WAYNE SURGICAL CENTER

STAFF APPOINTMENT: REQUIRED MATERIALS WORKSHEET

PHYSICIAN / STAFF NAME: _____

- ☐ Date of Birth _____ Government Photo I.D. _____
- ☐ Application ☐ Letter of Interest
- ☐ Reapplication
- ☐ Delineation of Privileges to be Approved by Center
- ☐ Copy of Current NJ Physician's License
- ☐ Copy of Current NJ CDS License
- ☐ Copy of Current DEA License
- ☐ Copy of Malpractice Insurance Certificate
- ☐ Copy of medical School Diploma
- ☐ Copies of Certificates of Residencies, Chief Residency, and Fellowships
- ☐ Copy of all Board Certifications or Letter of Eligibility
- ☐ Copy of Certificates of Training in Specialty Procedures
- ☐ Copy of Current CME print-out
- ☐ Current CV
- ☐ Letter of Good Standing from a Local Hospital (contact Medical Staff Office)
- ☐ Delineation of Privileges from a Local Hospital (contact Medical Staff Office)
- ☐ Reference 1 ☐ Reference 2 (Please use provided forms)
- ☐ ECFMG (If Applicable)

MEDICAL REQUIREMENTS

☐ History and Physical (every 6 years) ☐ PPD (2-step) ☐ Hepatitis Vacc ☐ Decline ☐ Consent

Titers: ☐ Rubella ☐ Rubeola ☐ Mumps ☐ Varicella ☐ Hepatitis B

To be done by surgical center: ☐ NJPDB ☐ AMA or ☐ State License check

APPLICATION FOR PRIVILEGES

DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ MI: _____

Degree: (CIRCLE) MD DO DC OD DDS DPM DMD ARNP OTHER _____ D.O.B. _____ SEX ____

Specialty: _____

Social Security: _____ N.J. Lic. _____ exp. _____
Medicare: _____ CDS Lic. _____ exp. _____
UPIN: _____ DEA Lic. _____ exp. _____
NPI: _____
Tax I.D.: _____

HOME ADDRESS

Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

OFFICE

Primary Location ☐ Group Practice ☐ Solo Practice

Name of Practice: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email: _____

AFFILIATIONS

Hospital Affiliations / Please list Primary admitting facility first

1. Name: _____
   Appointment dates: _____ Status: _____
2. Name: _____
   Appointment dates: _____ Status: _____
3. Name: _____
   Appointment dates: _____ Status: _____

Have you voluntarily or involuntarily been dismissed from any facility? ☐ YES ☐ NO

If yes,
explain: _____

PROFESSIONAL LIABILITY

Carrier
Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Number: _____ Expiration Date: _____

Per Occurrence: $ _____ Per Aggregate: $ _____

Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed, or terminated by an action of an insurance company? ☐ Yes ☐ No

Since your last application to this facility:

1. Have any professional liability suits been filed against you? ☐ Yes ☐ No
2. Have any judgements or settlements been made against you in professional liability cases? ☐ Yes ☐ No
3. Are there any claims pending? ☐ Yes ☐ No

If the answer to any of these questions is yes, please provide an explanation on a separate piece of paper.

HEALTH STATUS

Excluding question 1, if the following questions are answered in the affirmative, please provide an explanation on a separate piece of paper.

1. I certify that I am in good health and have no physical or mental limitations which impair my ability to render patient care. ☐ Yes ☐ No
2. Have you ever been hospitalized at any time during the past 5 years for a condition which impaired your ability to render patient care? ☐ Yes ☐ No
3. When was you last complete physical examination?
4. Were there any findings that indicated, in any degree, an inability to render care? ☐ Yes ☐ No
5. Are you currently taking medication that may affect either your clinical judgement or ability to otherwise render patient care? ☐ Yes ☐ No
6. Have you ever been hospitalized or treated at any time in the past 5 years for substance or alcohol abuse? ☐ Yes ☐ No
7. Are you currently under any limitations in terms of your ability or availability to render quality patient care? ☐ Yes ☐ No
8. Do you have any chronic illness which affects your ability to render quality patient care? ☐ Yes ☐ No

DISCIPLINARY ACTIONS

If any of the following questions are answered in the affirmative, please provide a full explanation on a separate piece of paper.

1. Has any action ever been taken against your license to practice in any state or jurisdiction including but not limited to denial, suspension, revocation restriction, limitation, probation,or reprimand, or have you ever voluntarily or involuntarily relinquished your license? ☐ Yes ☐ No
2. Has an application for privileges or your existing priviledges at any hospital ever been denied, suspended, revoked, or have you ever voluntarily or involuntarily relinquished priviledges at any hospital in lieu of disciplinary or peer review action or investigation? ☐ Yes ☐ No

3. Have you ever agreed to have your privileges or medical staff appointment at any hospital limited, reduced, or terminated? ☐ Yes ☐ No
4. Are you aware of any investigation by a state or any governmental licensing authority concerning your license? ☐ Yes ☐ No
5. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (i.e. Medicare, Medicaid, HMO's or PPO's etc)? ☐ Yes ☐ No
6. Have you ever been reported to the National Practitioner Data bank for any adverse action or any malpractice insurance payment? ☐ Yes ☐ No
7. Have you ever been censured by a medical society or other professional society or other professional board or association? ☐ Yes ☐ No
8. Have you ever had your Drug Enforcement Administration (DEA) number restricted, supended, revoked, or otherwise limited, or your application for this license refused? ☐ Yes ☐ No
9. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid? ☐ Yes ☐ No
10. Have you ever been convicted of a criminal offense other than minor traffic violations? ☐ Yes ☐ No
11. Has any hospital or facility ever, as a disciplinary action: a.) withdrawn permission for you to perform specific procedures, tests, or treatments; b.) require that another peer (physician or professional) evaluate any patients before you performed a treatment, procedure, test; c.) require another peer (physician or professional) to be physically present when you examine a patient or performed any treatments, procedures or tests; and/or d.) initiated any action against you in any of these areas by formal notice to you or your representatives? ☐ Yes ☐ No
12. Are you now an active or habitual user of narcotics, barbiturates, hypnotic, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substance? ☐ Yes ☐ No
13. Are you addicted to the consumption of alcoholic beverages? ☐ Yes ☐ No

EDUCATION

Professional Schools

Institution Name: _____

Address: _____

Dates Attended: _____ Degree: _____

Institution Name: _____

Address: _____

Dates Attended: _____ Degree: _____

Institution Name: _____

Address: _____

Dates Attended: _____ Degree: _____

Residency

Institution Name: _____

Dates Attended: _____ Type: _____

Institution Name: _____

Dates Attended: _____ Type: _____

Fellowship

Institution Name: _____

Dates Attended: _____ Speciality: _____

Board Certification

Speciality: _____ Board: _____

Date Certified: _____ Expiration: _____

Subspeciality: _____ Board: _____

Date Certified: _____ Expiration: _____

Qualifying Exam: please circle: ECFMG USMLE FLEX

Certification Date: _____ Certification Number: _____

Do any of the following apply?

1. Dismissed from any training program? ☐ Yes ☐ No
2. On probation in any training program? ☐ Yes ☐ No
3. Had disciplinary action taken against you in any Training program? ☐ Yes ☐ No
4. Resigned voluntarily from any training program? ☐ Yes ☐ No

If you checked "Yes" to any of the above questions, please explain and provide supporting documents if available. Give names that can verify explanation whenever possible on a separate piece of paper.

_____

ATTESTATION STATEMENT

I hereby agree to abide by the bylaws rules and regulations of **WASC HOLDING, L.L.C.** Further I agree to accept the professional obligations therein reflected along with accepting privileges and agree to provide for continuous patient care for patients. By signing this application, I attest that my mental and physical capabilities are sound and unchanged since the appointment / last reappointment. The information provided application is complete, true, and accurate to the best of my knowledge.

Signature of Applicant _____ Date _____

CONFIDENTIALITY POLICY

POLICY

The surgical center shall provide healthcare services to its patients while protecting the patients rights to confidential treatment of information.

PURPOSE: to ensure that only parties with legitimate interest have access to healthcare information and there is a conscious effort by all employees to constantly protect patient information through their work habits, computer transmissions, conversation, and handling patient paperwork.

Patient information will be maintained in secure areas.

Patient's identifiable information will be protected from inadvertent viewing by persons not directly involved in the patient's care.

Patient information will be accessed and discussed on a "need to know" basis.

Necessary patient discussions will be in a low tone with an awareness of others in the immediate area.

Phone conversations with, to or about patients will be conducted in a low tone.

Computer transmission of patient information will be in a secure manner.

The original medical records are not to be removed from the center except by subpoena or proper court order.

Employees will sign an employee confidentiality statement that will be maintained on an employee file, and agree to abide by its contents without exception.

Disciplinary action will be taken if a patient confidentiality is breached in any manner.

EMPLOYEE CONFIDENTIALITY STATEMENT

I have read and understand the above policy on patient confidentiality and agree to abide by its contents without exception.

Signature _____ Date _____

PRACTITIONER DATA RECORD / AUTHORIZATION AND LIABILITY RELEASE FORM

General Provisions:

In order to evaluate my application, I agree to the following terms and conditions:

1. That the information contained in the Practitioner Data record is true and accurate and that information important to my application has not been falsified and/or omitted intentionally. I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment.
   I understand that this is an application process and does not constitute acceptance or approval by a credentialing committee. I also acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that WASC HOLDING, L.L.C. and its affiliates will contract with me as a provider of services. I further understand that the burden of providing the necessary information to process my application is upon me (the applicant).
2. I give full permission and authorization to WASC HOLDING, L.L.C. to collect research, and verify any and all references, licenses, certificates, insurance related matters, appointments, and such matters that relate to consideration of my application. This permission extends to and includes the current application and periodic checks as required by the credentialing institution, State of New Jersey HRS, AHCA, AAAHC, NCQA, and AAAASF and for re-credentialing. The aforementioned shall be in effect as long as the applicant is affiliated the credentailing institution.
3. I hereby release from liability and hold harmless all employees, previous employees, staff, authorized representative, management and affiliates of all institutions, individuals, or groups for all acts and statements made in connection with collection, verification, review, and evaluation of my credentials and qualifications. These institutions, individuals, and groups include but are not limited to:

   WASC Holding, L.L.C.
   Governmental and non-governmental agencies
   Insurance companies
   Interviews
   Educational Institutions
   Previous employees
   Public or private record providers

   The foregoing of immunities from liability shall be in addition to those provided by law:
4. I, the undersigned, agree to waive any written notice from any present or past organization, individual or employer that prohibits release of information important to my application.
5. I, the undersigned, agree to accept a "faxed" or photocopy of this authorization to be accepted with the same authority as the original.

_____ _____

Applicant Signature Applicant Printed Name

_____

Date

Credentialing Institution: Wayne Surgical Center, L.L.C.

PEER REFERENCE FORM

NAME AND ADDRESS OF REFERENCE:

_____

_____

_____

_____

re:_____

_____

(Applicant name and title)

_____

(Name of Facility)

The above named practitioner has applied for appointment staff for the above named facility. It is our understanding that you have professional knowledge of this person. In order to appraise the practitioner's professional competence to the purpose of appointment please assist us by completing the questions below to the best of your ability. If any answer dictates the need for explanation. Please do so on the reverse side of this questionnaire. This information is considered confidential and privileged to the fullest extent protected by law.

Please check	Favorable	Unfavorable
Professional Judgement	☐	☐
Sense of Responsibility	☐	☐
Technical Proficiency	☐	☐
Clinical Knowledge	☐	☐
Ethical Conduct	☐	☐
Surgical Staff / Management Relationship	☐	☐
Physician / Patient Relationship	☐	☐
Quality / Timeliness of Recordkeeping	☐	☐
Participation in Medical Staff Affairs	☐	☐

1. Is the practitioner's quality of patient care routinely monitored through quality assurance mechanisms, and are the results consistent with the level of patient care established by your institutions? ☐ Yes ☐ No
2. To your knowledge, has the practitioner been subjected with disciplinary action, reduction, suspension, or revocation of privileges by a hospital, surgical center, or licensing body? ☐ Yes ☐ No
3. Has the practitioner displayed possible physical or mental health problems, or chemical dependence which might affect his/her ability to perform in a competent manner? ☐ Yes ☐ No
4. To your knowledge, has the practitioner been named in possible or filed professional liability cases in the past 12 months? ☐ Yes ☐ No
   If yes, have these claims been reviewed through quality assurance mechanisms? ☐ Yes ☐ No

Completed by _____ (Signature) _____ (Date)

_____ (Print)

Fax completed form to 973-709-9730

PEER REFERENCE FORM

NAME AND ADDRESS OF REFERENCE:

_____

_____

_____

_____

re:_____

_____

(Applicant name and title)

_____

(Name of Facility)

The above named practitioner has applied for appointment staff for the above named facility. It is our understanding that you have professional knowledge of this person. In order to appraise the practitioner's professional competence to the purpose of appointment please assist us by completing the questions below to the best of your ability. If any answer dictates the need for explanation. Please do so on the reverse side of this questionnaire. This information is considered confidential and privileged to the fullest extent protected by law.

Please check	Favorable	Unfavorable
Professional Judgement	☐	☐
Sense of Responsibility	☐	☐
Technical Proficiency	☐	☐
Clinical Knowledge	☐	☐
Ethical Conduct	☐	☐
Surgical Staff / Management Relationship	☐	☐
Physician / Patient Relationship	☐	☐
Quality / Timeliness of Recordkeeping	☐	☐
Participation in Medical Staff Affairs	☐	☐

1. Is the practitioner's quality of patient care routinely monitored through quality assurance mechanisms, and are the results consistent with the level of patient care established by your institutions? ☐ Yes ☐ No
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   If yes, have these claims been reviewed through quality assurance mechanisms? ☐ Yes ☐ No

Completed by _____ (Signature) _____ (Date)

_____ (Print)

Fax completed form to 973-709-9730

PERSONAL PHYSICIAN'S CERTIFICATE

Name of Applicant_____

Name of personal physician_____

Street Address of personal
physician_____
City_____State_____Zip_____

Telephone_____Fax_____

I.CERTIFICATION

This is to certify that I am a physician duly licensed to practice medicine in the State of New Jersey, that I am unrelated to the applicant named above, and that I have taken a full history and performed a complete physical examination upon that person. On the basis of that history and physical examination, I formed a professional opinion concerning his or her health as indicated by my signature below;

II.STATEMENT OF OPINION

PLEASE CHECK AND SIGN ONE OF THE FOLLOWING IN ACCORDANCE WITH YOUR OPINION.

____The applicant named herein does not suffer from any ailment which might prevent him/ or her from practicing medicine or surgery at your facility.

Signature_____date_____

____The health of the applicant herein is described in a separate statement which is enclosed.

Signature_____date_____

HEPATITIS B VACCINE

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself, however, I decline Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

Employee Signature _____

Witness _____

Date _____