ECRI Institute
The Discipline of Science. The Integrity of Independence.

Credentialing Application Packet for Free Clinics

WELCOME LETTER FOR APPLICANTS

Date

Name of Applicant

Address #1

Address #2

City, State, ZIP

Dear Applicant,

Thank you for interest in becoming part of (name of free clinic) clinical staff. Prior to beginning your service with (name of free clinic) you must complete our credentialing process and be approved by our board of directors. The credentialing process involves evaluating a practitioner's eligibility and competency for clinical privileges. Our credentialing policy applies to physicians, mid-level providers, and any licensed or certified healthcare practitioner who provides services in the (name of free clinic). All qualified applicants will receive an application for medical staff membership and/or clinical privileges. We will make every effort to process your application in a timely and efficient manner.

Credentialing is a five-step process:

Step 1. Applicant will receive the initial applicant packet

Step 2. Applicant will return completed applications along with requested documents

Step 3. Application will be reviewed and processed by our credentialing specialist to make sure all information is complete and accurate

Step 4. The completed and verified applicant packet will be forwarded to the medical director to be presented to the board of directors for approval

Step 5-. The Applicant will be notified of the board of directors' decision

The credentialing process can take up to 90 to 120 days to verify, review, and obtain final approval. To expedite the process, your application should be without blanks or missing requested documents; if anything is missing, the process will be delayed and could mean forfeiture of your privileges.

If at any time you have questions please contact our credentialing specialist at (phone number) or set up a meeting to come to (name of free clinic) and go over your application prior to submission. Our goal is to assist you to get on staff quickly while ensuring that we are compliant with Joint Commission and other relevant guidelines.

Sincerely,

Medical Director

CREDENTIALING APPLICATION

Please type or print responses legibly and in ink. Please complete the form in its entirety and attach all required documentation. Incomplete applications will be returned to you and may result in a delay in the credentialing process.

- Supplementary documents that must be completed and submitted include the following:

— Affiliation Certification Letter

— Three (3) Peer Reference Forms

— Delineation of Privileges

— Professional Liability Claims History Form

— Continuing Medical Education (CME) Form

— Attestation Statement

- Please also submit the following with your application:

— Curriculum vitae (CV)

— Copy of medical/professional license registration certificate

— Copy of medical board certification

— Other certificates (BLS, ACLS, ATLS, PALS, APLS)

— Current Drug Enforcement Administration (DEA) registration

— Current Controlled Dangerous Substances (CDS) registration

— Copies of diplomas (undergraduate, post-graduate, medical school, residency, fellowship)

— Proof of professional liability insurance (policy declarations page or letter from insurer)

— Copy of most recent hepatitis B vaccination and tuberculosis PPD test

— Copy of government-issued picture identification

— National Provider Identification number (NPI)

I. Demographic Information

Applicant Name: _____ SSN:_____

Address/City/State/Zip:_____

Phone: _____Email: _____Fax: _____

Date of Birth: ____/____/____ Place of Birth:_____

Gender: ☐ Male ☐ Female

Are you a United States Citizen? ☐ Yes ☐ No

If not a United States citizen, please check applicable box below:

☐ Work Permit (attach notarized copy) ☐ Visa Visa Type and Number: _____

II. Professional/Licensure Information

Primary Practice Specialty:_____Board Certified? ☐ Yes ☐ No

Certifying Board:_____

Certificate Number:_____Year Certified:_____Last Year Recertified:_____Expires:_____

Secondary Practice Specialty:_____Board Certified? ☐ Yes ☐ No

Certifying Board:_____

Certificate Number:_____Year Certified:_____Last Year Recertified:_____Expires:_____

Secondary Practice Specialty:_____Board Certified? ☐ Yes ☐ No

Certifying Board:_____

Certificate Number:_____Year Certified:_____Last Year Recertified:_____Expires:_____

Secondary Practice Specialty:_____Board Certified? ☐ Yes ☐ No

Certifying Board:_____

Certificate Number:_____Year Certified:_____Last Year Recertified:_____Expires:_____

If not board certified, are you board eligible? ☐ Yes ☐ No Application date:_____

Do you have a current Drug Enforcement Administration (DEA) license? ☐ Yes ☐ No

License Number:_____Date of Expiration:_____

Do you have a current Controlled Dangerous Substances (CDS) license? ☐ Yes ☐ No

License Number:_____Date of Expiration:_____

Are you licensed to practice medicine in the state of (name of state)? ☐ Yes ☐ No

License Number:_____Expiration Date:_____

Other Certifications (BLS, ACLS, ATLS, PALS, APLS)

Certification	Certifying Organization	Date Certified	Date Certification Expires

Professional History

Current Employer	Address	Position	Full Time?	Part Time? (include number of hours per week)	Date of Hire (Month, Year)	Employment End Date
Previous Employers	Address	Position	Full Time?	Part Time? (include number of hours per week)	Date of Hire (Month, Year)	Employment End Date

Please provide the following information:

	Yes	No
Have you ever practiced under another name? If yes, what name?_____		
Do you currently provide healthcare services in the state of (name of state)?		
Are you presently practicing in your specialty?		
Do you currently have active staff privileges at an accredited hospital?		

III. Insurance

Please attach proof of professional liability insurance, such as a policy declarations page or letter from insurer.

Name of Insurance Carrier:_____Dates of Coverage:_____

Full Address: _____

Name of Previous Carrier(s):_____Dates of Coverage:_____

Full Address: _____

Name of Previous Carrier(s):_____Dates of Coverage:_____

Full Address:_____

Has an insurance carrier denied, cancelled, or refused to renew your insurance coverage? ☐ Yes ☐ No

(If yes, please attach a separate sheet with an explanation)

Have you ever had any professional liability claims brought against you? ☐ Yes ☐ No

(If yes, please complete "Professional Liability Claims History Form")

IV. Education

Preprofessional Education

Name of School	Address (City, State, Zip Code)	Subject Major/Minor	Years Attended	Graduation Date (Month, Year)	Degree

Professional Education

Name of School	Address (City, State, Zip Code)	Years Attended	Graduation Date (Month, Year)	Degree

Residency Training and Fellowships (Post Graduation from Professional School)

Name of Institution	Address (City, State, Zip Code)	Specialty	PG Level	Date Completed (Month, Year)	Total Number of Months in Position

Teaching/Research Appointments

Name of Institution	Address (City, State, Zip Code)	Position	Dates of Appointment (From/To)

Visiting Staff Appointments

Name of Institution	Address (City, State, Zip Code)	Position	Dates of Appointment (From/To)

V. References

Please list three professional references who can attest to the candidate's qualifications, clinical and professional competence, mental competence, and character. At least one reference must be an attending or supervising physician. Each reference must also complete the "Applicant Peer Request Form" and return to (name of free clinic).

1. Name:_____Title:_____ Relationship to Candidate:_____ Address:_____ Phone:_____Fax:_____Email:_____
2. Name:_____Title:_____ Relationship to Candidate:_____ Address:_____ Phone:_____Fax:_____Email:_____
3. Name:_____Title:_____ Relationship to Candidate:_____

Address:_____

Phone:_____Fax:_____Email:_____

VI. Disciplinary Information

Please attach a separate sheet with an explanation for any "yes" answers

	Yes	No
Has your medical license ever been revoked, restricted, or suspended?		
Have your clinical privileges ever been revoked, restricted, or suspended?		
Has your membership on any medical staff ever been revoked, restricted, or suspended?		
Has your DEA license ever been denied or suspended?		
Have you ever been excluded from participation with Medicare or Medicaid program?		
Have you ever been requested to appear before a licensing agency (State Board of Examiner's, Drug Enforcement Agency) for any reason?		
Have you ever been sanctioned by a federal or state agency?		
Have you ever been convicted of a felony or misdemeanor other than a minor traffic offense?		
Have you ever discontinued your practice (other than for vacation, education/training, maternity leave, or leave due to illness) for three months or more?		

VII. Health Fitness

Please attach a separate sheet with an explanation for any "yes" answers

	Yes	No
Do you presently have any physical or mental condition, including alcohol or drug abuse, that may affect your ability to perform clinical or professional duties?		
Are you currently taking any medications that may affect your ability to perform clinical or professional duties?		
Do you have any communicable diseases?		

___ Please initial to certify that you are in good health and have no physical or mental conditions that may affect your ability to perform clinical or professional duties.

Most recent physical exam performed by: _____Date: _____/ _____/ _____

Results of examination: _____

VIII. Other Information

	Yes	No
Do you speak any other language other the English? If so, which language(s) _____ _____ _____		
Are you presently or planning to reside within commuting distance to the free clinic?		

AFFILIATION CERTIFICATION LETTER

_____

Name of Applicant Specialty

To Whom It May Concern:

I have submitted an application for appointment/reappointment to the staff of (name of free clinic). Please complete the information below and return it directly to the address below. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____

Release of information signature/date

Current Status:

_____

Membership from _____(date) to _____(date)

	Yes	No	N/A
Have the practitioner's privileges been restricted, suspended, or revoked?			
Have the practitioner's privileges been reduced?			
Has the practitioner attempted procedures beyond his or her skill or training?			
Has the practitioner been the subject of disciplinary action by your organization or licensing body?			
Have the practitioner's professional morbidity, mortality, infection, or complication rate exceeded your organization's criteria for the standard of practice?			
Has the practitioner been suspended for medical record violations since the last appointment or reappointment? If yes, how many times?_____			
Has the practitioner's behavior been disruptive to patient care?			
Have there been any written complaints about practitioner by patients, employees, or medical staff members?			
Has the practitioner been involved in a malpractice claim or lawsuit since the last appointment or reappointment?			
Is the practitioner compliant with organizational policies and medical staff bylaws?			
Does the practitioner have any physical, mental, emotional, or drug or alcohol dependence problems that may interfere with his or her ability to perform professional and staff duties?			
At the appropriate time, will you likely reappoint the practitioner to your medical staff?			

Verification provided by:

Name:_____

Signature:_____

Date:_____

Phone:_____

Title:_____

Fax:_____

Institution Name:_____

Return Form to: Free Clinic, Address, City, State, ZIP phone # fax #

APPLICANT PEER REFERENCE FORM

Three (3) references are required for all applicants for appointment / reappointment.

Name of Applicant:

Specialty:

To Whom It May Concern:

I have submitted an application for appointment/reappointment to the staff of the (name of free clinic). Please complete the information below and return it directly to the address below. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____
Signature/date

	Yes	No
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?		

Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?		
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?		
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?		
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?		
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?		
Does the practitioner make hospital rounds on a daily basis or as otherwise required and readily answer calls and consultations when requested?		
Does the practitioner exhibit personal integrity and adherence to professional ethics?		
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?		
What is your opinion regarding competency in performing the attached privileges?		
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinic privilege?		

The above evaluation is based on (check all that apply):

☐Close observation of clinical performance
☐General Impression
☐Composite information from file
☐Practitioner's reputation in the community
☐Co-worker

Recommendation:

☐Highly recommend without reservation
☐Recommend as qualified and competent

☐Recommend with reservation
☐Do not recommend

Signature:_____

Date:_____

Phone:_____

Print Name:_____

Title:_____

Fax:_____

Return Form to: Free Clinic, Address, City, State, ZIP phone # fax #

DELINEATION OF PRIVILEGES

Name of Applicant:_____Specialty:_____

Core Privileges[1]	Approved	Proctoring Required	Denied
List Additional Procedures[2]	Approved	Proctoring	Denied

		Required	

Applicant's Signature/Date:_____

Specialty Consultant Signature/Date:_____(if applicable)

Medical Director Signature/Date: _____

Medical Advisory Board Signature/Date:_____

Representative for Credentialing or Board Committee Signature/Date:

Notes:

1. The American Academy of Family Physicians (AAFP) defines Core or Category I privileges as "uncomplicated, basic procedures and cognitive skills." AAFP adds: "Physicians assigned to this category will be graduates of approved medical/osteopathic schools who are properly licensed and have demonstrated skills in family medicine. Each request for privileges will be considered on an individual basis and will require approval and supportive documentation." The free clinic should define Core or Category I privileges and skills necessary to be granted these privileges.

2. Additional procedures, defined by AAFP as Category II and Category III, are of increasing complexity and may require additional specific training, education, experience, and/or board certification as defined by the free clinic. The free clinic should list each procedure that it will grant privileges for and the specific documentation required of physicians to demonstrate that they meet privileging requirements.

For more information, see AAFP's "Ambulatory Privilege Delineation Form for Family Physicians" at http://www.aafp.org/online/en/home/practicemgt/privileges/misc/ambprivilege.html.

PROFESSIONAL LIABILITY CLAIMS HISTORY FORM

The following is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any professional liability claims and lawsuits reported to your professional liability insurance carrier, open or closed, settled or paid. Include only one case per sheet; copy this form if needed for more than one case.

Provider Name:_____

1. Plaintiff Name:_____

Date of Birth:_____ Age:_____

Name of patient involved:_____

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

Month and year of claim or lawsuit:_____

Insurance carrier time of claim:_____

2. What is/was your status: ☐ Primary defendant ☐ Co-defendant ☐ Other

Explain and list other defendants:

_____

_____

What was the patient's outcome?

_____

Provide a summary of the allegations made against you.

_____

What was your clinical role with regard to the patient?

_____

Current Status of Claim: (please check one)

☐Still pending as of date:_____

Name and address of your defense attorneys:

Has a trial date been set? ☐Yes ☐No Trial Date _____

Settled out of court before trial? ☐Yes ☐No

Amount of settlement on your behalf $_____

Current status of lawsuit:

☐ Dismissed: Date:_____

☐ Defense Verdict Date:_____

☐ Plaintiff Verdict Date:_____

☐ Judgment Amount $:_____ Date:_____

Amount of total judgment paid on your behalf $_____

This professional liability claim information form is required on all claims/lawsuits that are reported by your professional liability insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status of settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

_____
Applicant's Signature

_____
Print Name

_____
Date

CONTINUING MEDICAL EDUCATION (CME) FORM

Please use this form to list current continuing medical education (CME) credits earned within the last two years. (name of free clinic) requires (number) of CME credits. This form can be used in lieu of sending copies of your CME certificate(s). Please make as many copies of this page as needed.

Course Title	Date	Facility Address	# CME
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			

I, _____ (print full name of the physician/practitioner), agree, as evidenced by my signature, that the information provided in this CME form is true and complete to the best of my knowledge and that the omission or falsification of information may be cause of ineligibility or termination from medical staff membership

Applicant Signature:_____

Date:_____

ATTESTATION STATEMENT

I, _____ (print full name of the physician/practitioner), agree as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that the omission or falsification of information may be cause of ineligibility or termination from medical staff membership. I further agree that I have current professional liability coverage and I have disclosed the history of loss or limitation of privileges or disciplinary action.

_____

Applicant Signature Date

_____

Print Name

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