Bethel Family Cli c
Practitioner Application

To use the Practitioner Application, follow these instructions:

* Complete the application in its entirety using black or blue ink. Send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 9 and 11. Please document any YES responses on the Attestation Question page.
* Attach copies of requested documents each time the application is submitted.
* If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to:

1. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use *abbreviations.* *Current* copies of the following documents must be submitted with this application: (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

** All sections must be completed in their entirety."

II. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., 111)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions?			
Home Mailing Address:	City:	State:	Zip Code:
Home Telephone Number: ( )	Pager Number: ( )	E-Mail Address:	
Birth Date:	Birth Place (city, state, country):	Citizenship:	
Languages Spoken by practitioner			
Social Security Number:	☐ Male ☐ Female		
Medicare UPIN/NPI:	Medicare Number: (WA)	Medicaid Number(s):	L & I Number(s):
Specialty:	Sub specialties:		
Other Professional Interests in Practice, Research, etc.:			

010207 (10-2002)

111. PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) ________________		
Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):	
Primary Office Street Address:	City:	
	State:	Zip Code:
Patient Appointment Telephone Number: ( )	Fax Number: ( )	
Mailing Address: (if different from above)		
Billing Address: (if different from above)		
Office Manager/ Administrator:	Administration Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

Effective Date at Secondary Practice location (MM/YY) ________________		
Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):	
Secondary Office Street Address:	City:	
	State	Zip Code:
Patient Appointment Telephone Number: ( )	Fax Number: ( )	
Mailing Address:		
Billing Address: (if different from above)		
Office Manager / Administrator:	Administration Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
List other office locations with above information on a separate sheet.		

IV. PROFESSIONAL LICENSURE, . STRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (i.e. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

V. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Yr. Obtained	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Yr. Obtained	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Yr. Obtained	Exp. Date	Yr. Relinquish	Reason:

V11. UNDERGRADUATE EDUCATION *(Do not abbreviate)*

Does Not Apply ☐

College or University Name:	Degree Received		Graduation Date (mm/dd/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received		Graduation Date (mm/dd/yyyy)
Mailing Address:	City:	State:	Zip Code:

VIII. MEDICAL/PROFESSIONAL EDUCATION *(Do not abbreviate)*

Medical/Professional School:	Start Date:	Graduation Date:	Degree Received:
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date:	Graduation Date:	Degree Received:
Mailing Address:	City:	State:	Zip Code:

VIII. OTHER POSTGRADUATE EDUCATION **(Attach Additional Sheet if Necessary)**

Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/ — /)	Program or Course of Study:	Faculty Director:		

Modification to the wording or format of the Practitioner Application may invalidate the application.

IX. **INTERNSHIP/PGYI** **(Attach Additional Sheet if Necessary)**			**Does Not Apply** ☐	
Institution:		Phone Number:	Program Director:	
Mailing Address:		City:	State	Zip Code:
Type of Internship:	Specialty:		From (mm/yyyy):	To (mm/yyyy):

X. **RESIDENCIES** **(Attach Additional Sheet if Necessary)**			**Does Not Apply** ☐	
Institution:		Phone Number:	Program Director:	
Mailing Address:		City:	State	Zip Code:
Type of Residency:	Specialty:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if "No", please explain on separate sheet.)				
Institution:		Phone Number:	Program Director:	
Mailing Address:		City:	State:	Zip Code:
Type of Residency:	Specialty:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if "No", please explain on separate sheet.)				

X1. **FELLOWSHIPS** **(Attach Additional Sheet if Necessary)**		**Does Not Apply** ☐	
Institution:	Phone Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if "No", please explain on separate sheet.)			

XII. **PRIECEPTORSHIP** **(Attach Additional Sheet if Necessary)**			**Does Not Apply** ☐	
Institution:	Address:	City:	State:	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/)-(/)	Training:		Department Chairman:	

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XIII. FACULTYITEACHING APPOI ENTS (Attach Additional Sheet if Necessary)			Does Not Apply ☐	
Institution:	Address:	City:	State:	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/)-(/)	Position:		Faculty Director:	

XIV. BOARD CERTIFICATION				Does Not Apply
Are you board or otherwise professionally certified?				
☐ Yes If "Yes", please complete below:	☐ No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? If so, list certification and date:		☐ Yes	☐ No	
If you participate in a specialty which does not have board certification, please indicate specialty:				

XV. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (i.e., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XVI. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS — **Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, and (C) have had previous affiliations. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT AFFILIATIONS (Do *not abbreviate)*	
Name & Mailing Address of Primary Admitting Hospital:	Department:
Status (active, provisional, courtesy, temporary, etc.)-	Appointment Date:

Name & Mailing Address of Secondar nitting Hospital:	artment:
Status (active, provisional, courtesy, temporary, etc.)-	Appointment Date:
Name & Mailing Address of Other Institutions:	Department:
Status (active, provisional, courtesy, temporary, etc.)-	Appointment Date:
If you do not have hospital privileges, please explain on a separate sheet (practitioners without hospital privileges must provide written plan for continuity of care).	

B. APPLICATIONS IN PROCESS *(Do not abbreviate)*			
Hospital/institution:	Phone Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/institution:	Phone Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

C. PREVIOUS AFFILIATIONS *(Do not abbreviate)*		
Name & Mailing Address of Primary Admitting Hospital:		Department:
Previous Status (active, provisional, courtesy, temporary, etc.)-	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name & Mailing Address of Primary Admitting Hospital:		Department:
Previous Status (active, provisional, courtesy, temporary, etc.)-	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name & Mailing Address of Primary Admitting Hospital:		Department:
Previous Status (active, provisional, courtesy, temporary, etc.)-	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

PRACTITIONER NAME: ____________________

XVII. WORK HISTORY (Do not ab ate)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Name of Current Practice/Employer:	Contact Name:			Telephone Number: ( )	
				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Please account for all periods of time between date of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

XVIII. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current or pending partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.
NOTE: References must be from individuals who through recent observation are directly familiar with your work.

Name of Reference:	Title:	Telephone Number: ( )	
Mailing Address:	City:	State:	Zip Code:
Name of Reference:	Title:	Telephone Number: ( )	
Mailing	City:	State	Zip Code:
Name of Reference:	Title:	Telephone Number: ( )	
Mailing Address:	City:	State:	Zip Code:

XIX. **PROFESSIONAL AFFILIATION** *o not abbreviate)*		
Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ /	☐ YES ☐ NO
	/ /	☐ YES ☐ NO

XX PROFESSIONAL LIABILITY *(Do not abbreviate)*			
Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:
Please list all of your professional liability carriers within the past ten years:			

Name of Carrier:				
Mailing Address:	City:		State:	Zip Code:
Policy Number:	From (mm/yyyy):		To (mm/yyyy):	
Name of Carrier:				
Mailing Address:	City:		State:	Zip Code:
Policy Number:	From (mm/yyyy):		To (mm/yyyy):	
Name of Carrier:				
Mailing Address:	City:		State:	Zip Code:
Policy Number:	From (mm/yyyy):		To (mm/yyyy):	

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PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner

This attestation is submitted to: (Entity Name)	Practitioner Name:

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. If you attach *additional sheets, sign and* date each sheet.

		Question	YES	NO
A.		**PROFESSIONAL SANCTIONS**		
1.		Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
		Specialty or subspecialty board certification	YES ☐	NO ☐
	d.	Membership on any hospital medical staff	YES ☐	NO ☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f.	Medicare, Medicaid, or any public program	YES ☐	NO ☐
	g.	Professional society membership or fellowship	YES ☐	NO ☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO ☐
	i.	Academic Appointment	YES ☐	NO ☐
	J.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.		Have you ever been subject to review and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	YES ☐	NO ☐
3.		Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	YES ☐	NO ☐
4.		Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	YES ☐	NO ☐
B.		**CRIMINAL HISTORY**		
1.		Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐
C.		**AFFIRMATION OF ABILITIES**		
1.		Do you presently use any drugs illegally?	YES ☐	NO ☐
2.		Do you have, or have you had in the last two years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.	YES ☐	NO ☐
3.		Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
D.		**LITIGATION AND MALPRACTICE COVERAGE HISTORY**		
1.		Have you been named as a defendant in a professional liability suit at any time? If yes, please document in Section M. PROFESSIONAL LIABILITY ACTION DETAIL.	YES ☐	NO ☐
2.		Are there any such claims being asserted against you now? Please document on Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL, of the Practitioner Application.	YES ☐	NO ☐
3.		Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐
4.		Are any of the privileges that you are requesting not covered by your current malpractice coverage?	YES ☐	NO ☐

I warrant that all the statements made on this form and on any attached information sheets are true and correct. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:______________________________ Date______________

Type or Print name here______________________________

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XXI. PROFESSIONAL LIABILITY AC..ION DETAIL - CONFIDENTIAL	Does Not Apply
Practitioner Name:(print or type)	
Please list any past or current professional liability claim or lawsuit that has been filed against you. **Photocopy this page as needed and submit a separate page for EACH claim/event.** A legible signed practitioner narrative	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? $	

XXII. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: ______________________________

Signature: ______________________________

(Stamped signature is not acceptable)

Date: ______________________________

Review dates and initials:

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Healthcare Organization:
And/or Designated Agent:

PRACTITIONER AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Practitioner Application and/or the Practitioner Attestation, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the Practitioner Application for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this Practitioner Application. By submitting this Practitioner Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Practitioner Application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this Practitioner Application.

6. For healthcare organizations, I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies.

7. I agree to abide by the policies, procedures, and or contractual agreements of the Healthcare Organization(s) from whom I am seeking initial or recredentialing.

8. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the Practitioner Application/Attestation and attachments hereto may constitute cause for denial of the Practitioner Application or summary dismissal or termination of membership/clinical privileges/participation agreement.

9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where 'I have membership and/or clinical privileges/participation status before initiating judicial action.

10. I understand that completion and submission of the Practitioner Application/Attestation/Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the Practitioner Application or Attestation.

11. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Practitioner Application/attestation.

Print Name Here: ______________________________

Signature: ______________________________

(Stamped signature is not acceptable)

Date: ______________________________

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).

 PRACTITIONER NAME: ______________