



# RN/LVN 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 CPR/AED Card
- Current copy of Specialty Certifications (If Applicable)
- Current copy of TB Skin Test

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## 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

State	Type	Number	Date of Issue	Expiration Date

**CERTIFICATIONS**

Specialty: \_\_\_\_\_ Board Certified Yes No

Board Name: \_\_\_\_\_

Date Qualified: \_\_\_\_\_ Date Qualification Expires: \_\_\_\_\_

### 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: \_\_\_\_\_

\_\_\_\_\_

Last Name, First Initial: \_\_\_\_\_

**HEALTH FITNESS STATEMENT**

Healthcare Professional's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ (applicant'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's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant'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's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Printed Name

## NURSING PRIVILEGES REQUEST FORM

Name of Healthcare Professional: \_\_\_\_\_

- Take patient vital signs, update patient medication record, allergy lists and social history.
- Perform CLIA-waived laboratory testing, including urine dipstick tests, urine pregnancy tests, urine microalbumin tests, fecal occult blood tests, strep tests, and similar exams.
- Draw blood and collect and prepare specimens for outside laboratory testing.
- Perform EKG tests and provide reports to ordering provider.
- Conduct wound care and assessments.
- Administer PRN medications (blood pressure, breathing treatments, breathing treatments with medications ordered by a provider.
- Conduct Nurse Visits for patient education and assessment.
  - Hypertension Management
  - Diabetes Management
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- Other specialty privileges: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Acknowledgement of Volunteer

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's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Printed Name