



Application for Medical Staff Appointment and Clinical Privileges

Part I. Credential Review

I am applying for clinical privileges at the location(s) checked below:

- 6209 16th Avenue, Brooklyn, NY 11204 21-10 Borden Avenue, Long Island City, NY 11101 Both
 Starbright Shelter 179 Jamaica Ave Brooklyn NY 11207

I. IDENTIFYING INFORMATION

Last Name		Maiden Name		First Name		Middle Name Initial	
Residence Address			City		State		Zip Code
Home Telephone Number			Cell Phone Number			E-mail Address	
NPI Number				Social Security Number			
Date of Birth		Place of Birth (e.g. state)		Citizenship		Visa Status	

II. GENERAL PROFESSIONAL INFORMATION

Specialty/Subspecialty _____

Other Practice/Group Name (if applicable) _____

Office Address		City		State		Zip Code		Telephone		Fax	
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- This information is already on file and does not need to be updated.

III. MILITARY SERVICE INFORMATION

Dates of Service						Branch											
Address of Current Assignment						Telephone						Fax					

- I have not had any military service. This information is already on file and does not need to be updated.



IV. HEALTH INFORMATION

I hereby affirm that I am physically and mentally able to carry out the responsibilities of medical staff membership and exercise the privileges requested as indicated by supporting documentation that I have submitted.

Yes _____ No _____

IV. POST GRADUATE /RESIDENCY EDUCATION

Program _____ Address _____ State _____ Telephone Number/ Fax Number _____
Program completed successfully? Yes No

Program _____ Address _____ State _____ Telephone Number/ Fax Number _____
Program completed successfully? Yes No

Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? Yes No

This information is already on file and does not need to be updated.

V. FELLOWSHIPS

Program _____ Address _____ State _____ Telephone _____ Fax _____ Dates _____
Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? Yes No

Program _____ Address _____ State _____ Telephone _____ Fax _____ Dates _____
Does this represent an approved program, of sufficient duration, to fulfill that portion of the requirements to take boards in your specialty? Yes No

I have not completed any fellowships.

This information is already on file and does not need to be updated.

VI. BOARD CERTIFICATION AND RECERTIFICATION

1. Certified by: _____ Date: _____

Certificate Number: _____ Date: _____

Last Recertification: _____ Date: _____

2. Certified by: _____ Date: _____

Certificate Number: _____ Date: _____

Last Recertification: _____ Date: _____



- I am not board certified. I expect to undergo board examination on or by: _____
- I plan to undergo board re-examination on or by: _____
- This information is already on file and does not need to be updated.

VII. LICENSES HELD

MD DO DDS DMD Other _____

Number of current and valid NYS License Registration _____ Circle appropriate license

Drug Enforcement Administration (DEA) Registration Number: _____

- This information is already on file and does not need to be updated.

VIII. PROFESSIONAL SOCIETY MEMBERSHIPS

Society

Society

- I do not belong to any professional societies. This information is already on file and does not need to be updated.

IX. CURRENT ACADEMIC APPOINTMENTS

Title	Institution
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Title	Institution
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- I do not have any academic appointments. This information is already on file and does not need to be updated.

X. POST-LICENSE PRACTICE or PROFESSIONAL EMPLOYMENT

Beginning with current experience, list in chronological order going back ten years. Include any military experience. Add additional pages if necessary.

Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
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This information is already on file and does not need to be updated.

XI. CURRENT HOSPITAL AFFILIATIONS

Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
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Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
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Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
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Health Center	Address	Email	Telephone	Fax	Dates (Month/Year)
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I do not have any current hospital affiliations.

Hospital affiliation information is already on file and does not need to be updated.

XII. CURRENT MANAGED CARE ORGANIZATION, MEDICAL SERVICE ORGANIZATION AFFILIATIONS

Are you a Medicare Provider? Yes No Medicare Number: _____

Are you registered with PECOS?
(Medicare Provider Enrollment, Chain, and Ownership System) Yes No PECOS Number: _____

Are you a Medicaid Provider? Yes No Medicaid Number: _____

Are you registered with CAQH?
(Council for Affordable Quality Healthcare) Yes No CAQH Number: _____

Organization	Address	Email	Telephone	Fax
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Organization	Address	Email	Telephone	Fax
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Organization	Address	Email	Telephone	Fax
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Organization	Address	Email	Telephone	Fax
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I do not have any current managed care organization or medical service organization affiliations.

This information is already on file and does not need to be updated.

XIII. LIFE SUPPORT CERTIFICATION

I am currently certified to perform the following life safety interventions (check all that apply):



Technique	Date Certified	Technique	Date Certified
<input type="checkbox"/> Cardiopulmonary Resuscitation (CP)		<input type="checkbox"/> Basic Life Support (BLS)	
<input type="checkbox"/> Advance Cardiac Life Support (ACLS)		<input type="checkbox"/> Pediatric Advance Life Support (PALS)	

I am not current certified to perform any life safety intervention.

XIV. PROFESSIONAL LIABILITY INSURANCE INFORMATION

Current Insurance Carrier	(Agent (if any))	Policy Number	Expiration Date
Address		Telephone	Fax
Policy Limits			

List all previous professional liability insurance carriers for the past ten years.

Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax
Name/Policy Number	Address	Telephone	Fax

Are there any pending professional misconduct proceedings or any pending medical malpractice actions in this state or another state? Yes No

If yes, describe the substance of the allegations in such proceedings or actions on a separate sheet.

- I do not have any current professional liability insurance.
- This information is already on file and does not need to be updated.

XV. CONTINUING MEDICAL EDUCATION

On a separate sheet of paper list:

(A) All postgraduate activities which you have attended or for which you have received credit in the past two years or

(B) If you have reported your continuing medical education activities to an authorized association, please list:

- the name of the authorized association;
- the date when you reported your hours;



(C) Include American Medical Association Physician Recognition Award and inclusive dates if appropriate.

This information is already on file and does not need to be updated.

XVI. PROFESSIONAL REFERENCES

Please submit the names of three individuals we may contact for letters of recommendation for your appointment. These letters will be weighed by the end of direct clinical observation and other work with the applicant. List below the names, addresses, relationships, and the dates of association with each.

1. _____
Name Relationship Dates

Address

Telephone Fax Email Address

2. _____
Name Relationship Dates

Address

Telephone Fax Email Address

3. _____
Name Relationship Dates

Address

Telephone Fax Email Address

Professional references are currently on file and not need to be updated.

XVII. BIBLIOGRAPHY

On a separate sheet, furnish a list of scientific papers, essays, articles, and books published and papers presented at scientific meetings (include reprints).

I have not published any materials. This information is already on file and does not need to be updated.



XVIII. PRACTICE INTERESTS

Provide additional areas of professional practice interest, activities, procedures, diagnoses or populations.

XIX. MISCELLANEOUS INFORMATION

Are you now or were you subject to (provide full details for positive answers on a separate sheet):

	Yes	No
1. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of license or registration to practice in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
2. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of Drug Enforcement Administration (DES) registration?	<input type="checkbox"/>	<input type="checkbox"/>
3. Limitation, suspension, probation, revocation, denial, nonrenewal, voluntary or involuntary surrender of employment, appointment, privileges or training at any health center or healthcare related institution?	<input type="checkbox"/>	<input type="checkbox"/>
4. Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff <u>before</u> a potentially adverse decision was made by a health center's order or healthcare facility's governing board?	<input type="checkbox"/>	<input type="checkbox"/>
5. Formal investigation, corrective action, or discipline by any health center or healthcare related institution for any reason, including patient complaints?	<input type="checkbox"/>	<input type="checkbox"/>
6. Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
7. Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
8. Suspension, sanction or other restriction and participation in any private, federal or state insurance program (e.g. Medicare, Medicaid)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Current police or agency investigation, substantiated charges or convictions for sexual harassment, sexual abuse, child abuse, elder abuse, findings pertinent to violations of patient rights, or other human rights violations?	<input type="checkbox"/>	<input type="checkbox"/>
10. Criminal convictions, pending criminal proceedings, or arrest for felonies or misdemeanors?	<input type="checkbox"/>	<input type="checkbox"/>
11. Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	<input type="checkbox"/>	<input type="checkbox"/>
12. Resignation, withdrawal or termination of your position with the professional Association or health maintenance organization for reasons related to clinical, quality or patient care issues?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you currently have any physical or mental condition (including but not limited to habitual use of or dependent on drugs or alcohol) that impairs or could impair your ability to practice medicine?	<input type="checkbox"/>	<input type="checkbox"/>
14. I hereby waive any confidentiality provisions concerning, and grant HCC or its designee permission to obtain, the information requested by this application.	<input type="checkbox"/>	<input type="checkbox"/>

XX. AFFIRMATION OF INFORMATION



I hereby affirm under the penalties of perjury as follows: that I am the applicant named herein; that I have read the foregoing application and know the contents thereof; that the same is complete, true and accurate to the best of my knowledge and belief.

Signature: _____ Date: _____



When submitting the application, please include the documents listed below or check the box in the left column if current version of the document is already on file.

On File <input checked="" type="checkbox"/>	Documents
<input type="checkbox"/>	Current license or Three Year Agreement.
<input type="checkbox"/>	Current DEA registration with a New York State address, if applicable to the position.
<input type="checkbox"/>	Copy of Diplomas from Graduate, Medical school, and Under Graduate schools
<input type="checkbox"/>	Current curriculum vitae or resume (dates must be in month / year format).
<input type="checkbox"/>	Copies of all updated certification required for the position and privileges you are applying for (may include CPR, BLS, ACLS, PALS, and Infection Control).
<input type="checkbox"/>	Copy of government issued photographic identification (e.g. driver's license; passport)
<input type="checkbox"/>	Written explanation for any discontinuation or lapse in time in Section XIV responses.
<input type="checkbox"/>	Written explanation for "Yes" answers to questions in Section XXI.
<input type="checkbox"/>	Delineation of Privilege form(s) for your specific specialty.
<input type="checkbox"/>	Medical information including: (a) a recent (within the past year) health status assessment that assures freedom from health impairment which is of potential risk to patients or might interfere with the performance of duties; (b) recent (within the past year) result of a tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, or other examination result (e.g. chest X-ray) showing negative findings; (c) a certificate of immunization against rubella; and (d) a certificate of immunization against measles if born on or after January 1, 1957.

Please email the completed application to careers@healthcarechoicesny.org. Thank you.