RE: MEDICAL STAFF APPOINTMENT

Date _____
Physician Applicant _____
Name & Address _____

Dear Dr._____,

You have indicated your interest in becoming a member of the medical staff of _____ (the "Facility"). We have evaluated the credentials you submitted in response to the medical staff policies of our facility and have found them to be facially satisfactory. By virtue of your signature below, you acknowledge that we may rely on the veracity of your submission and that you are obligated to inform us should any of the information provided change in any way.

By your signature on the enclosed Physician Responsibility Agreement, you acknowledge receipt of the performance requirements expected of all physicians of the Facility and you agree to abide by the terms and conditions of this appointment.

We welcome you as a practitioner and we look forward to working with you.

Sincerely,

_____ _____

Administrator Medical Director

ATTACHMENT A

PHYSICIAN RESPONSIBILITY AGREEMENT

Dear Dr._____,

We would like to take this opportunity to welcome you to the staff of _____("Facility"). On behalf of myself and our Medical Director, _____M.D., we look forward to working with you to care for our residents.

There are comprehensive state and federal regulatory and licensure requirements that the Facility must carefully adhere to when providing medical services to our residents which are reflected in our policies and procedures. By signing this Agreement, you agree to adhere to all of the policies and procedures of the Facility and all applicable federal and state laws, including those applicable to Medicare and Medicaid benefits. In addition, we emphasize certain key policies and procedures as required by the Department of Health regulations and, by virtue of your signature below, you agree to strictly comply with these requirements as follows.

I. Within 48 hours of each admission and readmission, you agree to:
   A. Complete a History and Physical Examination
   B. Complete the Physician Plan of Care
   C. Write a Progress Note.

II. On a monthly basis for each resident, you agree to:
   A. Visit the Resident
   B. Write a Progress Note
   C. Timely acknowledge by "signoff" of all physician telephone orders.

III. On a yearly basis, you agree to complete a Physician Plan of Care for each resident.

IV. You acknowledge that the Facility may indicate documents needing your signature by red "flag" but may not flag each document in all instances. Accordingly, you agree to check the following:
   A. All Physician Order Sheets
   B. All Certification/Re-certification for signature and date
   C. Pharmacy Consultations (any disagreement with the Pharmacy Consultation must be stated)
   D. Any other Consultations
   E. Labs and X-rays.

V. You acknowledge that any Discharged Charts are inspected, flagged and include a blank Discharge Summary sheet. These charts are placed in the _____ (facility to designate area) within one week or

less after the date of discharge. You agree to complete the Discharge Summary to include:

A. A final diagnosis
B. Summary remarks
C. Signature.

VI. You agree to provide advance written notification to the Director of Nursing or Administrator of your anticipated vacations or other extended absences and the covering physician contact information.

VII. You hereby declare that you shall not, directly or indirectly, pay, solicit or receive remuneration for the referral of patients to the extent prohibited by federal and state law.

If you have any concerns regarding the overall operations of the Facility, or if you have any suggestions for clinical program development, please contact me at _____

Once again, we look forward to working with you.

Sincerely,

_____

Administrator

I, Dr._____, agree to comply with the policies and procedures of the Facility, including those policies and procedures referenced above.

Copies of each document below are required for our files:

Physician's Name:

	Expiration Date
Physician License	
CDS Certificate	
DEA Control Substance Certificate	
Insurance Certificate	

Attach Current Resume or Curriculum Vitae

GENERAL INFORMATION

Physician's Name _____ _____ _____
Last *First* *Middle*

Degree: _____Specialty: _____Social Security #_____

License#: _____UPIN#: _____

Medicare Provider#: _____

Medicaid Provider# (*if applicable*): _____

Other Licenses (list all states in which previously or currently held):

_____

_____

_____

DEA #: _____

State pharmacy certificate #: _____

Current office address(es) and telephone number(s) (please list all offices):

1. _____

   _____

   _____

   Telephone #: _____

   Fax#: _____

   Pager #/Answering Service: _____

2. _____

   _____

   _____

   Telephone #: _____

   Fax#: _____

   Pager #/Answering Service: _____

Group Practice Name:

_____

List partners/associates (*if applicable*):

_____

_____

_____

_____

_____

Years in practice: _____

Home Address:

_____

_____

Telephone #:_____

Date of Birth: ___/___/_____Place of Birth: _____Sex: _____

Citizenship: _____ Marital Status: _____

Spouses Name: _____

SPECIAL BOARD CERTIFICATION

(For Board Certified practitioners, attach a copy of Certificate. For Board Eligible practitioners, attach a copy of the letter from the Board)

Certified by the American Board of _____

Certification # _____ Date: ___/___/_____

Renewed: _____

Eligible for Board Certification: _____ Date: ___/___/____

HOSPITAL SKILLED NURSING AND SUB-ACUTE AFFILIATIONS

List all present health care affiliations

Hospital & Address	To	From	Status

PROFESSIONAL MEMBERSHIPS

If you are presently a member of, or are applying for membership, in any county, state or national professional societies, boards, or specialty organizations, please list below:

Organization	Current Status

DISCIPLINARY ACTION

Have any of the following ever been or are currently in the process of being investigated by pertinent regulatory authority, denied, revoked, suspended,

reduced, limited, placed on probation, not renewed, or voluntarily relinquished:

1. Medical license in any state
   Yes/No _____

2. Other professional registration or certification to practice profession
   Yes/No _____

3. DEA registration or state pharmacy registration or certification, if any
   Yes/No _____

4. Academic probation or other restriction
   Yes/No _____

5. Membership in any hospital medical staff
   Yes/No _____

6. Prerogatives/rights on the medical staff of any health care facility
   Yes/No _____

7. Clinical privileges in any facility
   Yes/No _____

8. Medicare or Medicaid enrollment and/or billing status
   Yes/No _____

9. Professional society membership, fellowship, or board certification
   Yes/No _____

10. Professional office
    Yes/No _____

11. Any other type of professional sanction(s)
    Yes/No _____

To your knowledge, has information pertaining to you ever been reported to the National Protection Data Bank or the Healthcare Integrity and Protection Data Bank?

Yes/No _____

If you answer "Yes" to any of these questions, please provide a detailed explanation on a separate piece of paper.

PROFESSIONAL LIABILITY INSURANCE

_____	_____	_____
Carrier Name	*Policy Number*	*Amount of coverage*

_____

Expiration Date

During the past ten (10) years, have there been or are there currently pending any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice?
Yes/No _____

Have you even been denied Professional Liability Insurance or has any coverage ever been canceled, restricted, or not renewed by your carrier based on your individual liability history?
Yes/No _____

Have you ever been assessed a surcharge or rated in a high-risk class by your carrier based on your individual liability history?
Yes/No _____

If you answered "Yes" to any of the questions, please provide a detailed explanation on a separate sheet of paper, including the name of carrier, nature of claim, the settlement, and other pertinent information.

_____
Physician Name (typed or printed)

_____ _____
Physician Signature Date

_____ _____
Reviewed by Medical Director Date

_____ _____
Approved by Administrator Date

APPLICANT'S ACKNOWLEDGEMENT

I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment or cause for dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief. In making this application for appointment to the medical staff of _____, (the "Facility"), I acknowledge that I: (1) have received and read the requirements of the medical staff of the Facility; (2) am familiar with the principles, standards, and ethics of the National, State, and Local associations which apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if l am granted privileges at the Facility. I further agree to be bound by the above terms in all matters relating to the consideration of my application or appointment to the medical staff.

Consent for Release of Information: By applying for appointment to the medical staff, I hereby signify my willingness to appear for interviews, if deemed necessary. I authorize the Facility medical staff and/or its representatives to consult with administrative personnel and/or members of the medical staff of other hospitals and/or institutions with which I have been associated and any past and present malpractice carriers who may have information regarding my professional competence, character, and ethics. I hereby further consent to the inspection by the Facility medical staff and its representatives of all records and documents, including medical records at other hospitals, which may be material to an evaluation of my professional qualifications and competence. I hereby release from liability all representatives of the Facility and its medical staff for acts performed in good faith and without malice while evaluating my application, credentials, and qualifications. I further hereby release from liability any individuals and organizations who provide information to the Facility or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications. I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information provided by me to the Facility and/or its medical staff to other hospitals, medical associations, and/or other interested persons/agencies who request such. A release of information must be done in good faith and without malice, and upon presentation to the staff of the Facility a release signed by me. I hereby release from liability this facility and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership of the Facility, have the burden of producing all of the information requested. I fully realize that there is a need for an adequate evaluation of my professional competence, ethics, and other qualifications. I recognize that any doubts or other concerns expressed about my qualifications by anyone contacted in connection with the facility's exercise of due diligence must be resolved to the facility's reasonable satisfaction.

_____ Date _____

Signature of Applicant

_____ Date _____

Reviewed by Medical Director

_____ Date _____

Approved by Administrator

_____ Date _____

Physician Signature