

INSTRUCTIONS FOR COMPLETING AN ALLIED HEALTH APPLICATION

ALLIED HEALTH APPLICATION PACKET

All Advance Practitioners (PA-C, CRNA, NP) must complete the TDI application, Hospital Addendums and appropriate Privilege Request Form.

Complete and sign the enclosed application for initial authorization as an Allied Health Professional at a Texas Health Resources Facility. **ALL QUESTIONS MUST BE ANSWERED.** The application must be **TYPED** or **PRINTED** in black ink. **DO NOT** respond to questions by stating see attached or refer to. If a particular question does not apply, please state "N/A."

ILLEGIBLE, INCOMPLETE OR INCORRECT APPLICATIONS WILL BE RETURNED.

The application and releases must be original signatures. Scanned, copied, or stamped signatures will not be accepted and returned to you. Provide complete addresses, which include suite, street location, city, state and zip codes for educational institutions, past/current hospital affiliations/work experience, references, liability carriers, etc. If this information is not provided, it will be requested, thus, causing delay in the application process. IT IS INCUMBENT UPON THE APPLICANT TO PROVIDE ANY REQUIRED DOCUMENTATION THAT THE HOSPITAL IS UNABLE TO OBTAIN.

DOCUMENTS WHICH NEED TO ACCOMPANYING YOUR APPLICATION

- A current photograph
- Copy of all certificates that apply to your professional credentials (even out of state)
- Copy of malpractice face sheet. Minimum requirements for AHP are \$200,000/\$600,000. If practicing under employing physicians insurance, your name must appear on as an insured on the face sheet.
- Applicant Disclosure and authorization for release of information (background check required by hospital)
- Copy of any/all state licenses/certifications/registrations you hold (RN, LVN, etc)
- Attach copy of current resume. Note: It must account for all time periods since receiving your degree/certification and be reflected in the application. If no activity during time frames, please provide an explanation of gaps in work history.
- CEU's for the past two years.
- Privilege/Scope of Service forms for your specialty. Each sponsoring physician must sign and date the scope of service/privilege forms as well as page 9 of the application packet. (If not received, it will be returned for completion).
- Copy of current, valid BLS course (if applies to specialty)
- Current TB skin test no older than 12 months old. If positive in past, a TB Risk Assessment form will be requested to be completed. (required by hospital)
- Application fee is \$100 for initial and \$75 for reappointment.

If you have questions in completing your application packet, please contact the Medical Staff Office Texas Health Harris Methodist Hospital Southlake.

RETURN APPLICATION, PRIVILEGES/SCOPE OF SERVICE FORM, AND OTHER DOCUMENTS TO:

June Lawrence, CPCS

1545 E Southlake Blvd

Southlake, TX 76092

Phone (817) 748-8782, Fax (817) 748-8787

KEEP A COPY OF YOUR COMPLETED PACKET FOR YOUR FILES!!!

DATE RECEIVED _____

Attach
Photograph
Here

Texas Health Harris Methodist
Hospital Southlake
Allied Health Application

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Birth Date	Birthplace
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Please provide any other name used and dates of use

Home Address	Street	City	State	Zip Code
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Office Address	Street	City	State	Zip Code
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() Cell Phone number	() Beeper/Pager	() Cell number	() Home Telephone
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Office Contact Person	Office number	Office fax number
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Additional Office Address	Street	City	State	Zip Code
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() Additional Office Telephone	() Additional Office Fax	E-Mail Address
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Social Security Number	Sex	Name of Spouse (if applicable)
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EDUCATION

High School _____ Name, City, State	Graduation Date _____
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College or University	Degree _____	From Date _____	To Date _____
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Name _____

Street	City	State	Zip
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Post-Graduate Education

Degree _____ From Date _____ To Date _____

Name From Date To Date

Street City State Zip

Training other than College or University

Name From Date To Date

Course of Study

Street City State Zip

PROFESSIONAL STATE LICENSES/REGISTRATIONS/CERTIFICATES

License _____ Yes _____ No If yes, License No. _____ State _____

Registration _____ Yes _____ No If yes, Registration No. _____ State _____

Certification _____ Yes _____ No If yes, Certification No. _____ State _____

If answer to above is no, are you eligible for:

License _____ Yes _____ No

Registration _____ Yes _____ No

Certification _____ Yes _____ No

OTHER STATE LICENSES OR CERTIFICATES (all past and present whether active or inactive). Attach additional page(s) as needed.

State License Number Expiration Date

State License Number Expiration Date

PROFESSIONAL LIABILITY INSURANCE Name and Full Address of applicant or employer's Medical Malpractice Insurance Company

Company Name Policy Number

Complete Address City State Zip

Effective Date _____ Expiration Date _____ / _____

Company Name _____ Policy Number _____

Complete Address _____ City _____ State _____ Zip _____

Effective Date _____ Expiration Date _____ Amounts of Coverage _____ / _____

PREVIOUS INSURANCE CARRIERS

Company Name _____ Policy Number _____

Complete Address _____ City _____ State _____ Zip _____

Effective Date _____ Expiration Date _____ Amounts Of Coverage _____ / _____

Company Name _____ Policy Number _____

Complete Address _____ City _____ State _____ Zip _____

Effective Date _____ Expiration Date _____ Amounts Of Coverage _____ / _____

Company Name _____ Policy Number _____

Complete Address _____ City _____ State _____ Zip _____

Effective Date _____ Expiration Date _____ Amounts Of Coverage _____ / _____

CURRENT INSTITUTIONAL/HOSPITAL AFFILIATIONS (LIST ALL)

_____ from _____ to _____

Category/Status _____

Institution Name _____

Address _____ City _____ State _____ Zip _____

_____ from _____ to _____

Category/Status _____

Institution Name _____

Address _____ City _____ State _____ Zip _____

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

PREVIOUS INSTITUTIONAL/HOSPITAL AFFILIATIONS (LIST ALL)

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Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Category/Status

Institution Name

_____ City _____ State _____ Zip

CURRENT EMPLOYMENT/AGENCY INFORMATION (LIST ALL)

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

PREVIOUS EMPLOYMENT HISTORY (LIST ALL)

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____

_____ from _____ to _____
Job Title

Employer/Agency Name

_____ City _____ State _____ Zip _____
Address

Have you ever discontinued practice/work for more than 30 days except for routine vacation?
Yes _____ No _____ If yes, please attach an explanation.

REFERENCES

Name **two members of your same discipline and one physician** who have personal knowledge of your current professional abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from PHP and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time. **None of the individuals should be related to you by family or recently initiated or impending professional partnership/financial association and each should currently have a hospital affiliation.**

1. _____ () _____
Name of Peer, Title Telephone

_____ City _____ State _____ Zip _____
Address

2. _____ () _____
Name of Peer, Title Telephone

_____ City _____ State _____ Zip _____
Address

3. _____ () _____
Name of Peer, Title Telephone

_____ City _____ State _____ Zip _____
Address

MILITARY

Branch of Armed Forces: _____ Type of Discharge: _____

Service: from _____ to _____ Special Training? _____

DISCIPLINARY ACTIONS

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, voluntarily or involuntarily relinquished, or have you ever withdrawn or

failed to proceed with an application for any of the following? *If yes, please provide full explanation on separate sheet.*

Professional registration/license/certificate to practice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Academic appointment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Membership on or affiliation with any hospital or its medical staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional services provided in hospital?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other institutional affiliation or status threat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional society membership or fellowship/board certification?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional Office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any other type of professional sanction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional liability insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH STATUS

If any of the following questions are answered in the affirmative, please provide full explanation on separate sheet.

Do you have or have you ever had a physical or mental condition, which could affect your ability to exercise the specified services requested/provided services? Would an accommodation presently be required in order for you to exercise the privileges requested safely and competently or to perform the essential functions of the position?

Yes No

Are you presently affected by any drug, chemical, alcohol, or behavioral problem which could affect your ability to exercise clinical privileges or provide professional care, or are you actively involved in treatment for use of or dependency on any of these?

Yes No

Are you currently taking any medicine which could affect your clinical judgment or motor skills?

Yes No

Most recent physical examination: Date: _____ / _____ / _____

Performed by: _____

Result of last physical exam:

Date of last TB skin test: _____ Results: _____ (provide a copy)

PROFESSIONAL LICENSES

Has your license to practice in any state, county, or other region been denied, suspended, or limited?

Yes No

Have you ever voluntarily relinquished your license or agreed to have your license limited, suspended, revoked, canceled, restricted or otherwise diminished in any manner? Yes No

Have you ever been the subject of any disciplinary action or proceeding by any licensing or monitoring agency (other than routine) involving limitation of practice or procedures or mandatory second opinions? Yes No

Are there any pending actions, proceedings or investigations related to your professional license? Yes No

APPOINTMENTS/CLINICAL PRIVILEGES

Has your staff appointment, clinical privileges, or provider status been denied, voluntarily or involuntarily reduced, suspended, limited, revoked, or otherwise diminished in any manner? Yes No

Have you been placed on probation, concurrent or retrospective review, or been subject to monitoring (other than routine), mandatory consultations or second opinions (other than for utilization review) by a hospital, other health care entity, or managed care organization? Yes No

Have you voluntarily or involuntarily relinquished a staff appointment, clinical privileges, or provider status or have you withdrawn your application or surrendered your privileges while under, or to avoid, an investigation by any hospital or health care entity? Yes No

Have you been required to obtain additional education or training as a result of peer review or quality assurance activities? Yes No

Are there any pending actions, proceedings or investigations related to any staff appointment, clinical privileges, or provider status? Yes No

CRIMINAL HISTORY

Have you ever been convicted of, pled guilty to, pled nolo contendere to, accepted deferred adjudication or formally charged with any felony or misdemeanor charges other than a minor traffic violation? Yes No

Are there any felony or misdemeanor charges currently pending against you? Yes No

PROFESSIONAL LIABILITY

Have you been denied malpractice coverage or has your coverage ever been limited, reduced, or canceled? Yes No

Has a claim for professional liability ever been asserted against you? This **includes** events that result in a lawsuit, judgment, or settlement without judgment **and** includes any payment made by you **or** by a malpractice carrier on your behalf. Yes No

If the answer to the last two (2) questions is yes, provide details on an attached sheet. Include claimant's name, summary of assertion and disposition or current status of lawsuits, style of case (___ v. ___), cause number, claims or reports to the National Practitioner Data Bank, as well as the circumstances of the denial, limitation or cancellation of malpractice coverage. The health care entity may request additional information.

CONTINUING EDUCATION

Please list all continuing education credits received during the last two years and specify the applicable category. *You may attach a separate sheet listing credits.* _____

THIS SECTION TO BE COMPLETED BY SUPERVISING/EMPLOYING PHYSICIAN

Is this applicant covered by your liability insurance carrier? _____ Yes _____ No

If so, what carrier: _____ In what amount _____

STATEMENT OF SUPERVISING/EMPLOYING PHYSICIAN

In employing/supervising _____ in providing services on at a Texas Health Resources facility premises I agree: Name of Allied Health Professional

- ❖ To accept full legal and ethical responsibility for the AHP’s performance of the duties and acts authorized for him/her while under my supervision;
- ❖ To accept full responsibility for the proper conduct of the AHP, for the AHP’s observance of all bylaws, policies and rules of the facility and Medical Staff, and for the correction and resolution of any problems that may arise;
- ❖ To abide by all bylaws, policies and rules governing the use of AHP’s in this facility, including refraining from requesting that the AHP provide services beyond, or that might reasonably be construed as being beyond, his authorized scope of practice in the hospital;
- ❖ To immediately notify the Director/Administrator in the event any of the following occur:
 - A. My approval to supervise the AHP is revoked, limited, or otherwise altered;
 - B. Notification is given to me of investigation of my supervision of the AHP;
 - C. The employment status of the AHP changes;
 - D. The AHP’s authorized scope of practice changes, or the AHP is under investigation;
 - E. My professional liability insurance coverage is changed insofar as coverage of the acts of the AHP are concerned;

Print Name of Principal Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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Print Name of Supervising Physician	Signature	Date
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NOTE: This page may be copied should additional signature lines be needed.

By applying for authorization as an Allied Health Professional Staff of Texas Health Harris Methodist Hospital Southlake, I hereby:

- ❖ Signify my willingness to appear for interviews if necessary in regard to my application;
- ❖ Authorize the hospital, its Medical Staff and their representative to consult with my prior associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications and ability to work cooperatively with others, and other qualifications for the services I request;
- ❖ Consent to the inspection by the facility, its Medical 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 any and all representatives of the facility and its Staff for their acts performed and statements made in good faith and without malice in connections with evaluating my application and my credentials and qualifications;
- ❖ Release from liability any and all individuals and organizations who provide information to the facility or the Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for professional services;
- ❖ Acknowledge that I have received, or been given access to, and read the Bylaws, Rules and Regulations, Policies and/or Guidelines of the Medical Staff and of the hospital, and any other manuals and policies relevant to the application process and generally to clinical practice by my category of allied health professionals at the hospital, and agree to be bound by the terms thereof in all matters relating to my professional services and to the consideration of my application for affiliation to the Medical Staff and for services;
- ❖ Acknowledge that the provisions of said Medical Staff bylaws relating to confidentiality and release from liability are express conditions to my application for, and acceptance of, Allied Health affiliation and the continuation of such affiliation and to my exercise of professional services;
- ❖ Pledge to maintain an ethical practice and to refrain from misrepresenting my position, status or scope of authorized practice to any patient hospital visitor, hospital employee, Medical Staff member, or any other person affiliated with or coming in contact with the hospital;
- ❖ Acknowledge that I, as an applicant for Allied Health affiliation and/or professional services, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for affiliation and professional services and for resolving any doubts about such qualifications;
- ❖ Agree to inform hospital representatives of any change made or proposed in the status of my license/certificate to practice, professional liability insurance coverage, relationship with any supervising physician (if applicable) and any of the other information provided on the application, and on the status of current or initiation of new malpractice claims; and acknowledge that any significant misstatements in, or omission from, this application constitute cause for denial of my request for services or cause for summary dismissal of the right to provide such services.

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

Signature of Applicant

Date

APPLICANT DISCLOSURE

In order to complete a full background check, we will need you to complete the following information. Please include home addresses for the last **FIVE YEARS**. (Counties are required)

Last Name	First Name	Middle Initial	Maiden Name
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Date of Birth	SSN
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Street Address	
City	County
State	Dates

Street Address	
City	County
State	Dates

Street Address	
City	County
State	Dates