NORTHSIDE
HOSPITAL

MEDICAL STAFF PRE-APPLICATION

Enclosed is the REQUEST FOR APPLICATION for medical staff membership and clinical privileges at Northside Hospital.

Please note that this is NOT the application. Complete the enclosed form and return to Medical Staff Services at the email or fax number listed below. Please keep a copy for your records.

Northside Hospital Medical Staff Services
Phone: 404-851-8743
Fax: 404-250-7330
Email: PhysicianAppRequest@northside.com

Once these documents have been returned to Medical Staff Services and you have satisfied the threshold eligibility requirements for medical staff membership, the initial application materials will be sent to you.

NORTHSIDE HOSPITAL
REQUEST FOR MEDICAL STAFF APPLICATION

PERSONAL INFORMATION:

Name: PROVIDERS_LONGNAME Cell Phone: _____

Social Security #: _____ Date of Birth: PROVIDERS_DATEOFBIRTH

NPI #: PROVIDERS_NPI

Have you previously been credentialed as a Medical Staff member at a Northside facility? This includes facilities that are now owned and/or operated by Northside Hospital (e.g., Gwinnett Medical Center, Northside Hospital Cherokee) ☐ Yes ☐ No
If yes, please identify the Medical Staff, practice area, and dates of credentialing: _____

_____

Have you been engaged in the active practice of medicine for the past 2 years?** ☐ Yes ☐ No
If no, please explain and provide the date when your active practice ended. _____

_____

_____

**An applicant who cannot demonstrate recent clinical activity during the past 2 years may not be eligible for privileges until he/she completes a specific plan for re-entry, which may include additional proctoring and/or additional clinical training.

PRIVILEGES:

Which Northside campus do you expect to be your **primary** campus? Please select only one. [required]
☐ Atlanta ☐ Forsyth ☐ Cherokee ☐ Gwinnett ☐ Duluth

I am requesting:

☐ Medical Staff membership and hospital clinical privileges.

CAMPUS(ES)
Please indicate all campus(es) you are **requesting privileges** as a physician by checking the appropriate box(es) [required]:
☐ Atlanta ☐ Forsyth ☐ Cherokee ☐ Gwinnett ☐ Duluth

Please state your reason(s) for applying: TSPMG Needs (default)

_____

☐ Ambulatory Center Staff Privileges only, no hospital privileges

☐ Community Medical Staff Privileges (for performing pre-admission and pre-surgical H&Ps for patients of other Medical Staff members or for supervision and related professional services pursuant to a contract with Northside Hospital; no hospital privileges)

☐ Telemedicine privileges only (requires approved contract with Northside Hospital)

☐ Membership only (no clinical privileges)

To which email address should your application be sent? Please indicate address in the space below.
Note: Application must be sent directly to the physician applicant.

Applicant Email: PROVIDERS_CONTACTEMAILADDRESS

PRACTICE INFORMATION:

Name of group/practice: ASSIGNMENTS_ACTIVE_ADDRESSES_GROUPNAME1_1

Primary office address: ASSIGNMENTS_ACTIVE_ADDRESSES_ADDRESSLINE21_1

ASSIGNMENTS_ACTIVE_ADDRESSES_CITY1_1, ASSIGNMENTS_ACTIVE_ADDRESSES_STATE1_1, ASSIGNMENTS_ACTIVE_ADDRESSES_ZIPCODE1_1

Anticipated start date: _____

EDUCATION/TRAINING:

Applicant must be a graduate of an approved medical, osteopathic, podiatric or dental school or otherwise comply with subsection (b) of the attached threshold eligibility criteria. With the exception of applicants for Community Medical Staff or applicants who are Board Certified in the applicable specialty, applicants must also have satisfactorily completed an accredited post-graduate training program, as required by subsection (k) of the attached threshold eligibility criteria. Please provide the following information regarding your education/training:

Medical School: EDUCATION_MEDICAL_SCHOOL_NAME1 Year Completed _____

Internship: EDUCATION_INTERNSHIP_NAME1 Year Completed _____

Residency: EDUCATION_RESIDENCY_NAME1 Specialty: _____ Year Completed _____

Fellowship: EDUCATION_FELLOWSHIP_NAME1 Specialty: _____ Year Completed _____

BOARD CERTIFICATION: (*not required for Community Medical Staff only)*

Applicants must be Board Certified or board eligible. An applicant who is board eligible must obtain certification within six years after completion of post-graduate training (residency and fellowship). Refer to subsections (o), (p), and (q) of the attached threshold eligibility criteria for further description of this requirement.

Are you Board Certified? ____ Yes ____ No If not, are you Board Eligible? ____ Yes ____ No

Board BOARDS_CERTIFIED_BOARD_RTK1 Month & Year Certified: _____

PROFESSIONAL LIABILITY INSURANCE: (Please provide a copy of current malpractice certificate)

Refer to subsection (d) of the attached threshold eligibility criteria for further description of this requirement.

Name of insurance provider: KAISER FOUNDATION (default)

Dates of coverage: _____ Amounts of coverage: $5M (default)

THRESHOLD ELIGIBILITY CRITERIA (Excerpt from Section 2.A.1 of the Credentialing, Quality, and Due Process Policy):

Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff or Clinical Privileges, the applicant must, as applicable:

(a) have a current, unrestricted license to practice medicine, podiatry, dentistry or oral and maxillofacial surgery in the State of Georgia and have never had a license to practice denied, revoked, restricted or suspended, in each case, either voluntarily or involuntarily, by any state licensing agency;

(b) be a graduate of an approved medical, osteopathic, podiatric or dental school, or be certified by the Educational Council for Foreign Medical Graduates, or have a Fifth Pathway certificate and have passed the Foreign Medical Graduate Examination in the Medical Sciences. For purposes of this subsection, an "approved" school is one fully accredited during the time of the applicant's attendance by the Liaison Committee on Medical Education, the American Osteopathic Association, the Commission on Dental Accreditation, the Council on Podiatric Medical Education, or a successor agency to any of the foregoing;

(c) have a current, unrestricted Drug Enforcement Administration ("DEA") registration authorizing the applicant to prescribe all medications typically used by members of his or her profession and specialty; provided that the foregoing requirement may be waived by the Credentials Committee for an applicant who demonstrates that his or her Clinical Privileges do not require a DEA registration and that such applicant does not intend to prescribe controlled substances;

(d) have and maintain at all times during Medical Staff membership valid professional liability insurance coverage in a form and in amounts as determined from time to time by the Board after consideration of recommendation of the Executive Committee;

(e) have never been convicted of 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;

(f) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program;

(g) have never had medical staff appointment or clinical privileges denied, revoked, or terminated by any health care facility for reasons related to clinical competence or professional conduct;

(h) have never resigned medical staff appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation;

(i) have never been convicted of, or entered a plea of guilty or no contest or the equivalent thereof, to (i) any felony or (ii) any misdemeanor related to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) demonstrate recent clinical activity in applicant's primary area of practice during the two years preceding the application;

(k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada in the specialty in which the applicant seeks Clinical Privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; provided that the foregoing requirement shall be waived for any applicant who is Board Certified in the applicable specialty;

(l) be free from or have under adequate control any significant physical or mental health impairment and be free from abuse of any type of substance or chemical that affects cognitive, motor or communication ability in a manner that interferes with, or presents a reasonable probability of interfering with, the applicant's ability to provide patients with care at a generally recognized level of quality and efficiency, consistent with current medical knowledge and clinical experience, and to discharge the other responsibilities of Medical Staff membership;

(m) be able to (i) read and understand the English language, (ii) speak and write the English language in an intelligible manner, and (iii) prepare medical record entries and other required documentation in an intelligible and legible manner;

(n) attest to completion of continuing education satisfying the requirements of the applicable licensing board (i.e., the Georgia Composite Medical Board, the Georgia State Board of Podiatry Examiners, the Georgia State Board of Examiners for Psychologists, or the Georgia Board of Dentistry). If an otherwise qualified applicant for reappointment is unable to provide such documentation, the applicant may be reappointed for a term of one year. If at the end of the one year term the applicant is again unable to document completion of required continuing education, the applicant may be ineligible for reappointment;

(o) be Board Certified in applicant's primary area of practice at the Hospitals; provided that this requirement shall not apply to a Dentist practicing in an area for which Board Certification is not available. Applicants who are not Board Certified at the time of application but who have completed their residency or fellowship training within the last six years will be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve Board Certification in their primary area of practice within six years from the date of completion of their residency or fellowship training. In lieu of Board Certification, an applicant may provide comparable alternate proof of competency, training and education, which may include evidence of teaching appointments at accredited medical schools, significant publication in his or her specialty area in recognized medical or scientific journals, or similar proof of widely renowned ability and professional reputation. The applicant shall have the burden of proving that such alternate criteria are comparable to Board Certification;

(p) maintain Board Certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements, provided that this requirement shall not apply to a Dentist practicing in an area for which Board certification is not available. Recertification will be assessed at reappointment; and

(q) must not have failed his or her Board Certification examination three or more times.

I represent that I fully satisfy all of the above threshold eligibility criteria. ☐ **Yes** ☐ **No**

If no, please explain which threshold eligibility criteria you are unable to satisfy. _____

_____

_____

_____

Signature of Applicant Date

REQUEST FOR APPLICATION
AUTHORIZATION AND RELEASE

I, PROVIDERS_LONGNAME, hereby request an application for membership to the Medical Staff and/or clinical privileges as requested (referred to herein as this "request"). I am willing to make myself available for interviews in response to this request.

I have the burden of producing adequate information for proper evaluation of this request. I also understand that I have the continuing responsibility to resolve any questions, concerns, or doubts regarding any and all information in this request. If I fail to produce this information, then I understand that Northside Hospital, Inc. ("Hospital") will not be required to evaluate or act upon this request. I also agree to provide updated information as may be required or requested by Hospital and its authorized representatives.

Information given in or attached to this request is accurate. As a condition to making this request, my misrepresentation or misstatement in, or omission from this request, whether intentional or not, shall constitute cause for automatic and immediate rejection of this request resulting in denial of appointment and/or clinical privileges. In the event that appointment and/or clinical privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment and/or privileges.

By requesting an application for appointment and/or clinical privileges, I acknowledge, understand, consent, and agree to the following conditions regardless of whether or not I am provided an application for membership and/or clinical privileges:

A. I specifically authorize Hospital and its authorized representatives to obtain and act upon, and consult with any third party who may have, information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on this request, as well as to inspect or obtain any and all communications, reports records, statements, documents, recommendations or disclosures of said third parties relating to such information. I also specifically authorize said third parties to release said information to Hospital and its authorized representatives upon request.

   The term "Hospital and its authorized representatives" means Hospital and any of the following individuals who have any responsibility for obtaining or evaluating my credentials or acting upon my request, including, but not limited to, Hospital employees and independent contractors, consultants to Hospital, Hospital's attorneys, and Hospital's Medical Staff members. The term "third parties" means all individuals from whom information has been requested by Hospital and its authorized representatives in connection with obtaining or evaluating my credentials or acting upon this request, including, but not limited to, professional or educational entities, appointees to the medical staffs of other hospitals or other physicians, health care practitioners, or nurses, government agencies, organizations, associations, partnerships and corporations, whether or not such entities are hospitals or health care facilities.

B. 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 this request, and I waive all legal claims of whatever nature against Hospital and its representatives acting in good faith and without malice in connection with the investigation and evaluation of this request.

C. I acknowledge that (1) Medical Staff appointment and/or clinical privileges at Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in Hospital's Bylaws and the Medical Staff's Bylaws, Credentialing, Quality, and Due Process Policy, and other policies and rules and regulations; and (3) appointment and/or clinical privileges shall be granted only after completion of a formal application, according to Hospital's Bylaws and the Medical Staff's Bylaws, Credentialing, Quality, and Due Process Policy, and other policies and rules and regulations, and final approval of Hospital's Board of Directors.

I have read and understand this Authorization and Release.

_____

Signature of Applicant DATE

NORTHSIDE HOSPITAL

Medical Staff Services Preapplication and Application Process