CLINICAL PROVIDER CREDENTIALING FORM

Please fill in the information below legibly and completely as possible. Include copies of the supporting documentation with your application.

Please provide photocopies/attach photos, if submitting electronically, of the Supporting Documentation items:

- ☐ Copy of Texas Driver's License or ID
- ☐ Current copy of Texas Professional license
- ☐ Current copy of DEA Certificate
- ☐ Current copy of DPS Drug Certificate
- ☐ Current copy of Malpractice Insurance
- ☐ Current copy of CPR/AED Card
- ☐ Current copy of TB Skin Test

PERSONAL INFORMATION

Name: _____

Home Address: _____

Home Phone: _____ Cell Phone:_____

Date of Birth:_____ Social Security #:_____

Other Names Used:_____

PRIMARY EMPLOYMENT

Name of primary employer: _____

Physical office address: _____

Telephone: ( )_____ Fax: ( )_____ E-mail:_____

Mailing address if different from above:_____

_____

EDUCATION

School Name:_____

Address: _____

Dates attended: From:_____ To:_____

Graduation Date:_____ Degree Earned:_____

POST GRADUATE TRAINING

Institution:_____

Address: _____

Dates attended: From:_____ To:_____

Type of Training/Specialty:_____

Was the program successfully completed?

☐Yes ☐No ☐In Progress Expected Completion Date _____

Institution:_____

Address: _____

Dates attended: From:_____ To:_____

Type of Training/Specialty:_____

Was the program successfully completed?

☐Yes ☐No ☐In Progress Expected Completion Date _____

LICENSURE

List all active professional licenses:

State	Type	Number	Date of Issue	Expiration Date

CERTIFICATIONS

Specialty:_____ Board Certified Yes No

Board Name:_____

Date Qualified: _____ Date Qualification Expires:_____

HOSPITAL PRIVILEGES

List healthcare organizations where you are currently privileged:

Organization	City	State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROVIDER INFORMATION

DPS Number: _____ ☐ I do not have a DPS number

DEA Number: _____ ☐ I do not have a DEA number

NPI Number: _____ ☐ I do not have a NPI Number

SANCTIONS/DISCIPLINARY ACTIONS

Have you ever had any actions taken against your license to practice or professional certification, including restriction or suspension, in the last ten years**?**

☐Yes ☐No

Have any professional disciplinary actions been taken against you in the last ten years?

☐Yes ☐No

CLAIMS INFORMATION

1. Have you ever been denied professional liability insurance or has your coverage ever been canceled? ☐ Yes ☐ No
If yes, please explain:_____

_____

2. Are there currently pending or have there been any malpractice claims, judgments or settlements involving your professional practice in the last ten (10) years? ☐Yes ☐No
If yes, please complete case specific liability claims summary below.

Month and year of occurrence (event precipitating claim): _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/was your status: ☐Primary Defendant ☐Co-Defendant ☐Other

Please provide specifics in reference to the event: _____

_____

_____

_____

_____

Current Status: _____

_____

HEALTH FITNESS STATEMENT

Healthcare Professional's Name:_____

Date of Birth:_____

I,_____(Applicant/Practitioner's Name) attest that I am fit to perform the care, treatment, and other services provided at Casa El Buen Samaritano. Further, the substantiation of this fitness may be confirmed by Casa El Buen Samaritano's medical director, the hospital where I may be privileged, or any other individual designated by the organization.

I further attest that I meet ongoing continuing education requirements not only to maintain any licensure or certification, but also to maintain practice skills and knowledge in the specific scope of patient care services I provide to patients at Casa El Buen Samaritano.

_____ _____

Applicant/Practitioner's Signature Date

_____

Applicant/Practitioner's Printed Name

AUTHORIZATION AND CONSENT

I fully understand that any misstatements or omissions in this application constitute cause for denial or termination of privileges. All information submitted by me in this application is true to the best of my knowledge.

In making this application, I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of Casa El Buen Samaritano, to make decisions as appropriate to the patient's needs, to maintain my practice knowledge and skills current through continuing education opportunities, to abide by the bylaws, rules and regulations of Casa El Buen Samaritano, and to participate in and cooperate fully with all programs to improve quality and reduce risks. I agree to participate in the review of records and documents relating to patient care and services, and to subject my performance to the review by Casa El Buen Samaritano and its representatives for the purpose of improving the quality of care and services and reducing risks, and I hold Casa El Buen Samaritano and its representatives free of all liability for such actions.

I hereby release from liability Casa El Buen Samaritano and all its representatives for their acts performed in connection with obtaining and evaluating my application, credentials and qualifications. I hereby release from any liability any and all individuals and organizations that provide information to Casa El Buen Samaritano or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and privileges and I hereby consent to the release of such information.

I hereby accept that I will abide by the requirements for coverage by the Federal Tort Claims Act, will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims. I understand that if I am made an offer for privileges or functions that an evaluation of my physical and mental fitness may be requested consistent with the requirements for liability coverage by the Federal Tort Claims Act.

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

I understand that my privileges with Casa El Buen Samaritano, if any, may be terminated at any time without cause.

_____ _____

Applicant/Practitioner's Signature Date

_____

Applicant/Practitioner's Printed Name

PRIVILEGES REQUEST FORM

Name of Healthcare Professional:_____

Core Privileges:

☐ Initial and ongoing assessment of a patient's medical, physical, and psychosocial status, including: conduct history and physical; develop treatment plan; provide patient education; order tests, examinations, medications, and therapies; write progress notes in clinic medical record.

Special Procedures:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Acknowledgement of Practitioner

I understand that in exercising clinical privileges granted, I am constrained by medical staff policies, rules, and regulations and b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situations my actions are governed by the applicable section of the Medical Staff bylaws.

_____ _____

Applicant/Practitioner's Signature Date

_____

Applicant/Practitioner's Printed Name