STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for initial credentialing only. Other forms are required for recredentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

- ☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature	Type or Print Name	Date

***** PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, *****
***** AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN *****
***** ATTESTATION AND RELEASE OF INFORMATION FORM. *****

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: ____
Last First MI Degree

List other names by which you have been known: ______________________________
Last First MI

If you have been known by other names, please explain why your name changed:

____

____

Birth Date: ____________ Place of Birth: ______________________________
(mm/dd/yy) City State Country

Sex: ☐ Male ☐ Female Language Fluency of Applicant: ☐ English ☐ Other: ____________

U.S. Citizen? ☐ Yes ☐ No ☐ Spanish

If no, do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: ____________________

Social Security Number: ____________________

Emergency Contact Person: ______________________________
Last First MI

Telephone Number: ( ) ____________

Mailing Address: ____
Street City State Zip

Daytime Phone: ( ) ____________ Fax Number: ( ) ____________

E-Mail Address: ____________________

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: ____________________

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: ____________________

____

Current and Previous Professional License(s) in Other States

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: ____________________

____

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: ____________________

____

State: ____________ License #: ____________ Exp. Date: ________ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: ____________________

____

Check here if you have appended additional information for this section: ☐

Current Federal DEA License Number: ____________________ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: ____________ License Unlimited? Yes ☐ No ☐

If No, please explain limitation: ____________________

____

Check here if you have appended additional information for this section: ☐

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State:	CS License #:	Expiration Date:
____________	____________	________ (mm/dd/yy)
____________	____________	________ (mm/dd/yy)
____________	____________	________ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

____

____

Medicare Unique Provider ID# (UPIN):____________________________

National Provider Identification Number (NPI):_______________________________

Medicaid ID#: ______________________________

X-Ray Certification: State:__________Certificate #: _____________Expiration Date: ____________(mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

Specialty I:____

Are you Board Certified in Specialty I? Yes ☐ No ☐

If Yes, name of Certifying Board:____

Date of Certification:_________________ (mm/yy) Date of Recertification (if applicable):___________________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date:_______________ (mm/yy) Certification Expiration Date, if Any: __________ (mm/yy)

If not taken, date scheduled to take Specialty Boards:_______________ (mm/yy)

Specialty/Subspecialty II: ____

Are you Board Certified in Specialty II? Yes ☐ No ☐

If Yes, name of Certifying Board:____

Date of Certification:_________________ (mm/yy) Date of Recertification (if applicable):___________________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date:_______________ (mm/yy) Certification Expiration Date, if Any: __________ (mm/yy)

If not taken, date scheduled to take Specialty Boards:_______________ (mm/yy)

(Please continue next page)

Specialty/Subspecialty III:____

Are you Board Certified in Specialty III? Yes ☐ No ☐

If Yes, name of Certifying Board:____

Date of Certification:______________ (mm/yy) Date of Recertification (if applicable):______________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date:____________ (mm/yy) Certification Expiration Date, if Any: ________ (mm/yy)

If not taken, date scheduled to take Specialty Boards:____________ (mm/yy)

Specialty/Subspecialty IV:____

Are you Board Certified in Specialty IV? Yes ☐ No ☐

If Yes, name of Certifying Board:____

Date of Certification:______________ (mm/yy) Date of Recertification (if applicable):______________ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date:____________ (mm/yy) Certification Expiration Date, if Any: ________ (mm/yy)

If not taken, date scheduled to take Specialty Boards:____________ (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:____

Address:____

Street City State Zip

Policy Number:____________________ Original Effective Date:___________ (mm/dd/yy) Expiration Date:___________ (mm/dd/yy)

Policy Limits: Per Occurrence: $_____________ Aggregate: $_____________

Retroactive Date:___________ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:____

Address:____

Street City State Zip

Policy Number:____________________ Original Effective Date:___________ (mm/dd/yy) Expiration Date:___________ (mm/dd/yy)

Policy Limits: Per Occurrence: $_____________ Aggregate: $_____________

Retroactive Date:___________ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:____

Address:____
Street City State Zip

Policy Number:____________________ Original Effective Date:__________ Expiration Date:__________
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $____________ Aggregate: $____________

Retroactive Date:__________
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:____

Address:____
Street City State Zip

Policy Number:____________________ Original Effective Date:__________ Expiration Date:__________
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $____________ Aggregate: $____________

Retroactive Date:__________
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name:____

Mailing Address:____
Street City State Zip

Telephone Number: ( )__________ Fax Number: ( )__________

Degree:______________ Year Graduated: __________

Dates attended: From:__________ To:__________
mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued:__________ Serial Number for ECFMG:__________
mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐

INTERNSHIP

Institution Name:____

Department Chair or Program Director:____
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: ( )__________ Fax Number: ( )__________

Dates attended: From:__________ To:__________
mm/yy mm/yy

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty:__________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

FIRST RESIDENCY

Institution Name: ______________________________

Department Chair or Program Director: ______________________________
Last Name First Name MI Degree

Mailing Address: ______________________________
Street City State Zip

Telephone Number: ( ) __________ Fax Number: ( ) __________

Dates attended: From: __________ To: __________
mm/yy mm/yy

Type of residency: ______________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

SECOND RESIDENCY

Institution Name: ______________________________

Department Chair or Program Director: ______________________________
Last Name First Name MI Degree

Mailing Address: ______________________________
Street City State Zip

Telephone Number: ( ) __________ Fax Number: ( ) __________

Dates attended: From: __________ To: __________
mm/yy mm/yy

Type of residency: ______________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

FIRST FELLOWSHIP

Institution Name:____

Department Chair or Program Director:______________________________
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: ( ) __________ Fax Number: ( ) __________

Dates attended: From:__________ To:__________
mm/yy mm/yy

Type of fellowship:____________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

SECOND FELLOWSHIP

Institution Name:____

Department Chair or Program Director:______________________________
Last Name First Name MI Degree

Mailing Address:____
Street City State Zip

Telephone Number: ( ) __________ Fax Number: ( ) __________

Dates attended: From:__________ To:__________
mm/yy mm/yy

Type of fellowship:____________________________

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name:____

Department Chair or Program Director:________________________________

Last Name First Name MI Degree

Mailing Address:____

Street City State Zip

Telephone Number: ( ) Fax Number: ( )

Dates: From: To: Rank/Position, if applicable:

mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name:____

Department Chair or Program Director:________________________________

Last Name First Name MI Degree

Mailing Address:____

Street City State Zip

Telephone Number: ( ) Fax Number: ( )

Dates: From: To: Rank/Position, if applicable:

mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name:____

Address:____

Street City State Zip

Membership Status:____________________ Dates: __________ **To Present**

From (mm/yy)

Department/Division:____________________ Medical Staff Office FAX #: ( ) ________

Department Telephone #: ( ) ________

Any Limitations in Your Area of Specialty at this Hospital? ____________________

____

B. Other Hospital

Hospital Name:____

Address:____

Street City State Zip

Membership Status:____________________ Dates: __________ To:__________

From (mm/yy) To (mm/yy)

Department/Division:____________________ Medical Staff Office FAX #: ( ) ________

Department Telephone #: ( ) ________

Any Limitations in Your Area of Specialty at this Hospital? ____________________

____

C. Other Hospital

Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

Department/Division: ____________________ Medical Staff Office FAX #: (   ) __________

Department Telephone #: (   ) __________

Any Limitations in Your Area of Specialty at this Hospital? ____________________

____

Check here if you have appended additional information for this section: ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

Department/Division: ____________________ Medical Staff Office FAX #: (   ) __________

Department Telephone #: (   ) __________

Any Limitations in Your Area of Specialty at this Hospital? ____________________

____

B. Hospital Name: ____________________

Address: ____________________
Street City State Zip

Membership Status: ____________________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

Department/Division: ____________________ Medical Staff Office FAX #: (   ) __________

Department Telephone #: (   ) __________

Any Limitations in Your Area of Specialty at this Hospital? ____________________

____

C. Hospital Name: ______________________________

Address: ______________________________
Street City State Zip

Membership Status: ______________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

Department/Division: ______________ Medical Staff Office FAX #: ( ) __________

Department Telephone #: ( ) __________

Any Limitations in Your Area of Specialty at this Hospital? ______________________________

____

Check here if you have appended additional information for this section: ☐

SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

A. Primary Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Membership Status: ______________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Membership Status: ______________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgery Center

ASC Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) __________ Fax Number: ( ) __________

Membership Status: ______________ Dates: __________ To: __________
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section: ☐

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: ______________________

Address: ______________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________

Time in this employment: From: __________ **to Present**
(mm/yy)

Previous work place: ______________________

Address: ______________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________

Address: ______________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________

Address: ______________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ______________________

Address: ______________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________

Time in this employment: From: __________ **to:** __________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ____________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ____________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ____________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ____________________

Address: ____________________
Street City State Zip

Telephone: (   ) ________ Fax Number: (   ) ________

Title or Professional Occupation: ____________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. Name:______________________________ Title:__________
Last First MI Degree

Specialty: ______________________________
Mailing Address:______________________________
Street City State Zip
Telephone: (   )__________ Fax Number: (   )__________
Relationship: ______________________________ Years Known:__________

2. Name:______________________________ Title:__________
Last First MI Degree

Specialty: ______________________________
Mailing Address:______________________________
Street City State Zip
Telephone: (   )__________ Fax Number: (   )__________
Relationship: ______________________________ Years Known:__________

3. Name:______________________________ Title:__________
Last First MI Degree

Specialty: ______________________________
Mailing Address:______________________________
Street City State Zip
Telephone: (   )__________ Fax Number: (   )__________
Relationship: ______________________________ Years Known:__________

(Please continue next page)

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No

3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No

4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ Yes ☐ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? ☐ Yes ☐ No
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ Yes ☐ No
3. Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☐ No
4. Has any person or entity ever been sued for your clinical actions? ☐ Yes ☐ No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? ☐ Yes ☐ No

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☐ No

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances? ☐ Yes ☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☐ No

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ Yes ☐ No

If Yes, please provide explanation: ______________________________

____

____

____

____

(Please continue next page)

CHAPTER B:
BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) Main Telephone Number

Office Administrator – Last First MI

( ) Beeper Number

( ) FAX Number

E-mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	**Existing Patient**
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner:____________________

Special Skills of Staff:____________________

Languages Spoken by Practitioner:____________________

Languages Written by Practitioner:____________________

Languages Spoken by Staff:____________________

Languages Written by Staff:____________________

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

____________________ ____________________ ____________________

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ____________________________________

Address: ____________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Name: ____
Last First MI Degree

Specialty: ____________________________________

Address: ____________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Name: ____
Last First MI Degree

Specialty: ____________________________________

Address: ____________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ____________________________________ Specialty: ______________
Last First MI

Name: ____________________________________ Specialty: ______________
Last First MI

Name: ____________________________________ Specialty: ______________
Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (   ) ______________

Business Arrangement #2
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (   ) ______________

Business Arrangement #3
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (   ) ______________

Business Arrangement #4
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (   ) ______________

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site #

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( )
Main Telephone Number

Office Administrator – Last First MI

( )
Beeper Number

( )
FAX Number

E-mail

( )
Emergency Number

( )
Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner:______________________________

Special Skills of Staff:______________________________

Languages Spoken by Practitioner:______________________________

Languages Written by Practitioner:______________________________

Languages Spoken by Staff:______________________________

Languages Written by Staff:______________________________

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

______________ ______________ ______________

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ____________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ______________________________________ Specialty: ______________
Last First MI

Name: ______________________________________ Specialty: ______________
Last First MI

Name: ______________________________________ Specialty: ______________
Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #2
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #3
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

Business Arrangement #4
Name of Business Arrangement On SS4 or W-9 Form: ______________________________

Type of Arrangement (e.g., solo or group practice, IPA, PHO): ______________________________

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: ____________________

Billing Address, if Different from Primary Site: ______________________________

Telephone Number, if Different from Primary Site: (___) ______________

End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes": Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

____
____
____
____
____

B. Provide an explanation of any actions taken. Please include the date the action was taken.

____
____
____
____
____

C. Provide the current status of the issue.

____
____
____
____
____

D. If known: Contact: ____________________________________

Department/Committee: ____________________________________

Address: ____________________________________
Street City State Zip

Telephone: (   )____________________

Signature:________________________________ **Date:**____________________

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

A. Plaintiff's Name:____
Last First MI

If court case, Case Name & Case Number:____
____

B. Your Involvement in the Care (Attending, Consulting, Etc.):______________________________

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.):____

D. Allegations, including Patient Outcome, if Available: ______________________________
____
____
____

E. Date of Incident (mm/yy):________________ F. Date Filed (mm/yy):________________

G. Date Case Closed (mm/yy):________________

Resolution Case: ☐ Dismissed ☐ Judgment ☐ Arbitration ☐ Other
☐ Settlement out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $________________

I. Professional Liability Insurer Name (if one was involved):______________________________

J. Insurer Telephone Number: ( )________________ K. Policy Number:______________________

L. Insurer Address (Street, City, State, Zip Code):
____
____

Signature:____ **Date:**____________________

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

A. **History of Professional Liability Insurance (Please check One)**

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name:______________________________________

C. Carrier Telephone Number: ( )__________________

D. Policy Number:______________________

E. Carrier Address (Street, City, State, Zip Code):

____

____

F. Dates of Coverage: From (mm/yy): ___________ To (mm/yy):___________

G. Circumstances Involved:____

____

Signature:____ **Date:**__________________

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

A. Date of Incident (mm/yy):____________

B. Date of Complaint or Conviction (mm/yy):______________

C. Date of Resolution (mm/yy):_______________

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony):_________________________________

E. Allegation(s):____

F. Details of Incident:____

G. Actions Taken Against You:______________________________________

H. Current Status of Situation:_____________________________________

I. Medical Practice Privileges Affected as a Result of This Situation:________________________

Signature:____ **Date:**_____________________

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name:____

Last First MI

A. Describe this medical condition:____

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

C. What is the current status of your condition? __________________________________

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name	**Telephone Number**
Last First MI Degree	( )
Last First MI Degree	( )

Signature:____ **Date:**________________

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name:____
Last First MI

Describe the substance you use:

____

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

____

____

B. Monitored by State Board Mandate (Name and Address)

____

____

____

C. Monitored Voluntarily (Name and Address)

____

____

____

D. Other information about the current status of your use of substances:

____

____

E. Abstinent since (mm/yy):____________

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name:______________________________________

Address: ____
Street City State Zip

Telephone: (   )________

Signature:______________________________________ **Date:**______________

Magna Surgical Center

7456 S. State Road, Suite 300
Bedford Park, IL 60638

Phone: 773-445-9696
Fax: 888-531-2827

Acknowledgement and Release from Liability

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment of cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of this facility, I acknowledge that I am familiar with the principles and standards of the facility's accrediting organization and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to abide by the Medical Staff Bylaws, Rules and Regulations and to the Bylaws, Policies and Procedures of the facility. I further agree to abide by such facility and medical staff rules and regulations as may be from time to time enacted and I pledge to provide for continuous care of my patients, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matter relating to the consideration of my application for appointment to the medical staff.

I will not participate in any form of fee splitting. Moreover, I pledge myself to shun unwarranted publicity, dishonest money-seeking, and commercialism; to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any procedures for which I am not qualified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges, and I am familiar with the laws of this state governing the practice of medical and pledge to abide by these laws.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the facility its medical staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the facility, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the facility and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability and all individuals and organizations who provide information to the facility or its medical staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this facility, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the facility and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the facility and its staff for so doing.

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

____ Date ____________________________

Signature of Applicant

Magna Surgical Center

7456 S. State Road, Suite 300
Bedford Park, IL 60638

Phone: 773-445-9696
Fax: 888-531-2827

APPLICANT AGREEMENT

In making application for appointment to the Medical Staff of the Magna Surgical Center (the “Center”) I:

1. I have received a copy of the operation policy and related policies of the Magna Surgical Center, I agree to abide by the Bylaws, Rules and Regulations of the Medical Staff and the Magna Surgical Center, as they may be from time to time amended.

2. Pledge to provide for continuous quality care for my patients;

3. Signify my willingness to appear for interviews in regard to the application;

4. Agree to execute and deliver to the Center or Center’s representatives all documents reasonably requested by the Center or Center’s representatives as prerequisites for Medical Staff membership or in connection with such membership, including, without limitation, an Authorization for Release of Information;

5. Represent and warrant that all information provided by me is true, correct and complete in all material respects and is not misleading;

6. Agree to update and correct any information provided by me to the Center or Center’s representatives in connection with this application if such information becomes, or I later discover that such information is or becomes, false or misleading in any material respect;

7. Pledge to comply with all laws, regulations and standards relating to my services at the Center’s facilities, including without limitation: (a) all statutes and regulations regulating my profession or specialty, (b) the principles and standards of the Center’s accrediting organization applicable to ambulatory care facilities, (c) the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty or profession, (d) all prohibitions or restrictions on fee-splitting and the corporate practice of my profession or specialty, (e) the Illinois Health Care Worker Self-Referral Act, 225 ILCS 47/1 et seq., (f) Section 1877 of the Social Security Act, 42 U>S>C> 1395nn (commonly known as “Stark II” and (g) all laws and regulations relating to fraud and abuse in connection with the Medicare or Medicaid programs, including, without limitation, Section 1128B of the Social Security Act, 42 U.S.C. 1320a-7b;

8. Pledge to comply with, and agree to be subject to the Bylaws, Rules and Regulations of the Medical Staff and Center and with the Center’s policies and procedures manual, code(s) of conduct, ethics and disruptive behavior and all policies and procedures of the Center or its Medical Staff, all as amended from time to time;

9. Understand and agree that I, as an applicant for Medical Staff membership, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications;

10. Recognize that although certification by a board does not necessarily qualify me to perform certain procedures, I believe that I am qualified to perform all procedures for which I have requested privileges; and

11. Recognize that failure to adequately complete and update the application form and documents and other information submitted in connection with my application, the withholding of requested information or the providing of false or misleading information, shall, in and of itself, constitute a basis for denial, suspension or revocation of Medical Staff appointment.

12. Moreover, I hereby declare that I shall not engage in the practice of the division of fees under any guise whatsoever. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit others to collect fees for me, nor make joint fees with physicians referring patients to me for operation or consultation, nor permit any agent or associate of mine to do so. Further, I agree to comply with the principle that all physicians participating in the care of a patient, or the group practices with which they are affiliated, shall render separate bills and receipts.

As used herein, the term “Center’s representative” includes, without limitation, the Center’s Board, consulting committee(s), members, committees, Officers and staff members; the Center’s Medical Staff; all Medical Staff members, departments and committees which have responsibility for collecting or evaluating my credentials or acting upon my application; and any authorized representative of any of the foregoing.

Signature ____ Date ____________________

MAGNA SURGICAL CENTER

INITIAL SUPPLEMENTAL INFORMATIONAL FORM

Applicant's Name: ____

Health Status Attestation

By applying for privileges as indicated on my delineation of privilege form, I attest that no health problems exist that could effect my ability to perform these privileges.

Signature _________________________________ Date ________________

Continuing Medical Education

I certify that I have previously met and are continuing to meet the State of Illinois Department of Financial and Professional Regulations CME requirements for renewal of licensure. I understand that I may be asked to produce documentation supporting this certification.

Signature _________________________________ Date ________________

Information for IDPH "Single Cycle Re-Credentialing" and Federal DEA Validation

Social Security No:____

(This is required for the purpose of meeting IDPH single cycle re-credentialing requirements)

Providers Taxonomy Number ____

Identifying Information

Home Address: ____

____

Home No.: ____

Magna Surgical Center

7456 S. State Road, Suite 300
Bedford Park, IL 60638

Phone: 773-445-9696
Fax: 888-531-2827

CONSENT / RELEASE OF INSURANCE INFORMATION

Insurance Company Name & Address

____

____

____

I authorize my professional liability insurance carrier and/or insurance broker listed above to release a copy of my certificate of insurance to the Magna Surgical Center.

Please provide a photocopy at this time, and add the Magna Surgical Center, / Medical Director, as a Certificate Holder so that they are notified of any future renewals, cancellations or non-renewal.

Policy Holder Signature ____

Policy Number ____

Date ____

Magna Surgical Center

7456 S. State Road, Suite 300
Bedford Park, IL 60638

Phone: 773-445-9696
Fax: 888-531-2827

POLICY ACKNOWLEDGEMENT

MINIMUM CASE ACTIVITY REQUIREMENTS

I acknowledge that I have read the following policy:

> It is the Magna Surgical Center policy that reappointment to the Medical Staff is dependent upon meeting the established minimum case activity level of three (3) cases per year or nine (9) cases during the three-year IDPH re-credentialing cycle or at the discretion of the Governing Board.

Signature ____

Date ____

MAGNA SURGICAL CENTER

Professional Reference Questionnaire

Professional Evaluation Concerning: ___________________________

Reference Provided By:

Name (Print) M.D. /Other Degree	Signature Date
Medical Specialty	Present Professional Position
Hospital/Organization Name	Telephone Number
Streets Address	City State Zip

Please answer all questions based on your personal knowledge and direct observations. Your candor will be greatly appreciated, and your answers will be confidential, except as is necessary for accomplishing the credentialing process, or for any related due process procedures. If you need additional space to answer any question, you may use the back of the form or attach additional sheets.

I. RELATIONSHIP OR REFERENCE SOURCE TO APPLICANT

1. How long have you known the applicant?____

2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine? ____

3a. In what setting(s) and with what frequency did you observe the applicant? (i.e., office, hospital residency program, etc.; daily, weekly, monthly, infrequently). ___________________________

b. Was your observation done in connection with any official professional title or position? If so, please indicate title?____

c. What was the applicant's title or position?____

4. Are you now or about to become related to the applicant as family or through a professional partnership or financial association? Yes_____ No_____ If yes, please explain: _____

____

II. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

1. Please rate the following:

	POOR	FAIR	GOOD	EXCELLENT	NO INFO
A. Medical knowledge					
B. Technical & clinical skills					
C. Clinical judgment					
D. Pattern of resource use (necessary for hospital admission, LOS, tests, etc.)					
E. Use of consultants when needed					
F. Availability					
G. Thoroughness in patient care					
H. Interpersonal skills					
I. Ability to understand English					
J. Ability to speak English					
K. Rapport with patient/family					
L. Ability to work with physicians and Other health professionals					

MAGNA SURGICAL CENTER

Professional Reference Questionnaire – Page 2

2. Have you ever observed or been informed of any physical/mental health/drug or alcohol dependencies or other problems which the applicant has that have or could potentially impair ability to exercise all or any of the privileges requested? Please include any problems which are currently under control by medication/therapy, but which could impair ability if the medication/therapy were stopped: Yes ____ No ____ Unknown ____ Please explain:_____

   ____

3. To the best of your knowledge, has the applicant's license, clinical privileges, practice patterns, hospital staff membership or any aspect thereof, or other professional status ever been denied, challenged, investigated, suspended, revoked, modified, placed on probation, made the subject of an individual focused review, or voluntarily surrendered, or do you have knowledge of any such actions that are pending? Yes _____ No _____ Unknown _____

4. Do you know of any malpractice actions instituted or in process against the applicant?
   Yes_____ No_____ If yes, please explain:____

5. Would you be pleased to have this applicant as an associate with you in practice?
   Yes _____ No______

III. MEDICAL STAFF PARTICIPATION

1. The applicant's participation in Medical Staff affairs, and fulfillment of medico-administrative duties (e.g., quality review program participation, medical records timeliness, clarity and completeness, committee attendance, ER coverage, etc.) is generally:

   Poor _____ Fair _____ Good _____ Excellent _____ Unknown _____

   AdditionalComments:____

   ____

IV. QUESTIONNAIRE SUMMARY

1. My general recommendation concerning this applicant is:
   Recommend without reservation: ______________
   Recommend with reservation: ______________ (Please explain below)
   Not recommend: ______________ (Please explain below)

   ____

   ____

2. Please add any additional comments relevant to the applicant's medical knowledge, competence, judgment, demonstrated skills and abilities. Are there any clinical areas, procedures or severity of illness levels, which you would be concerned about allowing the applicant to manage/perform if they were in practice with you? ____

   ____

Please date and sign where indicated on Page 1. Your prompt return of this recommendation is greatly appreciated.

Thank you for your time and cooperation.