

Dear Practitioner:

Please complete the attached application for health care organization privileges. Please note that “See Resume/CV” is not acceptable. The following items must be returned with your application or the verification process will not be started. This means that there will be a delay in sending your application to the health care organizations to which you are applying for privileges.

ATTACH THE FOLLOWING TO YOUR COMPLETED APPLICATION:

- ___ 1. Recent passport size photo of yourself
- ___ 2. Copy of all current License(s) and DEA Certificates (if applicable)
- ___ 3. Copy of your current face sheet of current professional liability insurance
- ___ 4. Copy of your diploma and/or training certificate(s)
- ___ 5. Copy of your certification (if applicable)
- ___ 6. Copy of your CPR, ACLS, ATLS, PALS, BLS certificates (if applicable)
- ___ 7. Copy of your current CV/Resume
- ___ 8. DD214 (prior military only)
- ___ 9. A check in the amount of \$225 to cover origination fee. (complex files will be charged \$600). Make checks payable to C CVS.
- ___ 10. CEU/CME certificates for past 36 months.
- ___ 11. Evidence of annual PPD
- ___ 12. **Nurse Practitioners with Prescriptive Authority:**
 - 1. **Attach Practice Agreement between nurse practitioner and supervising physician as required in 18 VAC 90-40-90 of the Virginia Board of Nursing regulations governing the Practice of Nursing.**
 - 2. **Attach a copy of your initial application to the Board.**

Physician Assistants:

- 1. **Attach written protocol as required in VAC 85-50-101 of the Virginia Board of Medicine Regulations governing the Practice of Physician Assistants.**
- 2. **Attach a copy of your initial application to the Board and your approval letter from the Board.**

Please mail your completed application and required documents to:

CCVS, Inc.
2201 West Broad Street, Suite 205
Richmond, VA 23220
(804) 643-2287
(804) 622-8144

**APPLICATION FOR APPOINTMENT
TO THE ALLIED HEALTH STAFF
FOR ALLIED HEALTH PROFESSIONALS**

(Please Type or Print Legibly)

Attach
Recent
Photo

Name: _____

Last Name

First Name

Middle

**SPONSORING PHYSICIAN(S) MUST BE ON STAFF AT FACILITY WHERE YOU
ARE APPLYING FOR PRIVILEGES**

Sponsoring Physician	Facility(ies) Requested

Each organization will consider this a Pre-Application until eligibility of the applicant is established. Upon establishment of eligibility, this application becomes official, and the application will be moved forward in the process. If it is determined that the applicant is not eligible for appointment, then the health care organization will notify the applicant.

PERSONAL INFORMATION

Last Name	First Name	Middle	Title
Gender	Marital Status	Maiden name (or other Names)	
Social Security #	Birth Date	Birth Place	Citizenship
Languages Spoken	Spouse's Name	NPI Number	

LIST ALL ADDRESSES: (Check preferred mailing address) Start Date of Affiliation _____

Practice Name

Primary Office Address	Suite	Telephone
City	State	Zip
		Fax

Residence Address

		Telephone
City	State	Zip
		Fax

Pager# _____ Email _____

LICENSURE/CERTIFICATIONS: (Please list all states and localities where you hold, or have held a professional license. Please provide a copy of all licenses.)

State	License Number	Date Issued	Expiration Date	Exam/Reciprocity
State	License Number	Date Issued	Expiration Date	Exam/Reciprocity
State	License Number	Date Issued	Expiration Date	Exam/Reciprocity
DEA	DEA Number	Date Issued	Expiration Date	Schedule

CERTIFICATION STATUS: (Check your present status)

Current Status Certified Qualified

Certified Or Qualified By: _____

Certified Date: _____ Expiration Date: _____

EDUCATION AND TRAINING: (Please begin with your professional education):

Institution		Degree/Major
Complete Address	From mm/yy	To mm/yy
City, State Zip	Phone Number	Fax Number
Institution		Degree/Major
Complete Address	From mm/yy	To mm/yy
City, State Zip	Phone Number	Fax Number

PEER REFERENCES:

1. Training program director, if such was completed within the past five (5) years. 2. Supervising physician at hospital or other employer from whom you have worked for in the past two (2) years. 3. Two (2) peers in your specialty who can attest to your competence and qualifications in the past two (2) years.

Name	Address	City, State Zip	Telephone/Fax
Name	Address	City, State Zip	Telephone/Fax
Name	Address	City, State Zip	Telephone/Fax

EXPERIENCE:

All time spans from your highest education to the date of this application must be accounted for on this application. If you require additional space please attach an addendum on a separate sheet of paper. "See Resume/CV" is not acceptable.

Facility	From mm/yy	To mm/yy
Address		
Position/Category/Specialty	Telephone	Fax
Facility	From mm/yy	To mm/yy
Address		
Position/Category/Specialty	Telephone	Fax
Facility	From mm/yy	To mm/yy
Address		
Position/Category/Specialty	Telephone	Fax
Facility	From mm/yy	To mm/yy
Address		
Position/Category/Specialty	Telephone	Fax

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER.

- | | | | |
|-----|----|-----|---|
| Yes | No | | Do you presently have, or ever had, any physical or mental condition which would affect your ability to exercise the clinical privileges requested safely and competently?
(Regardless of how the applicant answers this question, the application will be processed in the usual manner). |
| Yes | No | | Have you had any professional liability cases brought against you in the last five years? |
| Yes | No | | Have you had any final judgments or settlements on malpractice claims ever been paid by you or on your behalf by another entity? |
| Yes | No | | Do you currently have any pending malpractice cases? |
| Yes | No | | Has your liability coverage ever been canceled? |
| Yes | No | | Has your professional license to practice in any jurisdiction ever been limited, suspended, not renewed, refused, voluntarily or involuntarily relinquished, or revoked ? |
| Yes | No | | Have you ever had any disciplinary actions taken by any board you have been/are licensed by (including reprimands, censures, probation, etc.?) |
| Yes | No | | Are you currently charged with or have you ever been convicted of a felony or misdemeanor (other than a minor traffic violation)? |
| Yes | No | | Have you ever been refused membership on a hospital medical staff? |
| Yes | No | | Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges voluntarily or involuntarily been suspended, limited, revoked, or not renewed? If so, at what hospital? |
| Yes | No | | Have you ever voluntarily or involuntarily relinquished you hospital clinical privileges or medical staff memberships? If so, which hospital(s)? |
| Yes | No | N/A | Has your DEA number (narcotics license) or other controlled substance authorization or any state pharmaceutical certificate ever been suspended or revoked, denied, reduced or not renewed? |
| Yes | No | N/A | Have you voluntarily or involuntarily relinquished your DEA registration? |
| Yes | No | | Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization or local, state, or national professional society (including Medicare, Medicaid, any third party payor, or peer review organization)? |
| Yes | No | | Are you now or within the past five years alcohol or drug dependent? |
| Yes | No | | Are any actions currently pending against you by any federal or state regulatory authorities, or by any hospital or provider? |
| Yes | No | | Do you perform any procedure in your office for which you do not have privileges at a hospital? |

LIABILITY INSURANCE: (Please list all Insurance Carriers for the past five (5) years, beginning with the most recent.)

Carrier	Dates To/From	Claim Limit	Policy ID
Carrier	Dates To/From	Claim Limit	Policy ID
Carrier	Dates To/From	Claim Limit	Policy ID

PROFESSIONAL MEMBERSHIPS:

Society and address	Dates
Society and address	Dates

MILITARY STATUS: (Please enclose a copy of your DD-214. Reserves (Yes) (No))

Branch of Service	Date of Entry	Date of Separation	Type of Discharge
Last Duty Assignment			Station Where Separated

HEALTH CARE FACILITY AFFILIATIONS: (Please list all present and past affiliations with hospitals and/or other healthcare facilities)

Hospital Name & Address	Status	Start Date	End Date
Hospital Name & Address	Status	Start Date	End Date
Hospital Name & Address	Status	Start Date	End Date
Hospital Name & Address	Status	Start Date	End Date

Please indicate the facilities where you are seeking staff appointment:

- | | |
|---|--|
| <input type="checkbox"/> Memorial Regional Medical Center | <input type="checkbox"/> CJW Medical Center |
| <input type="checkbox"/> Richmond Community Hospital | <input type="checkbox"/> Henrico Doctors' Hospital |
| <input type="checkbox"/> St. Mary's Hospital | <input type="checkbox"/> John Randolph Medical Center |
| <input type="checkbox"/> St. Francis Medical Center | <input type="checkbox"/> Parham Surgery Center |
| <input type="checkbox"/> Sheltering Arms Rehab Hospital – Hanover | <input type="checkbox"/> Colonial Heights Surgery Center |
| <input type="checkbox"/> Sheltering Arms Rehab Hospital – South | <input type="checkbox"/> Hanover Outpatient Surgery Center |
| <input type="checkbox"/> Virginia Eye Institute | <input type="checkbox"/> Urosurgical Center of Richmond |

APPLICATION FOR APPOINTMENT/ REAPPOINTMENT

CONSENT & AUTHORIZATION FOR RELEASE OF INFORMATION

(A copy shall serve as original)

I understand and acknowledge that, as an applicant for medical staff membership at the hospital, ambulatory care center or other health care facility ("Facilities") indicated in this Application for Appointment, and/or for participation with any third party payors indicated in this Application ("Third Party Payors"), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by Facilities for medical staff membership or medical surgical privileges or by Third Party Payors for participation.

I acknowledge my pledge to provide for continuous care for my patients. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Facilities and their medical staffs and of the Third Party Payors, and agree to be bound by them in the application process and if granted membership or participation. I further understand and acknowledge that Centralized Credentials Verification Service ("CCVS") will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the reporting and information exchange activities of CCVS, Third Party Payors and Facilities as a part of the Centralized Credentials Verification Service program, as follows:

1. **Authorization of Investigation and Release of Information Concerning Application.** I hereby authorize all individuals, institutions and entities (including but not limited to administrators and members of the medical staffs of other Facilities or institutions with which I have been associated; administrators, employees and participants of other Third Party Payors with which I have been associated; and all professional liability insurers with which I have had or currently have professional liability insurance) who have knowledge concerning information requested in this Application, to consult with and release relevant information to CCVS, Third Party Payors and Facilities, their medical staffs and agents. I further authorize CCVS to release all such information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby authorize any Facilities at which I have, or have had, medical staff membership and any Third Party Payors with which I participate, or have participated, to release Disciplinary Information about any disciplinary action taken against me to CCVS, its other participating Facilities, other physician- sponsored credentialing programs and their participating Facilities, and as otherwise may be required by law. I further authorize CCVS to release Disciplinary Information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated. As used herein, Disciplinary Information means information concerning (i) any action taken by such Facilities, their administrators or medical staff or other committees to revoke, suspend, restrict or condition my privileges; (ii) any other denial of privileges to me; (iii) any other disciplinary action involving me; or (iv) my resignation prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.

3. **Release from Liability.** I hereby fully, absolutely, and unconditionally release from liability Facilities (including but not limited to those participating in the CCVS program and their medical staffs), CCVS, Third Party Payors and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this Application and the release and exchange of Disciplinary Information authorized above, including but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, CCVS, Facilities, or Third Party Payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise. I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have medical staff privileges at any Facilities participating in CCVS's credentialing program, and/or so long as I am participating with one or more Third Party Payors designated in this Application.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Facilities, CCVS and Third Party Payors and their agents are done to achieve, maintain and improve the quality of patient care. All information provided by me in the Application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical staff and/or Third Party Payors. I understand and acknowledge that the Facilities shall be solely responsible for all decisions concerning medical staff membership and the granting of medical and surgical privileges, and that Third Party Payors shall be solely responsible for all decisions concerning participation with such Third Party Payors. I further understand and acknowledge that CCVS shall have no responsibility or liability with respect to medical staff membership decisions by Facilities or participation decisions by Third Party Payors.

I further acknowledge that I have read and understand the foregoing Authorization and release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature: _____

Date: _____

Print Full Name: _____