Community Health Center

Application for Medical Staff Appointment and Clinical Privileges

Part I. Credential Review

I am applying for clinical privileges at the location(s) checked below:

☐ 6209 16th Avenue, Brooklyn, NY 11214 ☐ 21-10 Borden Avenue, Long Island City, NY 11101 ☐ Both

☐ Starbright Shelter ☐ Tillary Shelter

I. IDENTIFYING INFORMATION

Last Name **Maiden Name** **First Name** **Middle Name Initial**

Residence Address **City** **State** **Zip Code**

Home Telephone Number **Cell Phone Number** **E-mail Address**

NPI Number **Social Security Number**

Date of Birth **Place of Birth (e.g. state)** **Citizenship** **Visa Status**

II. GENERAL PROFESSIONAL INFORMATION

Specialty/Subspecialty

Other Practice/Group Name (if applicable)

Office Address **City** **State** **Zip Code** **Telephone** **Fax**

☐ This information is already on file and does not need to be updated.

III. MILITARY SERVICE INFORMATION

Dates of Service **Branch**

Address of Current Assignment **Telephone** **Fax**

☐ I have not had any military service. ☐ This information is already on file and does not need to be updated.

Community Health Center

IV. HEALTH INFORMATION

I hereby affirm that I am physically and mentally able to carry out the responsibilities of medical staff membership and exercise the privileges requested as indicated by supporting documentation that I have submitted.

Yes _______ No _______

IV. POST GRADUATE /RESIDENCY EDUCATION

Program	Address	State	Telephone Number/ Fax Number

Program completed successfully? ☐ Yes ☐ No

Program	Address	State	Telephone Number/ Fax Number

Program completed successfully? ☐ Yes ☐ No

Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? ☐ Yes ☐ No

☐ This information is already on file and does not need to be updated.

V. FELLOWSHIPS

Program	Address	State	Telephone	Fax	Dates

Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? ☐ Yes ☐ No

Program	Address	State	Telephone	Fax	Dates

Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? ☐ Yes ☐ No

☐ I have not completed any fellowships.
☐ This information is already on file and does not need to be updated.

VI. BOARD CERTIFICATION AND RECERTIFICATION

1. Certified by: ____ Date:_______________

   Certificate Number: ____ Date:_______________

   Last Recertification: _______________________________________ Date:_______________

2. Certified by: ____ Date:_______________

   Certificate Number: ____ Date:_______________

   Last Recertification: _______________________________________ Date:_______________

☐ I am not board certified. I expect to undergo board examination on or by: _________________________

☐ I plan to undergo board re-examination on or by: _______________________________________

☐ This information is already on file and does not need to be updated.

VII. LICENSES HELD

____ MD DO DDS DMD Other ________________________________
Number of current and valid NYS License Registration **Circle appropriate license**

Drug Enforcement Administration (DEA) Registration Number: ____

☐ This information is already on file and does not need to be updated.

VIII. PROFESSIONAL SOCIETY MEMBERSHIPS

____
Society

____
Society

☐ I do not belong to any professional societies. ☐ This information is already on file and does not need to be updated.

IX. CURRENT ACADEMIC APPOINTMENTS

____
Title **Institution**

____
Title **Institution**

☐ I do not have any academic appointments. ☐ This information is already on file and does not need to be updated.

X. POST-LICENSE PRACTICE or PROFESSIONAL EMPLOYMENT

Beginning with current experience, list in chronological order going back ten years. Include any military experience. Add additional pages if necessary.

____
Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

____
Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

____
Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

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Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

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Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

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Health Center/Program **Address** **Telephone** **Fax** **Dates – Month/Year)**

☐ This information is already on file and does not need to be updated.

XI. CURRENT HOSPITAL AFFILIATIONS

Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)

☐ I do not have any current hospital affiliations.
☐ Hospital affiliation information is already on file and does not need to be updated.

XII. CURRENT MANAGED CARE ORGANIZATION, MEDICAL SERVICE ORGANIZATION AFFILIATIONS

Are you a Medicare Provider? ☐ Yes ☐ No Medicare Number:________________________________

Are you registered with PECOS? ☐ Yes ☐ No PECOS Number:________________________________
(Medicare Provider Enrollment, Chain, and Ownership System)

Are you a Medicaid Provider? ☐ Yes ☐ No Medicaid Number:________________________________

Are you registered with CAQH? ☐ Yes ☐ No CAQH Number:________________________________
(Council for Affordable Quality Healthcare)

Organization	Address	Email	Telephone	Fax
Organization	Address	Email	Telephone	Fax
Organization	Address	Email	Telephone	Fax
Organization	Address	Email	Telephone	Fax

☐ I do not have any current managed care organization or medical service organization affiliations.
☐ This information is already on file and does not need to be updated.

XIII. LIFE SUPPORT CERTIFICATION

I am currently certified to perform the following life safety interventions (check all that apply):

Technique	Date Certified	Technique	Date Certified
☐ Cardiopulmonary Resuscitation (CP)		☐ Basic Life Support (BLS)	
☐ Advance Cardiac Life Support (ACLS)		☐ Pediatric Advance Life Support (PALS)	

☐ I am not current certified to perform any life safety intervention.

XIV. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Current Insurance Carrier	(Agent (if any)	Policy Number	Expiration Date

Address	Telephone	Fax

Policy Limits

List all previous professional liability insurance carriers for the past ten years.

Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax

Are there any pending professional misconduct proceedings or any pending medical malpractice actions in this state or another state? ☐ Yes ☐ No

If yes, describe the substance of the allegations in such proceedings or actions on a separate sheet.

☐ I do not have any current professional liability insurance.
☐ This information is already on file and does not need to be updated.

XV. CONTINUING MEDICAL EDUCATION

On a separate sheet of paper list:
(A) All postgraduate activities which you have attended or for which you have received credit in the past two years or

(B) If you have reported your continuing medical education activities to an authorized association, please list:
- the name of the authorized association;
- the date when you reported your hours;

(C) Include American Medical Association Physician Recognition Award and inclusive dates if appropriate.

☐ This information is already on file and does not need to be updated.

XVI. PROFESSIONAL REFERENCES

Please submit the names of three individuals we may contact for letters of recommendation for your appointment. These letters will be weighed by the end of direct clinical observation and other work with the applicant. List below the names, addresses, relationships, and the dates of association with each.

1.____

Name **Relationship** **Dates**

____

Address

____

Telephone **Fax** **Email Address**

2.____

Name **Relationship** **Dates**

____

Address

____

Telephone **Fax** **Email Address**

3.____

Name **Relationship** **Dates**

____

Address

____

Telephone **Fax** **Email Address**

☐ Professional references are currently on file and not need to be updated.

XVII. BIBLIOGRAPHY

On a separate sheet, furnish a list of scientific papers, essays, articles, and books published and papers presented at scientific meetings (include reprints).

☐ I have not published any materials. ☐ This information is already on file and does not need to be updated.

XVIII. PRACTICE INTERESTS

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

____

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____

____

XIX. MISCELLANEOUS INFORMATION

Are you now or were you subject to (provide full details for positive answers on a separate sheet):

		Yes	No
1.	Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of license or registration to practice in any jurisdiction?	☐	☐
2.	Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of Drug Enforcement Administration (DES) registration?	☐	☐
3.	Limitation, suspension, probation, revocation, denial, nonrenewal, voluntary or involuntary surrender of employment, appointment, privileges or training at any health center or healthcare related institution?	☐	☐
4.	Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff before a potentially adverse decision was made by a health center's order or healthcare facility's governing board?	☐	☐
5.	Formal investigation, corrective action, or discipline by any health center or healthcare related institution for any reason, including patient complaints?	☐	☐
6.	Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	☐	☐
7.	Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction?	☐	☐
8.	Suspension, sanction or other restriction and participation in any private, federal or state insurance program (e.g. Medicare, Medicaid)?	☐	☐
9.	Current police or agency investigation, substantiated charges or convictions for sexual harassment, sexual abuse, child abuse, elder abuse, findings pertinent to violations of patient rights, or other human rights violations?	☐	☐
10.	Criminal convictions, pending criminal proceedings, or arrest for felonies or misdemeanors?	☐	☐
11.	Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	☐	☐
12.	Resignation, withdrawal or termination of your position with the professional Association or health maintenance organization for reasons related to clinical, quality or patient care issues?	☐	☐
13.	Do you currently have any physical or mental condition (including but not limited to habitual use of or dependent on drugs or alcohol) that impairs or could impair your ability to practice medicine?	☐	☐
14.	I hereby waive any confidentiality provisions concerning, and grant HCC or its designee permission to obtain, the information requested by this application.	☐	☐

XX. AFFIRMATION OF INFORMATION

I hereby affirm under the penalties of perjury as follows: that I am the applicant named herein; that I have read the foregoing application and know the contents thereof; that the same is complete, true and accurate to the best of my knowledge and belief.

Signature: ____ Date:________________

Community Health Center

When submitting the application, please include the documents listed below or check the box in the left column if current version of the document is already on file.

On File ☑	Documents
☐	Current license or Three Year Agreement.
☐	Current DEA registration with a New York State address, if applicable to the position.
☐	Malpractice Insurance face sheet, listing HCC as a certificate holder, indicating no less than 1.3M per occurrence and 3.9M aggregate liability coverage.
☐	Excess malpractice liability insurance cover sheet, if applicable.
☐	Current curriculum vitae or resume (dates must be in month / year format).
☐	Copies of all updated certification required for the position and privileges you are applying for (may include CPR, BLS, ACLS, PALS, and Infection Control).
☐	Copy of government issued photographic identification (e.g. driver's license; passport)
☐	Written explanation for any discontinuation or lapse in time in Section XIV responses.
☐	Written explanation for "Yes" answers to questions in Section XXI.
☐	Delineation of Privilege form(s) for your specific specialty.
☐	Medical information including: (a) a recent (within the past year) health status assessment that assures freedom from health impairment which is of potential risk to patients or might interfere with the performance of duties; (b) recent (within the past year) result of a tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, or other examination result (e.g. chest X-ray) showing negative findings; (c) a certificate of immunization against rubella; and (d) a certificate of immunization against measles if born on or after January 1, 1957.

Please the application and related documents to:

Executive Director
ICL Health Care Choices, Inc.
6209 16th Avenue
Brooklyn, NY 11214
Tel.: (718) 234-0073
Fax: (718) 234-8656

Thank you.