



Community Health Center

Application for Non-Licensed 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
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Residence Address	City	State	Zip Code
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Home Telephone Number	Cell Phone Number	E-mail Address
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NPI Number	Social Security Number
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Date of Birth	Place of Birth (e.g. state)	Citizenship	Visa Status
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II. GENERAL PROFESSIONAL INFORMATION

Specialty/Subspecialty

Other Practice/Group Name (if applicable)

Office Address	City	State	Zip Code	Telephone	Fax
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This information is already on file and does not need to be updated.

III. MILITARY SERVICE INFORMATION

Dates of Service	Branch
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Address of Current Assignment	Telephone	Fax
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I have not had any military service. This information is already on file and does not need to be updated.



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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 _____

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-CERTIFICATE PRACTICE or PROFESSIONAL EMPLOYMENT

Beginning with current experience, list in chronological order going back five 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 _____

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 _____

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

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

Technique	Date Certified	Technique	Date Certified
<input type="checkbox"/> Cardiopulmonary Resuscitation (CP)		<input type="checkbox"/> Basic Life Support (BLS)	
<input type="checkbox"/> Advance Cardiac Life Support (ACLS)		<input type="checkbox"/> Pediatric Advance Life Support (PALS)	

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



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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
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Address

Telephone	Fax	Email Address
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2. _____

Name	Relationship	Dates
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Address

Telephone	Fax	Email Address
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3. _____

Name	Relationship	Dates
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Address

Telephone	Fax	Email Address
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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.



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XVIII. PRACTICE INTERESTS

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

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of Drug Enforcement Administration (DES) registration?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
4. Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff <u>before</u> a potentially adverse decision was made by a health center's order or healthcare facility's governing board?	<input type="checkbox"/>	<input type="checkbox"/>
5. Formal investigation, corrective action, or discipline by any health center or healthcare related institution for any reason, including patient complaints?	<input type="checkbox"/>	<input type="checkbox"/>
6. Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
7. Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
8. Suspension, sanction or other restriction and participation in any private, federal or state insurance program (e.g. Medicare, Medicaid)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
10. Criminal convictions, pending criminal proceedings, or arrest for felonies or misdemeanors?	<input type="checkbox"/>	<input type="checkbox"/>
11. Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
14. I hereby waive any confidentiality provisions concerning, and grant HCC or its designee permission to obtain, the information requested by this application.	<input type="checkbox"/>	<input type="checkbox"/>



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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: _____



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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
<input checked="" type="checkbox"/>	
<input type="checkbox"/>	Current license or Three Year Agreement.
<input type="checkbox"/>	Current DEA registration with a New York State address, if applicable to the position.
<input type="checkbox"/>	Malpractice Insurance face sheet, listing HCC as a certificate holder, indicating no less than 1.3M per occurrence and 3.9M aggregate liability coverage.
<input type="checkbox"/>	Excess malpractice liability insurance cover sheet, if applicable.
<input type="checkbox"/>	Current curriculum vitae or resume (dates must be in month / year format).
<input type="checkbox"/>	Copies of all updated certification required for the position and privileges you are applying for (may include CPR, BLS, ACLS, PALS, and Infection Control).
<input type="checkbox"/>	Copy of government issued photographic identification (e.g. driver's license; passport)
<input type="checkbox"/>	Written explanation for any discontinuation or lapse in time in Section XIV responses.
<input type="checkbox"/>	Written explanation for "Yes" answers to questions in Section XXI.
<input type="checkbox"/>	Delineation of Privilege form(s) for your specific specialty.
<input type="checkbox"/>	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.