Application for Non-Licensed 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 11214 ☐ 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

☐ 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 _____

IX. CURRENT ACADEMIC APPOINTMENTS

Title	**Institution**
Title	**Institution**

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

X. POST-CERTIFICATE PRACTICE or PROFESSIONAL EMPLOYMENT

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

Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)
Health Center/Program	Address	Telephone	Fax	Dates – Month/Year)

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

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

Technique	**Date Certified**	**Technique**	**Date Certified**

☐ Cardiopulmonary Resuscitation (CP)		☐ Basic Life Support (BLS)	
☐ Advance Cardiac Life Support (ACLS)		☐ Pediatric Advance Life Support (PALS)	

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

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?	☐	☐
2.	Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrenders of Drug Enforcement Administration (DES) registration?	☐	☐
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?	☐	☐
4.	Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff before a potentially adverse decision was made by a health center's order or healthcare facility's governing board?	☐	☐
5.	Formal investigation, corrective action, or discipline by any health center or healthcare related institution for any reason, including patient complaints?	☐	☐
6.	Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	☐	☐
7.	Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction?	☐	☐
8.	Suspension, sanction or other restriction and participation in any private, federal or state insurance program (e.g. Medicare, Medicaid)?	☐	☐
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?	☐	☐
10.	Criminal convictions, pending criminal proceedings, or arrest for felonies or misdemeanors?	☐	☐
11.	Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	☐	☐
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?	☐	☐
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?	☐	☐

	Yes	No
14. I hereby waive any confidentiality provisions concerning, and grant HCC or its designee permission to obtain, the information requested by this application.	☐	☐

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 ☑	Documents
☐	Current license or Three Year Agreement.
☐	Current DEA registration with a New York State address, if applicable to the position.
☐	Copy of Diplomas from Graduate and Under Graduate schools
☐	Malpractice Insurance face sheet, listing HCC as a certificate holder, indicating no less than 1.3M per occurrence and 3.9M aggregate liability coverage.
☐	Excess malpractice liability insurance cover sheet, if applicable.
☐	Current curriculum vitae or resume (dates must be in month / year format).
☐	Copies of all updated certification required for the position and privileges you are applying for (may include CPR, BLS, ACLS, PALS, and Infection Control).
☐	Copy of government issued photographic identification (e.g. driver's license; passport)
☐	Written explanation for any discontinuation or lapse in time in Section XIV responses.
☐	Written explanation for "Yes" answers to questions in Section XXI.
☐	Delineation of Privilege form(s) for your specific specialty.
☐	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.