES HISTORY PAGE TO LIST ADDITIONAL ENTRIES

****

Has your license to practice in any jurisdiction ever been limited, suspended, revoked or probated? ___ Yes ___ No

Have your privileges at any entity ever been suspended, reduced, revoked or not renewed? ___ Yes ___ No

Have you ever been denied membership or been subject to discipline by any health care entity? ___ Yes ___ No

Name of current professional liability insurance carrier ______________________________

Address City State Zip

Policy # ______________________________

List previous professional liability insurance carriers:

Name Address City State Zip Dates Covered

Name Address City State Zip Dates Covered

Have you ever had any liability claims filed against you? ___ Yes ___ No

For any liabili(v claims, provide full information on each claim and disposition or status. Use separate page(s)

Have you ever been restricted or sanctioned by Medicare or Medicaid? ___ Yes ___ No

If you answered "Yes" to any of the above, please attach explanation and related documents.

Applicant Signature Date

General Staff Application

AUTHORIZATION AND CONSENT

I fully understand that any misstatements in or omissions from this application constitute cause for denial or termination of privileges and employment. All information submitted by me in this application is true to the best of my knowledge.

In making this application, I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of the Center, to make decisions as appropriate to the patient's needs, to maintain my practice knowledge and skills current through continuing education opportunities, to abide by the bylaws, rules and regulations of the Professional Staff, and to participate in and cooperate fully with the Compliance/Performance Improvement Program and all programs to improve quality and reduce risks. I agree to participate in the review of records and documents relating to patient care and services, and to subject my performance to the review by the Center and its representatives or the purpose of improving the quality of care and services and reducing risks, and I hold the Center and its representatives free of all liability for such actions.

I hereby release from liability the Center and all its representatives for their acts performed in connection with obtaining and evaluating my application, credentials and qualifications. I hereby release from any liability any and all individuals and organizations that provide information to the Center or its representatives concerning my professional competence, character, ethics, and other qualifications tor employment and privileges and I hereby consent to the release of such information.

I hereby authorize the Center CPI Committee or subcommittee as a professional review committee through the Compliance/Performance Improvement Program to communicate with other entities and individuals concerning knowledge of my professional competence, character and ethics, and agree to hold the Center and its representatives free of liability. I hereby consent to the inspection by the Center or its representatives of all documents, including medical records at other entities, school transcripts, and county records, that may be material to an evaluation of my qualifications and competence for the clinical privileges and functions requested, as well as my moral and ethical qualifications tor employment. I agree to hold the Center and its representatives free of liability.

I hereby accept that I will abide by the requirements for coverage by the Federal Tort Claims Act, will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims. I understand that if I am made an offer for privileges or functions and employment, an evaluation of my physical and mental fitness may be requested consistent with the requirements for liability coverage by the Federal Tort Claims Act.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

I understand that my employment with the Center if any, may be terminated at any time without cause.

Signature of Applicant ______________________ Date ______________

Print Name ______________________