Maxillofacial Ambulatory Surgery Center

400 Townline Road, Suite 140
Street Address

Hauppauge | New York | 11788
City | State | Zip

Instructions

1. **Information must be typed or printed.**
2. **All questions must be answered and forms must be signed where indicated. Please initial the bottom of each page of this application.**
3. **If more space is needed, please attach additional sheets and reference the questions being answered.**
4. **If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.**

5. **Please return the following with your application:**
   a. Curriculum vitae
   b. Copy of your current state license
   c. Current IRS W-9s, if applicable
   d. Copy of narcotic registration (federal/state) (DEA and CDS)
   e. Request for Privileges (completed and signed)
   f. Copy of declarations page of professional liability insurance policy including applicant's name, effective date, expiration date, and policy limits
   g. Copy of Board Certification (if applicable)
   h. Copy of professional school/diploma, residency certificates, and Fellowship certificates
   i. Copy of hepatitis-B vaccination or waiver
   j. Copy of most recent tuberculosis PPD test, if applicable

Identifying Information

Last Name | Jr, Sr, etc. | First Name | Middle Name | SSN

List other name(s) by which you have been known

Last Name(s) | First Name(s) | Middle Name

Primary Professional Group and Address | Years Associated (YYYY-YYYY)

City | State | Zip

Telephone Number | Fax Number | Email Address

Home Address | Home Phone Number

City | State | Zip

Alternate Phone Number

Date of Birth | Place of Birth | Citizenship

Physician Providing Coverage | Phone Number | Cell Phone | Email

Medicare Unique Provider ID Number | NPI Number | Medicaid Number | Fax Number

Applicants Initials _____ Date _____

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Medical Licensure/Certification

State License Number | Original Date of Issue (MM/DD/YYYY) | Expires (MM/DD/YYYY)

Controlled Substances Certification Number (Your State Name) | Expires (MM/DD/YYYY)

DEA Registration Number | Expires (MM/DD/YYYY)

Other State Medical Licenses—Past & Present

State License Number | Original Date of Issue (MM/DD/YYYY) | Do you currently practice in this state? ☐ Yes ☐ No | Explain

Pre-Medical Education

College / University | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Medical Education

Medical / Professional School | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Other Professional Education

Name of Institution | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Internship

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Full Name of Program Director or Department Chair

City | State | Zip | Kind (e.g., Medical, Surgical)

Program successfully completed? If no, attach an explanation..... ☐ Yes ☐ No

☐ Rotating ☐ Straight If straight, list specialty:

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation ..... ☐ Yes ☐ No

☐ If more than one internship, check here and attach additional information including responses to the above items specific to the additional internships.

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Residency Programs

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Full Name of Program Director or Department Chair

City | State | Zip | Type of Residency

Program successfully completed? If no, attach an explanation.. ☐ Yes ☐ No

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Full Name of Program Director or Department Chair

City | State | Zip | Type of Residency

Program successfully completed? If no, attach an explanation.. ☐ Yes ☐ No

Training, Fellowships, Preceptorships & Post Graduate Education

List in chronological order. Give complete school or hospital name and address, including ZIP code, beginning and ending dates, and name of your immediate superior.

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Name of Immediate Superior

City | State | Zip | Type of Fellowship

Program successfully completed? If no, attach an explanation.. ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation .... ☐ Yes ☐ No

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Name of Immediate Superior

City | State | Zip | Type of Fellowship

Program successfully completed? If no, attach an explanation.. ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation .... ☐ Yes ☐ No

Name of Institution | Dates Attended (MM/DD/YYYY-MM/DD/YYYY)

Address | Name of Immediate Superior

City | State | Zip | Type of Fellowship

Program successfully completed? If no, attach an explanation.. ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation .... ☐ Yes ☐ No

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Hospital & University Affiliations

List all present and past affiliations in chronological order. Indicate "Membership Status" as: Active/Courtesy, etc., or Academic Title. Use additional sheets if necessary.

Name of Institution (1) | Dates Affiliated (MM/DD/YYYY-MM/DD/YYYY)

Address | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended / Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

City | State | Zip | Department Chief / Chair (Full Name)

Department/Division

Do you currently have privileges at this institution?..... ☐Yes ☐No

If yes, please list the type of privileges granted (e.g., Provisional, Limited, Conditional)

Name of Institution (2) | Dates Affiliated (MM/DD/YYYY-MM/DD/YYYY)

Address | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

City | State | Zip | Department Chief / Chair (Full Name)

Department/Division

Do you currently have privileges at this institution?..... ☐Yes ☐No

If yes, please list the type of privileges granted (e.g., Provisional, Limited, Conditional)

Name of Institution (3) | Dates Affiliated (MM/DD/YYYY-MM/DD/YYYY)

Address | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended / Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

City | State | Zip | Department Chief / Chair (Full Name)

Department/Division

Do you currently have privileges at this institution?..... ☐Yes ☐No

If yes, please list the type of privileges granted (e.g., Provisional, Limited, Conditional)

Name of Institution (4) | Dates Affiliated (MM/DD/YYYY-MM/DD/YYYY)

Address | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended / Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

City | State | Zip | Department Chief / Chair (Full Name)

Department/Division

Do you currently have privileges at this institution?..... ☐Yes ☐No

If yes, please list the type of privileges granted (e.g., Provisional, Limited, Conditional)

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Previous Group / Medical Practice

Name of Organization (1) | Type of Organization | Dates Practicing (MM/DD/YYYY-MM/DD/YYYY)

Address | City | State | Zip

Name of Organization (2) | Type of Organization | Dates Practicing (MM/DD/YYYY-MM/DD/YYYY)

Address | City | State | Zip

Name of Organization (3) | Type of Organization | Dates Practicing (MM/DD/YYYY-MM/DD/YYYY)

Address | City | State | Zip

Certification

Certified by American Board of (Specialty) | Certification # | Dates of Certification/Recertification/Expiration (MM/DD/YYYY-MM/DD/YYYY)

Subspecialty Board Status (Name of Board | Certification # | Dates of Certification/Recertification/Expiration (MM/DD/YYYY-MM/DD/YYYY)

If Not Certified, Give Present Status | Date | Date of Exam

Professional Societies, Awarded Fellowships (e.g., ACS, ACP)

List all memberships past, present, or pending in professional societies. Please include dates of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach additional sheets if necessary.

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Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

Last Name (1) | First Name | Middle Name | Degree | Title | Professional Relationship | Specialty | Years Known

Address | City | State | Zip

Phone | Email | Fax

Last Name (2) | First Name | Middle Name | Degree | Title | Professional Relationship | Specialty | Years Known

Address | City | State | Zip

Phone | Email | Fax

Last Name (3) | First Name | Middle Name | Degree | Title | Professional Relationship | Specialty | Years Known

Address | City | State | Zip

Phone | Email | Fax

Professional Liability

Insurance Carrier | Policy Limits | Per Occurrence ($) | Aggregate ($)

Address | City | State | Zip

Policy # | Agent | Effective Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)

Type of Coverage ☐ Claims Made ☐ Occurrence

Have any professional liability lawsuits been filed against you during the past ten years (including those closed?..... ☐ Yes ☐ No

Are there any now still pending?..... ☐ Yes ☐ No

Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases?.... ☐ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?..... ☐ Yes ☐ No

Have you ever been denied professional insurance, or has your policy ever been canceled?…….. ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

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Professional Sanctions

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐Yes ☐No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency that licenses providers? ☐Yes ☐No
3. Have you lost any board certification(s), and/or failed to rectify (may not apply)? ☐Yes ☐No
4. Have you been examined by a Capital Certifying Board but failed to pass (may not apply)? ☐Yes ☐No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) or any other practitioner data bank? ☐Yes ☐No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐Yes ☐No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or memberships been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation, or non-renewed? ☐Yes ☐No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐Yes ☐No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐Yes ☐No
10. Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs? ☐Yes ☐No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities, and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐Yes ☐No
12. Have you been denied membership and/or been subject to probation, reprimand, sanction, or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐Yes ☐No
13. Have you withdrawn an application or any portion or an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, health care entity, or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐Yes ☐No
14. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐Yes ☐No
15. Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse? ☐Yes ☐No
16. Have you had a refusal or cancellation of professional liability coverage? ☐Yes ☐No

If yes to any of the above, please explain on a separate sheet.

Health Status

1. Do you have a medical condition, physical defect, or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐Yes ☐No
2. Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? ☐Yes ☐No

If yes to any of the above, please explain on a separate sheet.

Chemical Substance or Alcohol Abuse

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐Yes ☐No
2. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐Yes ☐No

If yes to any of the above, please explain on a separate sheet.

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Attestation

By *applying* for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and I authorize the "Organization," its medical staff, and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the "Organization," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the "Organization" and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information

to the "Organization" or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions the "Organization" may have concerning me as long as such release of information is done

in good faith and without malice, and I hereby release from liability and hold harmless the "Organization" and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at (insert organization name), I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of the "Organization", as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards." I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the "Organization" of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as the original.

Signature of Applicant _____ Date _____

Print Name _____

Applicants Initials _____ Date _____

Organization Name | Street Address

RE: Applicants Name, Title | City | State | Zip

Reference Letter

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of (Organization Name). The applicant has given your name as a reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for clinical staff privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

	Reliable	Usually Reliable	Problems
Clinical Knowledge	☐	☐	☐
Clinical Judgment	☐	☐	☐
Technical Proficiency	☐	☐	☐
Professional Relations with Patients	☐	☐	☐
Ethical Conduct	☐	☐	☐
Record Keeping	☐	☐	☐
Ability to Understand and Speak English	☐	☐	☐
Participation in Medical Staff Affairs	☐	☐	☐

What is your opinion regarding the applicant's competency in performing the privileges shown on the attachment?

Additional comments:

Recommendation:

Signature | Title | Date

Name (Please Print)