EMORY SAINT JOSEPH'S HOSPITAL

Dear Provider,

Thank you for your recent inquiry in credentialing at Emory Saint Joseph's Hospital. To begin this process, please complete the attached Request for Application and return it to us, along with all requested attachments. Upon receipt of your request form, we will email you a link to complete the on-line application.

Under most circumstances, the credentialing process requires 60-90 days for completion so please plan accordingly.

If you have any questions, please do not hesitate to contact us. We look forward to working with you soon!

Sincerely,

Donna Colella, CPMSM
Manager, Medical Staff Office – Emory Saint Joseph's Hospital
Office: 678-843-7310; Fax: 678-843-5308
Donna.Colella@emoryhealthcare.org

Susan Lowry Lieberman CPCS CPMSM
Medical Staff Liaison- Emory Saint Joseph's Hospital
Office: 678-843-7318; Fax: 678-843-5308
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Kate Martiny
Credentialing Specialist - Emory Saint Joseph's Hospital
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Kate.martiny@emoryhealthcare.org

APPLICATION REQUEST FORM – Online application to follow if threshold eligibility is confirmed.

TODAY'S DATE: _____/_____/_____	**REQUESTED START DATE: _____/_____/_____**

PLEASE SELECT FACILITY AT WHICH APPOINTMENT AND/OR CLINICAL PRIVILEGES ARE REQUESTED:

☑ **Emory Saint Joseph's Hospital (ESJH)** ***5665 Peachtree Dunwoody Rd, Atlanta, GA 30342*** **NOTE:** EUHM **p**rivileges are required for using the infusion center located on the ESJH campus**.**	☐ **Emory Johns Creek Hospital (EJCH)** ☐ **Emory University Hospital Midtown (EUHM)**

Which Emory hospital will be your primary hospital? _____

IDENTIFYING INFORMATION

First Name	**Middle Name:**	**Last Name:** **Suffix (Jr. Sr. III)**
PROVIDERS_FIRSTNAME	PROVIDERS_MIDDLENAME	PROVIDERS_LASTNAME

Is there any other name under which you have been known? Name(s):
PROVIDERS_OTHERNAME_FIRST, PROVIDERS_OTHERNAME_last

Date of Birth	**Social Security Number:**
PROVIDERS_DATEOFBIRTH	

Is your residence and office practice within 45 minutes of the hospital(s) you are applying to?

E-Mail Address: PROVIDERS_CONTACTEMAILADDRESS

***Invitation will be sent to this email address to complete the application**

Are you currently applying for medical staff membership and clinical privileges at any other hospitals in the Atlanta metro area? If so, please list _____

Have you ever previously been, or applied to be, credentialed at any Emory facility? If yes, please provide:
Dates of previous affiliation: _____ to _____ Facility name: _____

Have you ever previously withdrawn an application, or had an application deemed incomplete, at any Emory facility?
If yes, please provide: Date of that action: _____ Facility name: _____

Please provide full details on separate sheet.

PRACTICE INFORMATION

Practice Name ASSIGNMENTS_ACTIVE_ADDRESSES_GROUPNAME1_1

Primary Office Street Address:
ASSIGNMENTS_ACTIVE_ADDRESSES_ADDRESSLINE21_1

City: ASSIGNMENTS_ACTIVE_ADDRESSES_CITY1_1 **State:** ASSIGNMENTS_ACTIVE_ADDRESSES_STATE1_1 **Zip Code:** ASSIGNMENTS_ACTIVE_ADDRESSES_ZIPCODE1_1

Telephone Number:	**Fax Number:**

PRIMARY CREDENTIALING CONTACT

Office Manager/Credentialing Contact Name:

Telephone Number:	**Fax Number:**

Email:

SPECIALTY

Degree: PROVIDERS_DISPLAYDEGREES_SHORT

Specialty: SPECIALTIES_HIPPATAXONOMY_RTK1 T **Subspecialties:**

COVERING PROVIDERS

Are you joining a group____ or sharing call ____ with physicians currently on staff at Emory Saint Joseph's?

If so list members sharing call or members of the group: _____

_____

REASON FOR YOUR INTEREST IN EMORY SAINT JOSEPH'S

Please explain the reason for your interest in joining Emory Saint Joseph's Medical Staff:

BOARD/PROFESSIONAL CERTIFICATION (Attach copies of documents)

Name of certifying organization: BOARDS_CERTIFIED_BOARD_RTK1

Certification Specialty 1: SPECIALTIES_HIPPATAXONOMY_RTK1 T	**Expiration Date:** BOARDS_EXPIRATIONDATE1

If not certified, describe your intent for certification, if any, and date of eligibility for Certification below.

Name of certifying organization:

Certification Specialty 2:	**Expiration Date:**

If not certified, describe your intent for certification, if any, and date of eligibility for Certification below.

ALLIED HEALTH PROFESSIONALS

PRIVILEGES REQUESTED:

☐ **Anesthesia Assistant – AA**	☐ **Orthopedic Technician - Certified**
☐ **Advanced Practice Registered Nurse (APRN)**	☐ **Pathology Assistant**
☐ **Certified Registered Nurse Anesthetist (CRNA)**	☐ **Physician Assistant**
☐ **Clinical Psychologist**	☐ **Radiology Assistant**
☐ **Optometrist**	☐ **Surgical Assistant**

Name of primary physician sponsor for your ESJH privileges:

Additional physician sponsors:

Please answer the following questions.

	YES	NO
1. Do you have a current, unrestricted license to practice in Georgia[1] that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have you never had a license to practice revoked, restricted or suspended by any state licensing agency?		
2. Are you available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and ED patients in a prompt, efficient, and conscientious manner?		
3. Have you been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third- party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same?		
4. Have you been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program?		
5. Have you ever had Medical Staff appointment, clinical privileges, or status as a participating provider denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct?		
6. Have you ever resigned Medical Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility or have had privileges automatically resigned due to an omission?		
7. Have you been arrested, charged, indicted or convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts, (v) sexual misconduct, (vi) moral turpitude, or (vii) child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse?		
8. Can you demonstrate clinical activity in your primary area of practice during the last two years?		
9. Do you have any business interests (including, but not limited to, ownership or investment interests) in any freestanding health care provider? If yes, give details:		
10. Are you employed by any other hospital (other than Emory Healthcare) or its affiliate? If yes, give details:		
11. Has a patient, practice employee, hospital employee or other physician ever lodged a complaint against you involving any of the following types of behavior: sexual harassment, using threatening, profane or abusive language, inappropriate physical contact with another individual, or any other type of disruptive behavior? If yes, give details:		
12. As applicable to relevant practice, do you have a current, unrestricted DEA?		

1 Applications may be processed from applicants awaiting a Georgia license. Conditional appointment and privileges may be granted to otherwise qualified applicants pending receipt of an unrestricted license.

ANNUAL HOSPITAL ACTIVITY	ESJH	EUHM	EJCH
How many hospital patient contacts (admissions, inpatient consults and procedures) do you anticipate having at each facility on an annual basis?			
Inpatient admissions:			
Inpatient consults:			
Outpatient procedures:			
MEDICAL STAFF CATEGORY	**ESJH**	**EUHM**	**EJCH**
Please check your desired category.			
ACTIVE: The Active Staff consists of practitioners who actively participate in the professional affairs of the Medical Staff, including regular admission and attendance of patients, professional supervision of patient care, and/or participation in educational or research programs. The Active Staff are involved in at least twenty-four (24) Patient Contacts per two (2) year appointment term.			
COURTESY: The Courtesy Staff consists of practitioners who are involved in fewer than twenty-four (24) but more than zero (0), Patient Contacts per two (2) year appointment term.			
COVERAGE: The Coverage Staff consists of practitioners who desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff Members who are members of their group practice or their coverage group.			
CONSULTING: The Consulting Staff consists of practitioners who provide a service not otherwise available or that is available in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Consulting Staff Members would not be eligible to request continued Consulting Staff status at the time of their next reappointment.) Consulting Staff shall only provide services at the Hospital at the request of other Members of the Medical Staff.			
REFERRAL: The Referral Staff consists of practitioners who desire to be associated with, but who do not intend to establish a practice at, this Hospital. Referral Staff members are not granted clinical privileges to treat hospital patients. The primary prerogatives of a Referral Staff member shall be to refer patients and attend educational activities sponsored by the Medical Staff and the Hospital. Referral Staff may review the medical records and test results (via paper or electronic access) and write informational notes for any patients who are referred.			

In making your request for an application to Emory Saint Joseph's Hospital of Atlanta Medical Staff, please be aware of several obligations of staff membership, which are requirements:

1. Completion of board certification requirements in your primary area of practice within the eligibility time period defined by your specialty and sub-specialty boards or, if such board has not defined an eligibility time period, then within five years following completion of medical specialty and sub-specialty training. Specialty and sub-specialty boards of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery (ABOMS), the American Dental Association ("ADA"), the American Board of Podiatric Medicine ("ABPM"), the American Board of Foot and Ankle Surgery ("ABFAS"), the College of Family Physicians of Canada ("CFPC"), be a Fellow of the Royal College of Physicians of Canada ("FRCPC") or a Fellow of the Royal College of Surgeons of Canada ("FRCSC")
2. Professional Malpractice Insurance Coverage of 1M/3M.
3. Compliance with Emergency Department call requirements of your Department and/or Section.

This pre-application should be returned with copies of the following. ***(Please explain any pending documents.)***

1. Current, unrestricted license to practice medicine in the State of Georgia.
2. Current Government Issued ID
3. Evidence of board certification status.
4. Evidence of successful completion of an accredited postgraduate residency program or podiatric residency training.
5. Proof of current DEA registration.
6. Certificate of professional liability insurance indicating effective date, amounts of coverage and classification of coverage. (minimum requirements $1M/3M)
7. Current curriculum vitae.

WAIVER, ATTESTATION, and SIGNATURE

By submitting this pre-application, signing this attestation, I certify, agree, understand and acknowledge the following:

1. The information in this pre-application, including all subparts and attachments, is complete, current, correct, and not misleading.

2. Any misstatements or omissions (whether intentional or unintentional) on this pre-application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement.

3. A photocopy of this pre-application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.

4. I have reviewed the information in this pre-application on the most recent date indicated below and it continues to be true and complete.

5. While this pre-application is being processed, I agree to update the information originally provided in this pre-application should there be any change in the information.

6. No action will be taken on this pre-application until it is complete and all outstanding questions with respect to the pre-application have been resolved.

7. This attestation statement and pre-application must be signed no more than 180 days prior to the credentialing decision date.

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my pre-application, application, and qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this pre-application, application, and my qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I understand that upon receipt of this request for an application for appointment to and/or clinical privileges at an Emory facility, Emory Healthcare will obtain an AMA profile (if applicable to my profession).

I request an application for appointment to and/or clinical privileges at the Emory facilities selected on page 2.

Signature: _____

Printed Name: PROVIDERS_LONGNAME _____ **Date:** _____

Please submit your completed application request form to:

Donna Colella, CPMSM, Manager, Medical Staff Office – Emory Saint Joseph's Hospital
Office: 678-843-7310; Donna.Colella@emoryhealthcare.org