LINCOLN COMMUNITY HEALTH CENTER

MEDICAL STAFF APPLICATION **AN EQUAL OPPORTUNITY EMPLOYER**

In compliance with Federal and State equal opportunity employment laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, or disability.

NAME ______________________________ SOCIAL SECURITY #: ________________

PRACTICE ADDRESS: ____________________ OFFICE PHONE#: ____________________

____________________ OFFICE FAX#: ____________________

NAME (S) OF PARTNERS (IF APPICABLE):

________________ ________________ ________________

________________ ________________ ________________

HOME ADDRESS: ____________________ HOME PHONE#: ____________________

____

PLACE OF BIRTH: ____________________ DATE OF BIRTH: ____________________

***CURRENT LICENSE INFORMATION ***

MEDICAL LICENSE#: ____________________ UPIN#: ____________________

DEA#: ____________________ SPECIALTY: ____________________

BOARD CERTIFICATION (S): ____________________ EXPIRATION DATE: __________

CURRENT MEDICAL STAFF AFFILIATIONS: ____________________

(Please attach a copy: original medical license, DEA & NC registration and Board certification.)

EDUCATION

UNDERGRADUATE EDUCATION

____
Name

____
Address

Degree ____________________ Date of Graduation ____________________

PROFESSIONAL MEDICAL EDUCATION (Medical /Dental/NP/PA)

____
Name

____
Address

Degree ______________________ Date of Graduation ______________________

OTHER PROFESSIONAL EDUCATION

____
Name

____
Address

Degree ______________________ Date of Graduation ______________________

EMPLOYMENT HISTORY

1. Dates of Employment From:_________ To:_________ Position: ______________________

   Name of Employer and Address: ____

   ____

   Description of Major Duties Performed: ____

   ____

   Supervisor's Name & Title: ____

   May We Contact for References? ( ) Yes ( ) No   If Yes, Give Phone #: ____________________

2. Dates of Employment From:_________ To:_________ Position: ______________________

   Name of Employer and Address: ____

   ____

   Description of Major Duties Performed: ____

   ____

   Supervisor's Name & Title: ____

   May We Contact for References? ( ) Yes ( ) No   If Yes, Give Phone #: ____________________

PROFESSIONAL SANCTIONS IN THE PAST	YES	NO
Has your license to practice medicine, dentistry, or any other profession in any jurisdiction been , or is it in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily relinquished?		
Have you been refused membership on a hospital staff or a health care facility for clinical or character related reasons?		
Have your membership and/or clinical privileges been reduced, suspended, not renewed or voluntarily relinquished at any other hospital or health care facility?		
Has your request for any specific clinical privileges been denied or granted with stated limitation(s), or have you voluntarily relinquished your privileges at any hospital health care facility?		
Has your employment at any hospital or health care facility ever been suspended, diminished, revoked, not renewed or voluntarily relinquished?		
Has your narcotics registration (DEA) ever been suspended, revoked or voluntarily relinquished?		
Have you been denied membership or renewal thereof or been subject to disciplinary action in any medical or dental organization?		
Have you voluntarily resigned or withdrawn your membership in any medical or dental organization?		
Are you or have you ever been the subject of any pending professional misconduct proceeding as defined by the North Carolina Board of Medical/Dental Examiners?		
Has your participation in Medicare, Medicaid, or any other government program ever been denied, revoked, suspended, reduced, not renewed or voluntarily relinquished?		
Are you or have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs?		
Except for minor traffic violations, have you been arrested/convicted of a crime?		
Have you ever been found guilty of professional misconduct by any Board or Agency?		

If you answered "YES," Please provide detailed information on a separate sheet.

* PROFESSIONAL LIABILITY INSURANCE CARRIER *

(Please have insurance carrier submit verification showing effective and expiration dates, minimum coverage of $1/$3 million, policy number and any claims experiences with this application.)

Insurance Carrier____

Address____

Policy No.____________________ Type of Coverage/Amount____________________

Effective Date____________________ Expiration Date____________________

LIABILITY INSURANCE ACTIONS IN THE PAST	YES	NO
Are there any malpractice actions pending against you in this or any other state?		
Have any judgements in a malpractice action been entered against you in this or any other state?		
Have you entered into a settlement of any malpractice action brought against you in this or any other state?		
Has your professional liability insurance ever been denied or canceled?		

If you answered "YES," Please provide detailed information on a separate sheet.

MANAGED CARE ORGANIZATION AFFILIATIONS

Please indicate all managed care organizations with which you are currently a provider:

____________________ ____________________ ____________________

CONTINUING EDUCATION ACTIVITIES & PROFESSIONAL RECOGNITION

a. Attach evidence of continuing medical education credits for the past two years.

b. Document professional recognition (offices held, honors) received in the past two years.

PEER RECOMMENDATIONS

List four (4) practitioners who can personally attest to your current clinical abilities (do not include family). Two (2) must be Practitioners who have supervised your work. NOTE: These must be "peers", i.e. dentists should list other dentists.

1. Name: ____________________ Address: ____________________

   ____

   Phone#: ____________________ Fax#: ____________________

2. Name: ____________________ Address: ____________________

   ____

   Phone#: ____________________ Fax#: ____________________

3. Name: ____________________ Address: ____________________

   ____

   Phone#: ____________________ Fax#: ____________________

4. Name: ____________________ Address: ____________________

   ____

   Phone#: ____________________ Fax#: ____________________

REQUEST FOR APPOINTMENT/REAPPOINTMENT

Your signature below signifies that you agree to the following conditions pertaining to this application.

- I have the burden of producing adequate information as requested by Lincoln Community Health Center, for proper evaluation of my professional training, experience, competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

- All the information contained in this application is complete and accurate. I understand that any misstatements or omissions from this application, whether intentional or not, whether discovered prior to or after appointment/reappointment and/or privileges have been granted, may result in the denial or termination of membership and/or privileges.

- I pledge that I am free from chemical dependency and physically and mentally able to practice medicine. I agree to report to Lincoln Community Health Center any changes in physical and mental health status, including impairment due to chemical dependency, that would affect my ability to practice medicine.

- I agree to report to Lincoln Community Health Center any changes in staff membership status at other hospitals or health care facilities during the next two years.

- I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff of Lincoln Community Health Center. I am familiar with the principles and standards of the Joint Commission on Accreditation of Health Care Organizations, and the National Committee for Quality Assurance as well as the principles, standards and ethics of national, state and local associations that apply to and govern my specialty and/or profession.

- I agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment/reappointment to the medical staff.

- I agree to abide by such hospital , medical staff and Lincoln Community Health Center Bylaws, Rules and Regulations as may from time to time be enacted.

- I pledge to provide continuous care for may patients and to refrain from delegating the responsibility or care of my patients to any practitioner not qualified to take that responsibility.

- I agree that I will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services and to abide by generally recognized ethical principles applicable to my profession and specialty.

- I agree to notify Lincoln Community Health Center within 30 days if I receive notification of an adverse Action Report or Medical Malpractice Payment Report filed on me with the National Practitioner Data Bank.

Signature ______________________________ Printed Name ______________________________

Date ______________________________