LICENSED & CERTIFIED HEALTH CARE PROFESSIONALS
APPLICATION FOR CREDENTIALING & PRIVILEGING

PERSONAL INFORMATION

Name _____

Home Address _____

_____

Home Phone ( ) _____ Cell Phone ( ) _____

E-mail Addess_____

Date of Birth _____ Social Security Number _____

PRIMARY PRACTICE INFORMATION, if applicable

Practice Name _____

Practice Address_____

_____

Mailing address if different from above:

_____

_____

Phone ( ) _____ Fax ( ) _____

Pager ( ) _____

Type of Practice

___ Family Practice ____ Internal Medicine ___ Dental

___ Specialty_____

Practice Manager _____
Practice Contact if other than Manager_____
_____

SECONDARY PRACTICE INFORMATION, if applicable

Address_____

_____

Phone ( ) _____ Fax ( )

_____

Contact Name_____

MEDICAL/DENTAL EDUCATION

Medical/Dental School

Institution_____

Address_____

Date of Graduation _____

Type of Training/Specialty_____

Internship

Institution_____

Address_____

Date of Completion_____

Type of Training/Specialty_____

Institution_____

Address_____

Date of Completion_____

Type of Training/Specialty_____

Residency

Institution_____

Address_____

Date of Completion _____

Type of Training/Specialty_____

Institution_____

Address_____

Date of Completion_____

Type of Training/Specialty_____

Fellowship

Institution_____

Address_____

Date of Completion_____

Type of Training/Specialty_____

Institution_____

Address_____

Date of Completion_____

Type of Training/Specialty_____

LICENSURE & REGISTRATIONS

List all active professional licenses:

State	Type	Number	Date of Issue	Expiration Date

Federal DEA number_____

New Jersey Controlled Dangerous Substance (CDS) Number _____

National Provider Identification (NPI) Number _____

CERTIFICATIONS

Specialty_____

Board Name _____

Current Certification Date_____ Expiration Date_____

FACILITY, HOSPITAL, and UNIVERSITY AFFILIATIONS

(List all hospital/health system affiliations where you are credentialed and privileged. Also please list any school affiliations/appointments.)

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

List any additional relevant information as an attachment

PROFESSIONAL MALPRACTICE INSURANCE

Present Carrier's Name_____

Address_____

Policy Number_____

Dates of Coverage From_____ To_____

Coverage Amounts_____

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 3 years? ☐ Yes ☐ No

If Yes, please explain

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REQUIRED COPIES & REFERENCES

Pleasse provide a photocopy of the following documents:

- ☐ Identification (via government issued picture ID-driver's license)
- ☐ New Jersey Medical/Dental License
- ☐ DEA Registration and CDS Certificate, as applicable
- ☐ Professional School Diploma plus Internship/Residency/Fellowship Certificates
- ☐ Current Malpractice Insurance with Loss History Report
- ☐ CPR Certification (BLS)
- ☐ Current Curriculum Vitae

The specific scope/content of patient care service I request to practice at Free Clinic Sussex County is:

_____

_____

I affirm that:

* **I have never been convicted of a felony.**
* **I have never been charged with sexual harassment.**
* **I have not and will not provide patient care under the influence of drugs or alcohol.**
* **I do not have any communicable disease. I further understand that if at any time I am considered to be infectious I will notify the clinic medical director and or executive director.**
* **I will not release any information regarding patient's diagnosis, finance, etc. unless authorized to do so. I will strictly adhere to patient confidentiality and privacy standards.**

_____ _____

Signature of Applicant **Date**

Authorization and Consent

In making this application:

- **I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of Free Clinic Sussex County,**
- **to make decisions as appropriate to the patient's needs, to maintain practice knowledge and skills current through continuing education opportunities,**
- **to abide by the bylaws, rules and regulations, policies and procedures of the clinic,**
- **to participate in and cooperate fully with the Quality Assurance Program and 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 the Clinic and its representatives for the purpose of improving the quality of care and services and reducing risk.**

I hold the Clinic and its representatives free of all liability for such actions.

I hereby release from liability Free Clinic Sussex County and all its representatives for their acts performed while evaluating my application, credentials and qualifications.

I hereby release from any liability any and all individuals and organizations that provide information to Free Clinic Sussex County or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

As applicable, I hereby accept that I will abide by the requirements for medical malpractice coverage for the Federal Tort Claims Act (FTCA). I will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims.

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 fully understand that any misstatements or omissions in the application constitute cause for denial or termination of privileges and/or employment. All information submitted by me in the application is true to the best of my knowledge.

_____ _____

Signature of Applicant **Date**

_____**Printed Name & Title**