

A HELPFUL TIP ON COMPLETING THIS FORM:

For your convenience, you may find it useful to complete this form by typing in the form fields of this PDF file before printing it out. The result will be cleaner and more easily edited.
Be sure to save the file to your computer for your records.

THE VERIFICATION GROUP

Application for Medical Staff Appointment & Clinical Privileges

PRACTITIONER

Return completed application to:

THE VERIFICATION GROUP
POST OFFICE BOX 14023
17 NORTHTOWN DRIVE
JACKSON, MS 39236
601/957-9754
FAX 601-957-9188

E-MAIL: TVG@JAM.RR.COM

WEB-SITE: www.Theverificationgroup.com

THE VERIFICATION GROUP has developed this form, all rights reserved

I. INSTRUCTIONS:

- This form should be typed or legibly printed in black or blue ink
- Please answer all questions completely and fully. If not applicable, please response with N/A
- If more space is needed, attach additional sheets and reference the question being answered
- Enclose current Curriculum Vitae, copies of current license(s); DEA certificate; Professional Liability Face Sheet; Drivers License; Social Security Card; Board Certification, if applicable, ECFMG certificate, if applicable and CME certificates.
- Incomplete applications cannot be processed and this will delay the credentialing process

STAFF CATEGORY:*(please check the appropriate box)*

- Active
 Courtesy
 Consulting

PRIVILEGES REQUESTED:*(please list the specialty of privileges desired)*

II. PERSONAL IDENTIFICATION INFORMATION:

Last Name:

First:

M.I.:

Degree:

Any other name under which you have been know:
(please provide)

Home Mailing Address:

Home Phone:

City:

State:

Zip:

County:

Marital Status: Single Married

Spouse:

Gender: Male Female

Date of Birth:

Social Security #:

Place of Birth: City:

State:

Citizenship:

Ethnic Origin(optional)

If NOT a U.S. citizen, are you authorized to work in the United States? Yes No N/A (Attach copy Alien Registration card)

III. PRACTICE INFORMATION:Practice Name: *(if applicable)*

Type of Practice: *(check the appropriate box)* Solo Group Single Specialty Multi-Specialty

Practitioner(s) Providing Coverage with EQUAL or GREATER staff category *(attach roster if more space required)*

Name

Specialty

PRIMARY OFFICE/CLINIC MAILING ADDRESS:

City:

State:

Zip:

County:

Office Manager/Administrator:

Contact:

Telephone:

Fax:

Pager:

Answering Service:

Cellular Phone:

E-Mail / Internet Address:

Tax ID Number:

Does this location provide Handicap Accessibility? Yes No

Do you have a preference for contact after hours: Pager _____ Answering Service _____ Office Number _____

SECONDARY OFFICE/CLINIC MAILING ADDRESS:

City:	State:	Zip:	County:
Telephone:	Fax:	Contact:	
Does this location provide Handicap Accessibility? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TERTIARY OFFICE/CLINIC MAILING ADDRESS:

City:	State:	Zip:	County:
Telephone:	Fax:	Contact:	
Does this location provide Handicap Accessibility? <input type="checkbox"/> Yes <input type="checkbox"/> No			

LIST YOUR OFFICE HOURS FOR EACH FACILITY:

Location:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Primary							
Secondary							
Tertiary							

LIST ALL LANGUAGES OTHER THAN ENGLISH THAT ARE SPOKEN FLUENTLY AT EACH OFFICE:

Primary:	Self:	Staff:
Secondary	Self:	Staff:
Tertiary:	Self:	Staff:

Indicate which address you wish to receive correspondence. (Please provide address)

Address:	City:	State:	Zip:
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IV. EDUCATION / TRAINING / HOSPITAL PRIVILEGES

UNDERGRADUATE / PROFESSIONAL TRAINING INFORMATION:

Institution:	Degree:	Graduation Year:	
Address:	Dates of Attendance:		
City:	State:	Zip:	Country:

MEDICAL SCHOOL INFORMATION:

Institution:	Degree:	Graduation Year:	
Address:	Dates of Attendance:		
City:	State:	Zip:	Country:

INTERNSHIP / RESIDENCY INFORMATION:

Institution:		Type of Training:	
Address:		Dates of Attendance:	
City:	State:	Zip:	Country:
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Program Director:	

RESIDENCY / FELLOWSHIP INFORMATION:

Institution:		Type of Training:	
Address:		Dates of Attendance:	
City:	State:	Zip:	Country:
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Program Director:	

RESIDENCY / FELLOWSHIP INFORMATION:

Institution:		Type of Training:	
Address:		Dates of Attendance:	
City:	State:	Zip:	Country:
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Program Director:	

RESIDENCY / FELLOWSHIP INFORMATION:

Institution:		Type of Training:	
Address:		Dates of Attendance:	
City:	State:	Zip:	Country:
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Program Director:	

V. MILITARY SERVICE*(Attach copy of DD Form 214)*

Branch of Military:	Location:
Type of Affiliation:	Dates:

VI. LICENSURE / CERTIFICATION:*(Please attach copies for documentation)*

State License Number:	State:	Issue Date:	Expiration Date:
State License Number:	State:	Issue Date:	Expiration Date:
Controlled Substance Number:	State:	Issue Date:	Expiration Date:
Federal DEA Registration Number:			Expiration Date:
Medicare Provider Number:	Medicaid Provider Number:	UPIN:	
ECFMG Number:	Certification Date:		
VISA Number:	Issue Date:	Expiration Date:	

VII. SPECIAL CREDENTIALS/TRAINING: (ie, BLS, ACLS, ATLS, PALS and other special procedures)

NOTE: Indicate and enclose special certificates you may possess for additional procedures

Procedure:

Date Issued:

Date of Expiration:

Procedure:

Date Issued:

Date of Expiration:

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

*American Board of Medical Specialties

*American Osteopathic Association

*Royal College of Surgeons

Name of Issuing Board

Certification #

Date of Certification/Recertification

Expiration Date

1.)

2.)

3.)

4.)

Have you ever taken and failed a certification exam? Yes No

If yes, specify: _____

Have you applied for Board Certification other than those listed above?

 Yes No

If so, list Board(s) and date(s).

If not certified, are you actively involved in the certification process? Yes No

If no, describe your intent for certification, and date of admissibility for certification on a separate sheet.

IX. PROFESSIONAL SOCIETY MEMBERSHIP / FELLOWSHIPS

List all current and pending, including offices held.

X. CURRENT HOSPITAL / INSTITUTIONAL AFFILIATIONS

There should be no unexplained gaps. Including teaching appointments

(A.) PRIMARY HOSPITAL AFFILIATION:

Department:

Staff Category:

Dates of affiliation: From:

To:

(B.) ADDITIONAL HOSPITAL AFFILIATION:

Department:

Staff Category:

Dates of affiliation: From:

To:

(C.) ADDITIONAL HOSPITAL AFFILIATION:

Department:

Staff Category:

Dates of affiliation: From:

To:

(D.) ADDITIONAL HOSPITAL AFFILIATION:

Department:

Staff Category:

Dates of affiliation: From:

To:

PREVIOUS HOSPITAL AFFILIATION: within the last ten (10) years.			
(E.) Hospital:			
Department:		Staff Category:	
Dates of affiliation: From:		To:	
(F.) HOSPITAL			
Department:		Staff Category:	
Dates of affiliation: From:		To:	
XI. PREVIOUS PRACTICE /WORK HISTORY (Last 10 years) This information must be complete. A Curriculum Vita is not sufficient.			
1.) Name of Practice/Employer:			Contact Name:
Mailing address:			Telephone:
City:	State:	Zip	Dates: from to
2.) Name of Practice/Employer:			Contact Name:
Mailing address:			Telephone:
City:	State:	Zip	Dates: from to
3.) Name of Practice/Employer:			Contact Name:
Mailing address:			Telephone:
City:	State:	Zip	Dates: from to
XII. PEER REFERENCES:			
List <u>3</u> professional references, one of which may be a partner or professional associate. Do <u>not</u> list program directors previously listed.			
NOTE: References must be from individuals who are directly familiar with your work, either through direct clinical observation or close working relations. Peers from the same specialty are preferred.			
1.)Name:		Title:	Telephone:
Mailing address:			
City:	State:	Zip:	
2.)Name:		Title:	Telephone:
Mailing address:			
City:	State:	Zip:	
3.)Name:		Title:	Telephone:
Mailing address:			
City:	State:	Zip:	

XIII. PROFESSIONAL LIABILITY INFORMATION: (Answer in full. There must not be any gaps in coverage.)

1.) Current Insurance Carrier:

Street Address:

City: State: Zip:

Coverage Amount: *(Individual/Aggregate)* Policy No.:

Date of Coverage: Coverage Expiration:

Type of Coverage: Claims Made Occurrence

Agent: Telephone:

Address: City: State: Zip:

2.) Previous Insurance Carrier: Policy No.:

Street Address:

City: State: Zip:

Date of Coverage: Coverage Expiration:

Type of Coverage: Claims Made Occurrence

3.) Previous Insurance Carrier: Policy No.:

Street Address:

City: State: Zip:

Date of Coverage: Coverage Expiration:

Type of Coverage: Claims Made Occurrence

You must provide an answer for each question in this category. **Submit a copy of your current policy "face sheet" indicating coverage amounts, limitations and expiration dates. Provide full explanation to any "Yes" answers on separate sheet**

Yes No Does your liability policy cover managed care activities or Limited Health Professionals you supervise?

Yes No Has your professional liability insurance coverage ever been surcharged, suspended, denied, not renewed or terminated by action of any insurance company?

Yes No Has your professional liability insurance carrier excluded any specific procedures from your coverage?

Yes No Has your professional liability insurance carrier excluded any specific procedures from your coverage?

MALPRACTICE HISTORY

Yes No Have any professional liability suits been filed against you that are currently pending?

Yes No Have any judgements or settlements regarding professional liability suits made against you ?

Yes No Have you ever had judgments or settlements filed with the National Practitioner Data Bank?

If the answer to any of these questions is "Yes", provide a full explanation on a separate sheet. The explanation must include the name of the court in which the suit was filed, the name of the attorney defending you, relevant details and the substance of the findings in such actions or proceedings.

XIV. HEALTH STATUS:

- Yes No Do you presently have any limitations which would impair your ability to perform the clinical privileges requested, with or without reasonable accommodations? *(If "Yes" please attach explanation.*
- Yes No Are you currently engaged in the illegal use of drugs?
- Yes No Have you used illegal drugs within the last two years?

Most recent physical examination: Date: _____ Performed by: _____

Significant Findings: _____

XV. CORRECTIVE OR DISCIPLINARY ACTIONS:

- You must provide an answer for each question in this category. *(If "Yes" provide explanation on separate sheet)*
- Yes No Have you ever been subject to a National Practitioner Data Bank adverse action report?
- Yes No Have there been any felony criminal charges brought against you?
- Yes No Have you been the subject of an individual focused review by a state agency , PRO or similar agency.
- Yes No Have you ever discontinued practice for any reason not solely related to your mental or physical health for one month or more?
- Have any of the following been voluntarily or involuntarily relinquished or currently in the process of being denied, revoked, suspended, reduced, limited, or withdrawn?
- Yes No Employment, medical staff appointment, including avoiding disciplinary action?
- Yes No License to practice in any jurisdiction?
- Yes No Federal (DEA) or State Narcotics Registration Certificate?
- Yes No Other Professional Registrations/Licenses?
- Yes No Participation in any Federal or State Health Insurance Program?
- Yes No Clinical Privileges?
- Yes No Academic Appointment?
- Yes No Prerogatives/Rights on any Medical Staff?
- Yes No Other Institutional Affiliations?
- Yes No Professional Society Membership?
- Yes No Specialty Board Certification?
- Yes No Professional Office or other Professional Sanction?
- Yes No Professional Liability Insurance?
- Yes No ECFMG Certification?
- Yes No Other Health Care Organizations?

XVI. LIMITED HEALTH PRACTITIONERS

Do you currently or plan to employ a Health Professional Affiliate who will assist you in this facility? Yes No

List name(s) and credentials.

XVII. CONTINUING EDUCATION

Attach documentation (certificates) of a minimum of 40 hours of Category I continuing medical education for the last two years. These hours must be specific to your specialty.

XVII. ATTESTATION STATEMENT

All information submitted by me herein and attached is true, complete and correct and without omission to the best of my knowledge. I fully understand that any significant misstatements or omissions shall be grounds for denial or revocation of staff appointment and clinical privileges without right to a hearing or appellate review Yes No

Print Name: _____

Signature: _____ Date: _____

THE VERIFICATION GROUP

17 Northtown Drive/PO Box 14023, Jackson, Mississippi 39236-4023 Telephone: 601/957-9754
Fax 601/957-9188 e-mail: tv@jam.rr.com Web-Site: www.Theverificationgroup.com

Statement of Applicant/Consent to Release and Receive Information

I acknowledge that The Verification Group (TVG), a National Committee for Quality Assurance (NCQA) certified credentials verification organization (CVO), located in Jackson, Mississippi, has contracted with _____ to collect and verify information submitted by me for appointment or reappointment to the medical staff.

It is acknowledged that “TVG” does not take part in the decision making of membership or privileges; a process that is left entirely to the governing board through recommendation by the medical staff. It is also acknowledged that information will not be released to any entity other than specified above and collected documents will be filed in my credential file in the Medical Staff Office at this facility.

I hereby consent to, authorize and release from liability “TVG” to release to the “entity” listed above, all data collected and verified on their behalf as it relates to my request for membership and clinical privileges. I hereby consent and authorize my professional liability insurance carrier and any other third party organization that “TVG” may reasonably request on behalf of the “entity”, to release and/or verify information directly to “TVG” regarding my medical professional claims, underwriting, licensure and credentialing history, as long as this information is provided in good faith, without malice and in reasonable belief that any information gathered, exchanged or released is warranted by the facts known to them.

I attest that the information I have provided in my application packet is accurate and complete to the best of my knowledge.

I understand that a photocopy or facsimile of this waiver, which is effective for two (2) years from the date of signature, shall be as effective as the original when so presented, unless cancelled by me in writing.

Print or Type Name of Practitioner

Signature of Practitioner

Date of Signature