CCMH
CARROLL COUNTY MEMORIAL HOSPITAL

CARROLL COUNTY MEMORIAL HOSPITAL

1502 North Jefferson | Carrollton, Missouri 64633 | Phone: (660) 542-1695 | Fax: (660) 542-1944

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Dear Practitioner:
Thank you for choosing Carroll County Memorial Hospital. If you have not completed the pre-application process, contact the Medical Staff Office.

Instructions:
This application form must be typed or clearly printed using black ink only. Provide all requested information. If more space is needed, additional sheets may be attached. Unfortunately, we are not able to accept submission of a curriculum vitae or resume in lieu of completing this application form. We require all information to be entered on the application form. Responses of "Refer to CV" will **not** be accepted and the application form will be returned to you for completion.

So that it is understood that you did not intentionally omit an item, type or print N/A (Not Applicable) beside those items that do not apply to you, unless instructions indicate otherwise. Failure to complete this form in its entirety will delay the credentialing process and your appointment to the Medical Staff. Misrepresentations, inaccuracies, or falsification of information can be grounds for termination of Medical Staff appointment and associated clinical privileges, and reporting to the National Practitioner Databank.

TIPS FOR EXPEDITING YOUR APPLICATION:

- Fill out all of the forms completely
- Account for all time periods since the completion of medical school. If gaps in practice or training are identified it could delay the process.
- Provide complete addresses for prior education, practice sites, work/hospital affiliations, and references. Contact names, phone and/or fax numbers are also extremely helpful.
- Provide a list of all liability carriers for the past 5 years.
- Provide full explanations to affirmative responses as required on the application form

The application and all of its supporting documents and policies are available on our website, www.carrollcountyhospital.org under the "Medical Professionals" section.

The Medical Staff Office will notify you of your appointment upon final approval. Questions regarding the application and/or documents should be directed to the Medical Staff Office by phone at 660-542-1695 or by email to credentialing@ccmhospital.org

Sincerely,

Cassy Buehler

Cassy Buehler
Credentialing Specialist

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APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Full Name: _____ Professional Degree: _____

Date of Birth: _____ Social Security Number: _____

Place of Birth: _____ Citizenship: _____

Office Name: _____

Office Address: _____
Street City State Zip Code

Residence Address: _____
Street City State Zip Code

Office Telephone: _____ Residence Telephone: _____

Emergency Contact: _____ Phone Number: _____

Medical Staff Status Requested:

☐ **Active** – Must reside or have office within close proximity to the hospital, can admit patients without limitation.	☐ **Consulting** – Must possess specialized skills needed for consultation, may not admit patients to the hospital.
☐ **Hospitalist** – practitioner/group contracted by the Hospital to provide coverage of inpatients and consultation in Emergency Room if requested.	☐ **Locum Tenens** – practitioner/group contracted by the Hospital to provide coverage for defined periods of time.
☐ **Emergency Room** – Practitioner/group contracted with hospital for provision of services in the emergency department.	☐ **Courtesy** – Not active in the hospital and honored by emeritus positions.

LICENSES AND REGISTRATIONS – Please List all active licenses and provide a copy.

- Missouri State License _____
- Other State Licenses _____
- NPI Number _____
- Medicaid Provider Number _____
- Medicare Provider Number _____
- Controlled Substances
  a) Federal DEA Number _____
  b) Missouri BNDD Number _____

EDUCATION & TRAINING (Please list date as MM/YY)

Medical School: _____
Name City/State Dates Attended Degree

Internship: _____
Name City/State Dates Attended Specialty

Residency: _____
Name City/State Dates Attended Specialty

Fellowship: _____
Name City/State Dates Attended Specialty

BOARD CERTIFICATION

Board Name	Certified (mm/yyyy)	Recertified (mm/yyyy)	Qualified for Exam (mm/yyyy)
______________________	________	________	____________
______________________	________	________	____________

Are you currently applying for board certification? Yes _______ No _________

PROFESSIONAL SOCIETY MEMBERSHIPS/FELLOWSHIPS (List all Current)

____

____

OTHER CERTIFICATIONS

____

____

CURERNT HOSPITAL AFFILIATIONS – Please list all facilities that you currently have medical staff membership or privileges granted. Attach additional sheets as necessary

Hospital/Practice Name:	**Dates of Affiliation:** **From**: / / **To:** / /		
Address:	**City**	**State**	**Zip**

Hospital/Practice Name:	**Dates of Affiliation:** **From**: / / **To:** / /		
Address:	**City**	**State**	**Zip**

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Hospital/Practice Name:	**Dates of Affiliation:** **From**: / / **To:** / /		
Address:	**City**	**State**	**Zip**

Hospital/Practice Name:	Dates of Affiliation: From: / / To: / /		
Address:	City	State	Zip

PROFESSIONAL WORK HISTORY (Include Military)
Please include all work history from residency to present. Gaps greater than **30** days MUST be explained. Attach additional sheets if there is insufficient space and/or to explain gaps greater than 30 days.

Name and Nature of Affiliation:	Dates of Affiliation: From: / / To: / /			
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone:
Reason for Discontinuance if No Longer Affiliated:				

Name and Nature of Affiliation:	Dates of Affiliation: From: / / To: / /			
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone:
Reason for Discontinuance if No Longer Affiliated:				

Name and Nature of Affiliation:	Dates of Affiliation: From: / / To: / /			
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone:
Reason for Discontinuance if No Longer Affiliated:				

Name and Nature of Affiliation:	Dates of Affiliation: From: / / To: / /			
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone:
Reason for Discontinuance if No Longer Affiliated:				

REFERENCES

Name at least three medical or health care professionals who have personal knowledge of your clinical knowledge and judgement, patient care/procedural skills, communication and interpersonal skills, professionalism, practice-based learning and improvement, systems-based practice, health status and who will provide specific written comments on these matters upon request from Medical Services authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time. Preferably, the individuals should not be related to you by family or recently initiated or impending professional partnership/financial association. (Requested sources: Program Director of residency training program, department chairman/service chief, or practitioners in same specialty).

Name: Professional Degree/Title:				
Complete Address:	City:	State:	Zip:	Phone: Fax:

Name: Professional Degree/Title:				
Complete Address:	City:	State:	Zip:	Phone: Fax:

Name: Professional Degree/Title:				
Complete Address:	City:	State:	Zip:	Phone: Fax:

PROFESSIONAL LIABILITY INSURANCE – Must provide the last 5 years of coverage and a photocopy of your current policy.

Insurance Company: _____
Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

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Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

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Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

Insurance Company: _____
Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

Insurance Company: _____
Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? If yes, please provide explanation on separate sheet.	☐ Yes	☐ No
Has your malpractice ever been denied, revoked, or canceled? If yes, please provide explanation on separate sheet.	☐ Yes	☐ No
Has your professional liability insurer ever refused to renew your policy or placed limitations on the scope of your coverage, or has any professional liability carrier ever expressed any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage? If yes, please provide explanation on separate sheet.	☐ Yes	☐ No
Are there any exclusions on your current liability insurance? If yes, please provide explanation on separate sheet.	☐ Yes	☐ No

HEALTH STATUS

Do you have a physical or mental health condition, which may adversely affect your ability to competently and safely perform the essential functions of a practitioner in your specialty area of practice without posing a risk of harm to your patients? If Yes, Please explain.	☐ Yes	☐ No
Do you have a history of chemical dependence or substance abuse that may adversely affect your ability to competently and safely perform the essential functions of a practitioner in your specialty area of practice without posing a risk of harm to your patients? If Yes, please explain.	☐ Yes	☐ No
Can you perform these functions and the privileges, which you have requested, with or without reasonable accommodations? If "No" please explain.	☐ Yes	☐ No

CONFLICT OF INTEREST DISCLOSURE:

List and describe any potential conflict(s) of interest with the Hospital or its related entities. (Including ownership or contractual interest of the Application or his or her immediate family members might have with the Hospital or with entities that do business with the hospital.)
If none, please check here ☐

_____

_____

RESIGNATIONS, SUSPENSIONS, OR ACTIONS - If yes, please provide a full explanation on a separate sheet.

Have you ever been disciplined by any State Board of Medical Examiners or Professional Conduct Board or ever been reprimanded, or fined by any State agency that disciplines physicians or allied health professionals? Has your authorization to practice in any jurisdiction (State or County) ever been revoked, voluntarily/involuntarily suspended, or subjected to probation or any conditions or limitations?	☐ Yes	☐ No
Has your DEA and/or controlled substances registration ever been voluntarily/involuntarily suspended, revoked, or otherwise limited?	☐ Yes	☐ No
Have your privileges or membership in any hospital or institution ever been denied, voluntarily/involuntarily suspended, reduced, or not renewed or have disciplinary proceedings been brought against your by any medical organization?	☐ Yes	☐ No
Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical organization?	☐ Yes	☐ No
Has any action, including investigation, ever been undertaken (pending or completed) of your status in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes	☐ No
Has any action, including investigation, ever been undertaken (pending or completed) of your professional school faculty position or membership?	☐ Yes	☐ No
Have you ever been or are your currently suspended or excluded from participation in any government program including Medicare or Medicaid, or have sanctions (including civil money penalties) ever been imposed against you by any governmental agency?	☐ Yes	☐ No
Have you ever been convicted of a felony or are you presently indicted for a felony?	☐ Yes	☐ No
Have you had any civil or criminal charges or convictions (other than traffic violations) during the last five years?	☐ Yes	☐ No
Do you have any charges currently pending? (If yes, please provide full explanation on a separate sheet, including resolution of charges)	☐ Yes	☐ No
Has any action been undertaken, whether still pending or completed, against you by any governmental agency or law enforcement body for your alleged failure to comply with laws, statues, regulations, or other legal requirements, which may be applicable to the practice of your profession or rendering service to patients?	☐ Yes	☐ No
Have you ever been the subject of a focused review required by a PSRO, PRO, or similar agency? (If yes, please provide full explanation on a separate sheet.)	☐ Yes	☐ No

CONDITIONS OF APPLICATION:

By applying for appointment to the Medical Staff of Carroll County Memorial Hospital,

I hereby:

Signify my willingness to appear for interviews in regard to my application;

Authorize the Hospital, its Medical and Allied Health Staff and their representatives to consult with my prior and current associates and others who may have information bearing on my clinical knowledge and judgement, patient care/procedural skills, communication and interpersonal skills, professionalism, practice-based learning and improvement, systems-based practice, health status, and other qualifications for membership and the clinical privileges I request;

Consent to the inspection by the Hospital, its Medical and Allied Health Staff and their representatives of all documents that may be material to an evaluation of my qualifications and competence; Consent to the release of such information;

Release from liability all representatives of the Hospital and its Staff for their acts performed and statements made in good faith and without malice in connection with evaluating my application and my credentials and qualifications;

Release from liability any and all individuals and organizations who provide information to the Hospital or the Medical and Allied Health Staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for Staff appointment and clinical privileges;

Acknowledge that I have received, or been given access to and read the CCMH Bylaws of the Medical/Allied Health Staff and any other manuals and policies relevant to the application process and generally relating to Staff membership and clinical privileges and to the consideration of my application for appointment to the Staff and for clinical privileges;

Acknowledge that the provisions of said CCMH Staff Bylaws relating to the confidentiality and release from liability are express conditions to my application for, and acceptance of, Staff membership and the continuation of such membership and my exercise of clinical privileges;

Pledge to maintain an ethical practice, to provide for continuous care for my patients and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility;

Agree to keep Hospital representatives informed of any change made proposed in the status of my professional license to practice, DEA or other controlled substances registration, malpractice insurance coverage, and membership or clinical privileges at other institutions, and on the status of current or initiation of new malpractice claims;

Acknowledge that I am an applicant for CCMH Medical Staff membership and privileges, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications and acknowledge that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the Medical and Allied Health Staff.

Acknowledge awareness of EMTLA and HIPAA rules and regulations and hereby agree to abide by such.

All information submitted by me in this application is true and complete to my best knowledge and belief.

Applicant Signature:_____ Date: _____

Applicant Printed Name: _____

Carroll County Memorial Hospital will treat this application and any information secured in connection therewith in confidence and will employ all reasonable safeguards to prevent the unauthorized disclosure of any such information.

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FOR MEDICAL STAFF OFFICE USE ONLY

Date Application Received by Medical Staff Office**:** _____

Credentials Committee: *Based on the evaluation of the education, training, current competence, health status, skill, character, and judgement of the applicant the following recommendations are made*:

_____ Medical Staff membership be granted
_____ Medical Staff membership be modified as follows: _____
_____ Medical Staff membership not be granted

_____ _____
Credentials Committee Representative Date

Medical Staff Committee: *Based on the evaluation of the education, training, current competence, health status, skill, character, and judgement of the applicant and recommendations of the Credentials Committee, the following recommendations are made*:

_____Concur with recommendation(s) of the Credentials Committee and forward these recommendations to the Governing Board for consideration.

_____Do not agree with the recommendations of the Credentials Committee and instead make the following recommendations: _____
_____

_____ _____
Medical Staff Committee Representative Date

Governing Board: *Based on the evaluation of the education, training, current competence, health status, skill, character, and judgement of the applicant and on the recommendations of the Medical Staff Committee, the following action is taken:*

_____ Concur with and approve the recommendation(s) of the Medical Staff Committee.
_____ Do not concur with the recommendations of the Medical Staff Committee. Action taken is documented in Board Minutes.

_____ _____
Governing Board Representative Date

Effective Dates of Appointment: _____ to _____

Carroll County Memorial Hospital
CONFIDENTIALITY STATEMENT AND ACKNOWLEDGEMENT
MEDICAL AND ALLIED HEALTH STAFF MEMBER

I understand and recognize that in the performance of my duties at Carroll County Memorial Hospital ("Hospital"), I must hold all Protected Health Information, as defined in 45 C.F.R. § 160.103, and all Hospital information to include risk management, quality assurance, and peer review and medical and allied health staff credentialing, in strict confidence. I agree to respect the confidentiality of any information obtained in connection with my responsibilities as a medical and/or allied health staff member.

I understand that if I am involved in investigating information pertaining to patients and employees as well as other medical and/or allied health staff members and other professionals, I will have the responsibility of ensuring the privacy and confidentiality of any information gathered through the course of these investigations and reporting of such information.

I hereby acknowledge that I received a copy of Carroll County Memorial Hospital's HIPAA policies and procedures ("HIPAA Policies") and other Hospital policies on my initial appointment to the medical staff. I have read and understand these documents, and further understand the possible consequences if I fail to comply with the requirements that apply to me as described therein. I understand copies of these documents are available to me at any time upon my request. To the best of my knowledge and belief, I have not been, nor am now, involved in any situation which should be reported pursuant to the HIPAA Policies and other Hospital policies, except such situation or situations as have already been reported by me in writing if any. I have not used, and will not use, any confidential patient information or proprietary business information obtained from Carroll County Memorial Hospital outside the scope of my association with the Hospital or for any unlawful purpose.

I further understand that Carroll County Memorial Hospital has policies and procedures to assure compliance with regulations promulgated under the Health Insurance Portability and Accountability Act. I agree to abide by all such policies and procedures. I further agree to immediately report to the Privacy and Security Officer any suspected or actual unauthorized use, disclosure, acquisition or access to Protected Health Information or any loss of a mobile device that stores or transmits Protected Health Information including but not limited to PDAs, laptops, and/or smart phones.

I agree that I will not post or transmit any confidential or protected health information related to the Hospital's medical staff, employees, Workforce members, contractors, patients, patients' families or other confidential or proprietary information to any social networking site, website, blog, tweet or similar site or function. I understand this provision is intended to protect the confidential information created and maintained in the course of my association with the Hospital related to patient care and the Hospital's business operations, but is not intended to in any way limit my right to discuss conditions of employment.

Any breach of confidentiality or failure to comply with HIPAA Policies and other Hospital policies will represent a failure to meet the professional and ethical standards of the medical and/or allied health staff and constitute a disruption to the operations of Carroll County Memorial Hospital. If it is determined that a breach of this type has occurred, the medical staff may undertake appropriate corrective action. This agreement will become part of my credentials file.

_____ _____
Date Printed or Typed Name

_____
Signature