

**Medical Staff Application Instructions**

We are pleased to provide you with our Medical Staff application packet. Please do not write “see attached” or “see resume or CV” on the application. All sections must be completed by the applicant or the application will be deemed incomplete and will not be processed.

In order to expedite the credentialing process for membership and privileges, we ask that you submit a complete, signed and dated application and privilege form. **INCLUDE A \$150.00 CHECK PAYABLE TO NASHVILLE SURGERY CENTER.**

In addition, please be sure to include copies of the following:

- State Medical License
- State Controlled Substance Certificate, if applicable
- Federal DEA Certificate
- Certificate of malpractice liability coverage, showing current malpractice insurance in an amount not less than \$1 million/\$3 million
- Documentation of continuing education during the past two years

A government-issued photo ID (such as driver’s license or passport) or hospital photo ID must be viewed by a facility representative prior to approval of medical staff membership/clinical privileges.

Return the application and requested documents to -

**MEDICAL STAFF SERVICES/Administrator  
NASHVILLE SURGERY CENTER  
1717 PATTERSON ST  
NASHVILLE, TN 37203**

Expect a time period of 8-12 weeks for action by the SCA Governing Body. During this time your application will be reviewed by the Medical Director, forwarded to the Medical Executive Committee and transmitted to the Governing Body for final approval. You can expedite this process by returning a completed application along with the requested documents.

Should you have any questions, please contact, Michael Patchen, Medical Staff Coordinator/Administrator, at 615-329-1888 between the hours of 7 a.m. and 3 p.m. Monday through Friday.

Thank you.

# Surgical Care Affiliates

## APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF AND/OR CLINICAL PRIVILEGES

### PERSONAL INFORMATION

Last Name	First Name	Middle	Date of Birth	Social Security No.
Residence Address	City	State	Zip	Home Phone ( )
List all names used for licensing, enrollment	Citizenship	Place of Birth	Pager/Beeper # ( )	
UPIN Number	E-mail Address			Answering Service # ( )
NPI Number	Languages Spoken in Addition to English			ECFMG Number (if applicable)

### PRACTICE INFORMATION

Clinical Specialty/Subspecialty	Practice Name			
Practicing with Whom and Nature of Affiliation:	Name(s) of Covering Physicians			
Office Address	Suite	City	State	Zip
				Office Phone ( )
Office Manager or Credentialing Contact	Mgr Phone Number ( )	Mgr Fax Number ( )	Office Fax Number ( )	

### EDUCATION/TRAINING

<b>Medical/Dental/Podiatric School</b>			Degree	Fax Number ( )
Street	City	State	Zip	Date of Graduation
<b>Internship</b> (Institution name)			Phone Number ( )	Fax Number ( )
Street	City	State	Zip	Dates
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)			
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, please explain on separate sheet.)				
<b>Residency</b> (Institution name)			Phone Number ( )	Fax Number ( )
Street	City	State	Zip	Dates
Type of Training	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)			
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, please explain on separate sheet.)				

# Surgical Care Affiliates

## EDUCATION/TRAINING (continued)

Residency (Institution name)		Phone Number ( )	Fax Number ( )
Street	City	State	Zip
Type of Training		Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, please explain on separate sheet.)			
Fellowship (Institution name)		Phone Number ( )	Fax Number ( )
Street	City	State	Zip
Type of Training		Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, please explain on separate sheet.)			

## TEACHING APPOINTMENTS

<b>LIST IN CHRONOLOGICAL ORDER. IF ADDITIONAL SPACE IS REQUIRED, ATTACH A SEPARATE SHEET.</b>			
Facility (Full name)		Phone Number ( )	Fax Number ( )
Street	City	State	Zip
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)		
Facility (Full name)		Phone Number ( )	Fax Number ( )
Street	City	State	Zip
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairman of Dept., etc.)		

## CONTINUING MEDICAL EDUCATION

<b>ON A SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES THAT YOU HAVE ATTENDED OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWO YEARS RELATED TO THE CLINICAL PRIVILEGES REQUESTED.</b>
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## HEALTHCARE AFFILIATIONS

<b>LIST ALL PRESENT AND PREVIOUS AFFILIATIONS WITH HEALTH CARE FACILITIES, IN CHRONOLOGICAL ORDER. Include assistantships, appointments and military experience. If more space is needed, attach additional sheet.</b>			
Facility (Full name)			Staff Category
Street	City	State	Zip
Facility (Full name)			Staff Category
Street	City	State	Zip
Facility (Full name)			Staff Category
Street	City	State	Zip

## HEALTHCARE AFFILIATIONS (continued).

Facility (Full name)				Staff Category
Street	City	State	Zip	Dates
Facility (Full name)				Staff Category
Street	City	State	Zip	Dates
Facility (Full name)				Staff Category
Street	City	State	Zip	Dates

## BOARD CERTIFICATION

Name of Certifying Board	Specialty	Date Certified	Date Re-Certified	Expiration Date

If not certified, describe your intent for certification, if any, and date of eligibility for certification.

Have you ever been examined by any specialty board, but failed to pass? **If yes, please provide details on separate sheet.**

## PROFESSIONAL LICENSES (MD, DO, DDS, DPM, PhD, etc)

State Medical License Number	Issuance Date	Expiration Date	Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>LIST ALL PAST AND PRESENT STATE LICENSES/CERTIFICATIONS IN CHRONOLOGICAL ORDER.</b>				
Out of State Name	License Number	Expiration Date	Active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Controlled Substance Certificate, if applicable			Expiration Date:	
Drug Enforcement Administration Number			Expiration Date:	
<input type="checkbox"/> I do not prescribe controlled substances and therefore am not required by law to have a DEA certificate.				

## PROFESSIONAL LIABILITY INSURANCE

Insurance Carrier	Amount of Coverage	Expiration Date	Policy No.
Agent (Full Name and Address)		Type of Coverage <input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
Prior Carriers (Use additional sheet if necessary)			
If you carried claims made insurance, which carrier is providing your "tail coverage"?			
<b>If either of the following is answered in the affirmative, provide full explanation on a separate sheet.</b> During the past 10 years, have there been, or are there currently pending, any malpractice claims or suits, settlements, judgments, or arbitration proceedings involving your professional practice? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been denied Professional Liability Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

## PROFESSIONAL ACTIONS

<b>Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed probation, modified, not renewed, voluntarily or involuntarily relinquished? If Yes, please provide full explanation on a separate sheet.</b>	
Medical license in any state	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other professional registration/license	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEA Registration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Academic appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare, Medicaid, or other private, federal or state health insurance program	<input type="checkbox"/> Yes <input type="checkbox"/> No
Managed care organization, i.e., HMO, PPO, IPA, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Membership on any hospital medical staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other institutional affiliation or status	<input type="checkbox"/> Yes <input type="checkbox"/> No
Professional society membership or fellowship/Board certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Privileges	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other type of professional sanction, investigation, hearing, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have there been any felony criminal charges brought against you in the last 5 years? If yes, please provide full explanation on separate sheet, including resolution of charges.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever discontinued practice for any reason (other than for routine vacation, formal education/training) for 30 days or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been, or are you proposed to be, excluded or otherwise ineligible to participate in any Federal program, including any health care program (e.g. Medicare, Medicaid, etc) or have you ever been convicted of a criminal offense related to the provision of health care services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MISCELLANEOUS QUESTIONS

Have you ever entered into an Asset Purchase or other agreement with the Facility, or any of its Affiliates, subsidiaries or parent in which you agree not to refer any patients to it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been screened for TB? Please attach a copy of your PPD skin test results or chest x-ray from within the past year.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you opted out of Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## HEALTH STATUS

**IF THE FOLLOWING IS ANSWERED IN THE AFFIRMATIVE, PROVIDE FULL EXPLANATION.**

If any of the following is answered in affirmative, provide full explanation on a separate sheet. ( Exceptions # 2 below)

1. Are you presently taking medications or other substances that could impair your ability to provide Patient care services for which you are seeking Clinical Privileges?  Yes  No
  2. Are you able to perform, with or without accommodation, all of the essential functions, both Physical and mental, necessary to provide patient care services for which you are seeking Clinical Privileges?  Yes  No
  3. In the past 3 years, have you had a physical or mental health condition, including alcohol or drug Dependence, that affects or is reasonably likely to affect your ability to perform professional Duties?  Yes  No
  4. During the past three years, have you used illegal drugs or illegally used prescription drugs?  Yes  No
  5. Are you currently engaged in any rehabilitation program?  Yes  No
  6. Do you have a physical or mental condition that could affect your ability to exercise the clinical Privileges requested or would require an accommodation for you to exercise those privileges safely and competently?  Yes  No
- Regardless of how this question is answered, the application will be processed in the usual manner. If you have answered this question affirmatively and are found to be professionally qualified for medical staff appointment and/or the clinical privileges requested, you will be given an opportunity to meet with Physician's Leadership to determine what accommodations are necessary or feasible to allow you to practice safely.*

## PROFESSIONAL REFERENCES

**Name two individuals who are peers (preferably within your specialty) who are directly familiar with your current clinical work, either through direct clinical observation or through close working relations. Do not include relatives, current partners, or associates in practice.**

Name and Address	Phone # ( )
	Fax # ( )
Name and Address	Phone # ( )
	Fax # ( )

## APPLICANT'S ACKNOWLEDGMENT

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the facility, I acknowledge that I have received, read and been oriented to the by-laws, rules and regulations of this facility, and that I am familiar with the principles and standards of The Joint Commission and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment. I further agree to abide by such facility and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the Medical Staff, I hereby signify my willingness to appear for the interviews in regard to my application and authorize the facility, its Medical Staff and their representatives to consult with administrators and members of Medical Staffs of other facilities or institutions with which I have been associated and with others (including past and present malpractice carriers) who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the facility, its Medical Staff and its representatives, of records and documents, including medical records at other facilities, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the facility and its Medical Staff for their acts performed in good faith, without malice, in connection with evaluating my application, credentials and qualifications. I further hereby release from liability any and all individuals and organizations who provide information to the facility or its Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of all such information.

I hereby further authorize and consent to the release of information by this facility or its Medical Staff to other facilities, medical associations and other interested persons regarding any information the facility and the Medical Staff may have concerning me as long as such release of information is done in good faith and without malice and I hereby release from liability this facility and its staff for so doing.

I understand and agree that I, as an applicant for Medical Staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Upon request by the facility, I agree to submit to a medical and/or psychological examination and to take a drug-screening test.

I have not requested privileges for any procedures for which I am not certified or qualified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

As required to make my appointment to the Medical Staff effective, I agree that I will at all times:

- a. Provide continuous medical care and supervision to all patients within the Facility for whom I am responsible;
- b. Abide by all the Bylaws, policies and directives of the Facility applicable to me, including the bylaws, policies, rules and regulations of the Medical Staff and its programs, as shall be in force from time to time during the term of my appointment to the Medical Staff;
- c. Accept committee assignments and such other reasonable duties and responsibilities as may be assigned to me by the applicable authorities of the Governing Body and the Medical Staff;
- d. Abide by generally recognized principles of medical and professional ethics;
- e. Refrain from delegating responsibility for diagnosis or care of facility patients to a medical, dental, or other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;
- f. Seek consultation whenever necessary;
- g. Immediately inform your office of any change made or proposed in the status of my license to practice, DEA, or controlled substances registration, professional liability insurance coverage, and membership or clinical privileges at other institutions, and on the status of current or initiation of new malpractice claims;
- h. Participate in facility Medical Staff Orientation; and
- i. Maintain confidentiality of all information discussed in any committees for which I am a member or participant.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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

## Verification of Professional Liability Insurance

Please complete the following form. Naming this facility as Certificate Holder on the malpractice policy will facilitate automatic notification of renewal to the facility by the malpractice carrier and eliminate the need for the practitioner to provide copies to each organization at every renewal.

I, \_\_\_\_\_, authorize my professional  
(print name) liability insurance carrier

\_\_\_\_\_  
Name of Insurance Carrier

\_\_\_\_\_  
Street Address of Insurance Carrier

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Policy Number

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage and any limitations in coverage to **Surgical Care Affiliates** who will hereinafter be a Certificate Holder and is to be notified of the amount of my coverage and any future changes to my insurance status.

I also authorize my professional liability carrier to issue a lawsuit history report concerning information on past or pending lawsuits.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_