SENECA HEALTHCARE DISTRICT

P.O. Box 737
130 Brentwood Drive
Chester, CA 96020
(530) 258-2151 - Fax (530) 258-2068

APPLICATION FOR ALLIED HEALTH PROFESSIONAL STATUS

Name: ____ _____

Date: ____ _____

Instructions:

1. All information must be typed or legibly printed.
2. If more space is needed, attach additional sheets and make reference to the question being answered.
3. **INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED**; all information must be current and accurate.
4. Current copies of the following documents **MUST** accompany this application:
    a. Current licenses and certificates to practice your profession;
    b. Current DEA registration and State-controlled substance license (if applicable);
    c. Current certificate of professional liability insurance coverage from insurance carrier;
    d. Evidence of board certification (if applicable);
    e. Evidence of CMEs for past two years;
    f. Copy of Degree or Certificate from your University
    g. Scope of Practice and/or Delineation of Clinical Privileges (attached);
    h. Health Status Confirmation Form;
    i. Information Release/Acknowledgment;
    j. Copy of ECFMG certificate (if applicable);
    k. Curriculum Vitae (or resume);
    l. Picture identification (i.e., copy of your driver's license, passport) WITH AN IDENTIFIABLE PICTURE
    m. Other documents that are pertinent (e.g., ATLS, CPR, ACLS, PALS).
5. Submit the completed, signed application form to the Medical Staff Office, along with all requested documentation, the required application processing fee of $100.00 made payable to Seneca Healthcare District Medical Staff.

SENECA HEALTHCARE DISTRICT

APPLICATION FOR ALLIED HEALTH PROFESSIONAL STATUS

I. INSTRUCTIONS:		
This form should be typed or legibly printed. If more space is needed than provided, attach additional sheets and reference the question being answered.		
II. IDENTIFYING INFORMATION:		
Last Name:	First:	Middle:
Are there any other names under which you have been known? □ Yes □ No Names:		
Home Mailing Address:	City: State: ZIP:	
Home Telephone #: ( ) Home Fax #: ( )	E-mail Address: Pager #: ( )	
Birth Date: Birth Place (City/State/Country):	Citizenship: _____ (Include copy of Alien Registration Card or J1 VISA, if applicable.)	
Social Security #:	Gender: □ Male □ Female	
Specialty:	Ethnicity (voluntary):	
Subspecialties:		
III. PRESENT PRACTICE INFORMATION:		
Practice Name (if applicable)	□ Full-time □ Part-time □ Military Service Discharge Date: □ Not in practice at this time	
Office Address:	City: State: ZIP:	
Telephone #: ( )	Fax #: ( )	
Office Manager/Administrator: _____	Telephone #: ( ) Fax #: ( )	
Name Affiliated with Tax ID #: _____	Federal Tax ID #:	
What are your plans for coverage when you are unavailable?		
Other Medical Interests in Practice, Research, etc:		
IV. UNDERGRADUATE EDUCATION (Please attach additional sheets if necessary; provide complete addresses).		
College or University Name:	Degree Received: Date of Graduation:	
Mailing Address:	City: State & Country ZIP:	
Telephone #: ( )	Fax #: ( )	
College or University Name:	Degree Received; Date of Graduation:	

Mailing Address:	City: State & Country: ZIP:
Telephone #: ( )	Fax #: ( )
V. GRADUATE/PROFESSIONAL EDUCATION (Please attach additional sheets if necessary)	
College or University Name:	Degree Received: Date of Graduation:
Mailing Address:	City: State & Country: ZIP:
Graduate/Professional School:	Degree Received: Date of Graduation:
Mailing Address:	City: State & Country: ZIP:
VI. POST-GRADUATE TRAINING/EXPERIENCE	
Institution:	Program Director:
Mailing Address:	City: State & Country: ZIP:
Type of Training/Experience: Specialty:	From: To:
VII. RESIDENCIES/FELLOWSHIPS (Please attach additional sheets if necessary)	
Please include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic) in chronological order, giving name, address, city and ZIP code, and dates. Include all programs you attended, whether or not completed.	
Institution:	Program Director:
Mailing Address:	City: State & Country: ZIP:
Type of Training: Specialty:	From: To:
Did you successfully complete the program? □ Yes □ No (if no, please explain on separate sheet)	
Institution:	Program Director:
Mailing Address:	City: State & Country: ZIP:
Type of Training: Specialty:	From: To:
Did you successfully complete the program? □ Yes □ No (if no, please explain on separate sheet)	

VIII. BOARD CERTIFICATION (Evidence/copies of certification or eligibility must be attached to application)

Name of Issuing Board:	Specialty:	Date Certified / Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? □ Yes □ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

IX. OTHER CERTIFICATIONS (please attach copies)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. LICENSURE/REGISTRATIONS:		
California State License #:	Issue Date:	Expiration Date:
Registration #:	Issue Date:	Expiration Date:
Registration #:	Issue Date:	Expiration Date:
Certificate #::	Issue Date:	Valid through:
Certificate #	Issue Date:	Valid through:

XI. ALL OTHER STATE LICENSES (list all medical licenses now or previously held)		
State:	License #:	Expiration Date:
State:	License #:	Expiration Date:
State:	License #:	Expiration Date:

XII. PROFESSIONAL LIABILITY: **Coverage amounts must be at least $1,000,000 per claim/$3,000,000 aggregate.**		
Current Insurance Carrier:	Policy #:	Original Effective Date:
Mailing Address:		City: State: ZIP:
Per claim Amount: $	Aggregate Amount: $	Expiration Date:
Please explain any surcharges to your professional liability coverage on a separate sheet.		
Please list all other professional liability carriers used during the past seven years:		
Name of Carrier:	Policy #:	From: To:
Mailing Address:		City: State: ZIP:
Name of Carrier:	Policy #:	From: To:
Mailing Address:		City: State: ZIP:
Name of Carrier:	Policy #:	From: To:
Mailing Address:		City: State: ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS: attach additional sheet if necessary	
Please list all current and previous ten years of hospital affiliations, starting with most current (include assistantships, appointments, hospitals, surgery centers, institutions, corporations, military assignments etc.).	
Name and mailing address of hospital/institution, etc.:	City: State: ZIP:
Department/Status:	Appointment Date:
Name and mailing address of hospital/institution, etc.:	City: State: ZIP:
Department/Status:	Appointment Date:
Name and mailing address of hospital/institution, etc.:	City: State: ZIP:
Department/Status:	Appointment Date:

XIV. PEER REFERENCES

Please list three professional references, preferably from your specialty area, not including relatives, and only one who is an associate. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Note: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Reference:	Specialty:	Telephone #: ( )
Mailing Address:		City: State: ZIP:
Reference:	Specialty:	Telephone #: ( )
Mailing Address:		City: State: ZIP:
Reference:	Specialty:	Telephone #: ( )
Mailing Address:		City: State: ZIP:

XV. WORK HISTORY (attach additional sheet if necessary)

Chronologically list all work history activities since completion of postgraduate training; this information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below.

Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone #: ( ) Fax #: ( )
Mailing Address:		City: State: ZIP:
From:	To:	
Name of Practice/Employer:	Contact Name:	Telephone #: ( ) Fax #: ( )
Mailing Address:		City: State: ZIP:
From:	To:	
Name of Practice/Employer:	Contact Name:	Telephone #: ( ) Fax #: ( )
Mailing Address:		City: State: ZIP:
From:	To:	

XVI. MEMBERSHIP IN PROFESSIONAL SOCIETIES:

Are you a member or applicant to any county, state, or national medical societies? ☐ Yes ☐ No

Societies: _____

List professional college or academy of which you are a member:

Name:_____ Membership Status:_____ Date Elected:_____

Name:_____ Membership Status:_____ Date Elected:_____

Name:_____ Membership Status:_____ Date Elected:_____

XVII. SPECIFIC PRIVILEGES REQUESTED: Please attach Scope of Practice (or Delineation of Clinical Privileges).

XVIII. HEALTH STATUS CONFIRMATION FORM: Please complete the Health Status form (attached).

XIX. ALLIED HEALTH PROFESSIONAL CONTINUING MEDICAL EDUCATION DOCUMENTATION:

To what official recording body do you report your CME hours: _____

Please attach copies of CME certification(s) or provide the following information for each course completed (attach separate sheet, if necessary):

Date of Class	**Name of Class**	**Provider No.**	**Credit Units**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

XX. ATTESTATION QUESTIONS: Please answer the following questions. If any answer is "yes," please provide full details on a separate sheet.

A. Has your license or certificate to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary conditions, or have proceedings towards any of those ever been initiated or recommended? ☐ Yes ☐ No

B. Have your clinical privileges or Allied Health Professional status at any other hospital or health care institution ever been limited, suspended, revoked, or not renewed, or subjected to probationary conditions, or have proceedings toward any of those ends ever been initiated or recommended? ☐ Yes ☐ No

C. Has any request by you for Allied Health Professional status or for any clinical privileges ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation ever been recommended? ☐ Yes ☐ No

D. Have you ever been denied membership or renewal or been subject to any disciplinary action in any professional organization or society, or have proceedings toward any of those ends ever been initiated or recommended? ☐ Yes ☐ No

E. Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended or reduced, or have proceedings toward any of those ends ever been initiated or recommended? ☐ Yes ☐ No

F. Have you ever voluntarily relinquished any clinical privileges or a professional license or certificate while under investigation or threat of disciplinary action? ☐ Yes ☐ No

G. Have you ever been denied professional liability insurance or has your policy ever been cancelled? ☐ Yes ☐ No

H. Has any judgment or settlement been made against you as the result of a professional liability claim, or is any such claim or case pending? ☐ Yes ☐ No

I. Have you ever been convicted by a civilian or military court? ☐ Yes ☐ No

J. Have you ever been discharged for unsatisfactory service or misconduct, or forced to resign from any position? ☐ Yes ☐ No

K. Do you have any physical or mental condition that may interfere with or limit your ability to exercise any of the clinical privileges that you have requested? ☐ Yes* ☐ No

*If yes, have you sought medical attention for it? ☐ Yes ☐ No

*If yes, is there any reasonable accommodation that the hospital or Medical Staff might make to allow you to exercise the clinical privileges in a full and complete manner? ☐ Yes ☐ No

I, _____, do hereby make formal application for Allied Health Professional Status and Privileges at Seneca Healthcare District.

I hereby affirm that all information furnished by me is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial of my application or revocation of Allied Health Professional status and clinical privileges.

Furthermore, I agree and consent to the following:

1. **To appear, if requested, for interviews or inquiries regarding this application;**

2. **If granted Allied Health Professional status and clinical privileges, to maintain an ethical practice, which will include refraining from fee splitting or other inducements related to patient referral; providing for continuous care of my patients; seeking consultation or supervision as required by my license, certificate or clinical privileges or as otherwise appropriate in the best interests of patient care.**

_____

(Printed Name)

_____ _____

Signature **Date**

(Stamped Signature is Not Acceptable)

SENECA HEALTHCARE DISTRICT
MEDICAL STAFF PEER REVIEW ACTIVITY

CONFIDENTIALITY STATEMENT

As a member of the Medical Staff Committee involved in the evaluation and improvement of the quality of care rendered in the hospital, I recognize that confidentiality is vital to the free and candid discussions necessary to effective Medical Staff Peer Review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.

Furthermore, my participation in peer review and quality management activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Medical Staff or other individual involved. I understand the hospital and the Medical Staff are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including application to a court for injunctive or other relief in the event of a threatened breach of this agreement.

Date:_____ **Signature: _____**

Printed Name: _____

SIGNATURE VERIFICATION

Please provide your signature and initials below in the same way that you will write prescriptions and/or sign Medical Records.

Name (type or print): _____

Signature: _____

Initials: _____

Professional License #: _____

DEA Number: _____

UPIN Number: _____

NPI Number: _____

STATEMENT OF AUTHORIZATION AND RELEASE
FROM LIABILITY TO MEDICAL LIABILITY COVERAGE PROVIDER

(Name/Address of Insurance Entity)

_____

_____

_____

POLICY #: _____

I am applying for Allied Health Professional reappointment to Seneca Healthcare District and hereby authorize my carrier to release to the Hospital all information regarding my claims history occurring during the past ten (10) years, but not necessarily limited to:

1. Judgments entered
2. Claims settled, and
3. Cases and lawsuits pending.

Please return this information to: Seneca Healthcare District
Attention: Medical Staff Office
P.O. Box 737
Chester, CA 96020

- or -

Fax to: (530) 258-2004
Attention: Medical Staff Services

In authorizing the release of such information to the hospital, I hereby release you from liability and indemnify you for acts performed in good faith and without malice in connection with supplying of this information needed for the processing of my application for AHP appointment to Seneca Healthcare District.

Sincerely,

_____ _____
Signature of Applicant Date

_____
Printed or Typed Name and Title of Applicant

HEALTH STATUS CONFIRMATION FORM

The purpose of this form is to confirm whether you are safely and competently capable of performing the duties and responsibilities of appointment and exercising your scope of practice and/or delineation of clinical privileges as outlined.

You are encouraged, but not required, to complete this form and return it at this time to the Medical Staff Office, sealed in the enclosed envelope. The completed form shall remain in the sealed envelope and shall not be reviewed until a determination has first been made by the Medical Staff Leadership that you are professionally qualified for appointment.

If you choose not to submit this form at this time, you will be required to submit it following a determination by the Medical Staff Leadership that you are professionally qualified for appointment. However, please note that this may cause some delay in the processing of your application. Completion of this form is a necessary component of the application process and final action on your application will not be taken until this form is received and reviewed.

1. Do you have any physical or mental condition which could affect your ability to exercise the scope of practice and/or delineation of clinical privileges outlined and perform the duties of staff appointment, or that would require an accommodation in order for you to safely and competently exercise the scope of practice and/or delineation of clinical privileges outlined? ☐ **YES** ☐ **NO**

2. Have you been hospitalized at any time during the past five years? ☐ **YES** ☐ **NO**

3. Have you ever been denied health, life or disability insurance? ☐ **YES** ☐ **NO**

4. Do you have any limitations on your health, life or disability insurance? ☐ **YES** ☐ **NO**

5. Have you ever had any problems with alcohol or drug dependency? ☐ **YES** ☐ **NO**

6. Are you currently taking any medication that may affect either your clinical judgment or motor skills? ☐ **YES** ☐ **NO**

7. Are you currently under any limitations concerning your activities or workload? ☐ **YES** ☐ **NO**

8. Are you currently under the care of a physician? ☐ **YES** ☐ **NO**

If the answer is "YES" to any question, please explain and submit a report from your treating physician specifically addressing how the condition may affect your ability to exercise the scope of practice and/or delineation of clinical privileges as outlined. Please also explain any proposed accommodation.

AFFIRMATION

I understand that my appointment is conditional upon my demonstrating that I am capable of exercising my scope of practice and/or delineation of clinical privileges safely and competently and performing the duties of appointment. I affirm that all my responses provided above are accurate in accordance with the terms and conditions on the application form I submitted. I understand that the burden is on me to request any proposed accommodation and to justify its reasonableness.

Date: _____ _____

Signature of Practitioner

_____

Printed or Typed Name of Practitioner

Seneca Healthcare District

INFORMATION RELEASE/ACKNOWLEDGMENT

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications, back-ground and performance ("credentialing information and peer review information") by and between Seneca Healthcare District and other healthcare organizations (e.g., hospital medical staffs, medical groups, IPAs, HMOs, PPOs, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, license authorities, and businesses and individuals acting as their agents) for the purpose of evaluating my licensure, professional training, experience, current competence and ability to perform the privileges requested, as well as my character, conduct and judgment, ethics and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed except as required by law.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including Seneca Healthcare District, Medical Staff and authorized representatives engaged in quality assessment, peer review and credentialing on behalf of this healthcare organization, and all persons and entities who, in good faith and without malice, provide peer review and other information relevant to the appointment application to such representatives of this healthcare organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my appointment application and/or qualifications for participation at Seneca Healthcare District, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation at Seneca Healthcare District as may be required by state and federal law and regulation, including but not limited to, California Business and Professional Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. By filing an application for appointment/reappointment, and in connection with this application, I agree to be bound by the Bylaws of the hospital, and the Bylaws, Rules and Regulations of the Medical Staff, as adopted by the Governing Board and the laws of the State of California and Hospital compliance policy. During such time as this application is being processed, I agree to update the application should there be any change in the information provided. I also agree to notify Seneca Healthcare District immediately in writing of the occurrence of any of the following:

(i) the unstayed suspension, revocation or nonrenewal of my license(s);

(ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or

(iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify Seneca Healthcare District in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license(s); or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by registration of my clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any criminal law (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original; however, a stamped signature is not acceptable.

Print Name Here: _____

Signature: _____ **Date:** _____

(Stamped signature is unacceptable