K'IMA:W MEDICAL CENTER MEDICAL APPLICATION

Application for Medical Staff Appointment

SEPTEMBER 27, 2022

KMC
PO Box 1288, 535 Airport Rd, Hoopa, CA 95546

License #

SECTION ONE
PERSONAL INFORMATION

Name _____
Last First Middle

Other Name(s) By Which You Have Been Known:_____
Dates This Name Was Used: From:_____ To _____
Day/Mon/Year Day/Mon/Year

Other Name(s) By Which You Have Been Known:_____
Dates This Name Was Used: From:_____ To _____
Day/Mon/Year Day/Mon/Year

Home Address _____
No. & Street City State Zip

Home Telephone(_____)_____ **Cell Phone**(_____)_____

Primary Office Address _____
No & Street City State Zip

Primary Office Telephone (_____) _____

Fax Number (_____) _____ **E-Mail Address**_____

Address To Which All Correspondence Should Be Sent:

Social Security Number _____ **Date of Birth** _____/_____/_____

Place of Birth _____ **Citizenship:** _____

If Not American Citizen, Status and Visa Number _____

Gender: Male Female

☐ ☐

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SECTION TWO
EDUCATION

(Medical/Dental/Graduate Professional Schools, List all-completed or not)

School Name _____ **Degree Awarded** _____

Mailing Address _____
No. & Street City State Zip

Dates Attended (Month, Day, Year) From _____ To _____

Graduation Date (Month, Day, Year) _____

School Name _____ **Degree Awarded** _____

Mailing Address _____
No. & Street City State Zip

Dates Attended (Month, Day, Year) From _____ To _____

Graduation Date (Month, Day, Year) _____

School Name _____ **Degree Awarded** _____

Mailing Address _____
No. & Street City State Zip

Dates Attended (Month, Day, Year) From _____ To _____

Graduation Date (Month, Day, Year) _____

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SECTION THREE
TRAINING
Internship/Residencies/Fellowships/Preceptorship

(List All Completed or Not. If you require additional space, attach separate sheet)

Institution ____

Mailing Address ____
No & Street City State Zip

From (Month, Day, Year) ______________________ **To** ______________________

Type of Training Specialty ____
Program Directors Full Name ____
Current Program Director (If Known)____
Was the program successfully completed? ☐ Yes ☐ No

Institution ____

Mailing Address ____
No & Street City State Zip

From (Month, Day, Year) ______________________ **To** ______________________

Type of Training Specialty ____
Program Directors Full Name ____
Current Program Director (If Known)____
Was the program successfully completed? ☐ Yes ☐ No

Institution ____

Mailing Address ____
No & Street City State Zip

From (Month, Day, Year) ______________________ **To** ______________________

Type of Training Specialty ____
Program Directors Full Name ____
Current Program Director (If Known)____
Was the program successfully completed? ☐ Yes ☐ No

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SECTION FOUR
LICENSURE

(List all current professional licenses; examples of "type" of license: MD, DO, DPM, DDS, DMD, etc.)

If you are an International Medical Graduate, are you: ECFMG certified? ☐ Yes ☐ No

UCMLE/ECFMG Number _____ Certification Issue Date _____

List all **current** professional licenses:

State	Type	Number	Original Date of Issue	Expiration Date

List all **past** professional licenses:

State	Type	Number	Original Date of Issue	Expiration Date

SECTION FIVE
CERTIFICATIONS AND REGISTRATIONS

(List all current certifications and registrations)

Federal DEA Number _____
Date Issued Expiration Date

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SECTION FIVE
CERTIFICATIONS AND REGISTRATIONS
Continued

(List all current certifications and registrations)

Federal DEA Number _____
Date Issued Expiration Date

Specialty _____**Board Certified?** ☐ Yes ☐ No
If No, are you qualified to sit for the examination? ☐ Yes (attach confirmation letter) ☐ No

Board Name _____ Date of Initial Certification_____
Date of Most Recent Certification _____
Date Qualified _____ Qualification Expires _____
–

Sub-Specialty _____**Board Certified?** ☐ Yes ☐ No
If No, are you qualified to sit for the examination? ☐ Yes (attach confirmation letter) ☐ No

Board Name _____ Date of Initial Certification_____
Date of Most Recent Certification _____
Date Qualified _____ Qualification Expires _____

Sub-Specialty _____**Board Certified?** ☐ Yes ☐ No
If No, are you qualified to sit for the examination? ☐ Yes (attach confirmation letter) ☐ No

Board Name _____ Date of Initial Certification_____
Date of Most Recent Certification _____
Date Qualified _____ Qualification Expires _____

CPR CERTIFICATIONS:

Are you certified in CPR? ☐ Yes (attach copy) ☐ No Expiration Date_____

Check Classification(s):
☐ Basic Life Support (BLS) Expiration Date_____
☐ Advanced Cardiac Life Support (ACLS) Expiration Date_____
☐ Health Care Provider (Core C) Expiration Date_____
☐ Advanced Trauma Life Support (ATLS) Expiration Date_____
☐ Neonatal Advanced Life Support(NALS) Expiration Date_____
☐ Pediatric Advanced Life Support (PALS) Expiration Date_____
☐ Other Expiration Date_____

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SECTION SIX
HEALTH CARE AFFILIATIONS

List all hospitals/health system affiliations here you have been employed, practiced, associated, or privileged for the last ten (10) years for the purpose of providing patient care. If there is insufficient space, continue on Page 20. Do not list affiliations that were part of your training (internship, residency, fellowship). Your response must include the reason(s) for any termination or discontinuance of practice, privileges, employment, or association at any kind and the name of the health care facilities.

Facility Name _____

Mailing Address_____
No. & Street City State Zip

Department/Service _____

Dates of Appointment (Mo/Day/Yr) From _____ To _____

Staff Category _____

Reason for Discontinuance _____

Facility Name _____

Mailing Address_____
No. & Street City State Zip

Department/Service _____

Dates of Appointment (Mo/Day/Yr) From _____ To _____

Staff Category _____

Reason for Discontinuance _____

Facility Name _____

Mailing Address_____
No. & Street City State Zip

Department/Service _____

Dates of Appointment (Mo/Day/Yr) From _____ To _____

Staff Category _____

Reason for Discontinuance _____

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SECTION SIX CONTINUED...
HEALTH CARE AFFILIATIONS

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Facility Name _____

Mailing Address_____
No. & Street City State Zip

Department/Service _____

Dates of Appointment (Mo/Day/Yr) From _____ To _____

Staff Category _____

Reason for Discontinuance _____

Indicate which of the above is your "current primary admitting facility" (where you currently spend the greatest portion of your time.)

SECTION SEVEN
OTHER PROFESSIONAL WORK HISTORY

List chronologically all professional work history for the past five (5) years not included previously under academic appointments or health care affiliations (i.e. clinics, solo practice, employment, or practice. Account for all time gaps of thirty (30) days or more.

Name and Nature of Affiliation _____

Complete Mailing Address _____
No. & Street City State Zip

From (Mo/Day/Yr) _____ To _____

Reason for Discontinuance _____

Name and Nature of Affiliation _____

Complete Mailing Address _____
No. & Street City State Zip

From (Mo/Day/Yr) _____ To _____

Reason for Discontinuance _____

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SECTION SEVEN CONTINUED...
OTHER PROFESSIONAL WORK HISTORY

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Name and Nature of Affiliation _____

Complete Mailing Address _____
No. & Street City State Zip

From (Mo/Day/Yr) _____ To _____

Reason for Discontinuance _____

Name and Nature of Affiliation _____

Complete Mailing Address _____
No. & Street City State Zip

From (Mo/Day/Yr) _____ To _____

Reason for Discontinuance _____

Name and Nature of Affiliation _____

Complete Mailing Address _____
No. & Street City State Zip

From (Mo/Day/Yr) _____ To _____

Reason for Discontinuance _____

SECTION EIGHT
PROFESSIONAL LIABILITY INSURANCE

(Submit current face sheet of policy.)

Present Carrier's Name _____

Complete Address _____
No. & Street City State Zip

Policy Number _____ Coverage Amount _____

Dates of Coverage (Mo/Day/Yr) From _____ To _____

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SECTION EIGHT CONTINUED...
PROFESSIONAL LIABILITY INSURANCE

Prior Carrier's (during the past five years)

Prior Carrier's Name_____

Complete Address _____
No. & Street City State Zip

Policy Number _____ Coverage Amount _____

Dates of Coverage (Mo/Day/Yr) From _____ To _____

Prior Carrier's (during the past five years)

Prior Carrier's Name_____

Complete Address _____
No. & Street City State Zip

Policy Number _____ Coverage Amount _____

Dates of Coverage (Mo/Day/Yr) From _____ To _____

1. Have you ever been denied professional liability insurance or has your coverage ever been canceled?
   ☐ Yes* ☐ No

2. Within the last five (5) years, have there been final judgments or settlements involving your professional practice?

   ☐ Yes* ☐ No

*If "Yes", please provide the following information for each situation on a separate sheet. This would include final settlements or judgments where no liability was assigned to you.

a. name of insurance carrier
b. policy number
c. nature and substance of claim
d. date and place at which claim arose
e. amounts paid, if any, and date and manner of disposition, judgment, settlement, or otherwise
f. date and reason for final disposition, if no judgment or settlement

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SECTION NINE
CURRENT PROFESSIONAL PRACTICE

Primary Specialty of Practice_____

Sub-Specialty _____

_____

_____

Secondary Specialty of Practice _____

Sub-Specialty _____

_____

_____

If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s)

_____

_____

_____

Medicare ID# _____ **Medicaid ID#** _____

National Provider ID# (formerly UPIN) _____

Are you a member of an IPA? ☐ Yes ☐ No If "Yes" complete the following:

IPA Name _____

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SECTION TEN
REFERENCES

Please list three (3) peers who have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others. These should be individuals who will provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time.

Examples of professional references are other practitioners in the same field and/or other practitioners in your specialty. None of your references should be relatives or current professional associates.

If your training was completed within the past three (3) years, you may list your Program Director(s) as professional reference(s). If you have been out of training for more than three (3) years, it is important to name individuals who have not been listed in any other part of the application.

1. Name_____

Mailing Address_____

No. and Street City CA 95546

2. Name_____

Mailing Address_____

No. and Street City CA 95546

3. Name_____

Mailing Address_____

No. and Street City CA 95546

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SECTION ELEVEN
DISCLOSURE INFORMATION

Have any of the following ever been, or are currently in process, either on a ***voluntary** or **involuntary** basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

All yes answers require full explanation on a separate page.

1.	Medical license in any state	☐ Ye s	☐ No
2.	Other professional registration/license	☐ Yes	☐ No
3.	State Controlled Substance Registration	☐ Yes	☐ No
4.	Federal DEA Registration	☐ Yes	☐ No
5.	Membership on any hospital/medical staff	☐ Yes	☐ No
6.	Clinical privileges	☐ Yes	☐ No
7.	Participation in the Medicare/Medicaid Program	☐ Yes	☐ No
8.	Other health care organizations, (Surgicenter, managed care, PPO, PHO, MSO, etc...)	☐ Yes	☐ No
9.	Professional society membership	☐ Yes	☐ No
10.	Board certification	☐ Yes	☐ No
11.	ECFMG certification	☐ Yes	☐ No

Additional Information A. Have you been convicted of a felony**?** ☐ Yes ☐ No

*A voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct.

1.) Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?

☐ Yes ☐ No

2.) Are you currently engaged in the illegal use of drugs?* ☐ Yes ☐ No

3.) Have you used illegal drugs within the last 2 years?* ☐ Yes ☐ No

*If you are making application to a governmental entity, you have the right to elect not to answer questions 2 & 3, if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution.

4.) Have you had any privileges revoked?* ☐ Yes ☐ No

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SECTION ELEVEN
DISCLOSURE INFORMATION

Continued

5.) Have you ever been sued for malpractice?* ☐ Yes ☐ No

6.) Involuntary license or medical staff resignations, suspensions, disciplinary actions or denials?*

☐ Yes ☐ No

Notes for yes answers above:

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SECTION TWELVE
ATTESTATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership or participation.

A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

Name: (print):_____

Signature:_____

Date:_____

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SECTION THIRTEEN
REQUIRED COPIES

PLEASE INCLUDE A COPY OF THE FOLLOWING WITH THIS APPLICATION:

- ☐ Current State License(s) (wallet card)
- ☐ State Controlled Dangerous Substance Certificate (if applicable)
- ☐ Current Federal DEA registration
- ☐ Board Certification Certificate or qualifying letter
  Copies may be obtained through your respective specialty board.
- ☐ Current Professional Liability Insurance face sheet
  A copy may be obtained from your individual carrier and/or your agent.
- ☐ Standard ECFMG certificate (if applicable)
  International medical graduates requiring a copy of their certificate should contact the;
  Educational Commission for Foreign Medical Graduates
  3624 Market Street
  Philadelphia, PA 19104
- ☐ Emergency Care Training Certificates (CPR, BLS, ACLS, HCPC, ATLS, NALS, PALS, etc…)
- ☐ Photo Identification. Four (4) prints of a valid state or federal identification with picture.
- ☐ Curriculum Vitae

SECTION FOURTEEN
ADDITIONAL INFORMATION

THIS PAGE IS FURNISHED FOR YOUR CONVENIENCE IN PROVIDING ADDITIONAL INFORMATION. PLEASE MAKE AS MANY COPIES OF THIS PAGE AS YOU REQUIRE TO FULLY ANSWER ALL QUESTIONS.

License #

SECTION FOURTEEN
CONTINUED

NAME:_____

CONDITION OF APPLICATION

By applying for appointment to the Medical Staff at K'ima:w Medical Center, I hereby:

- ☐ signify my willingness to appear for interviews in regard to my application;
- ☐ authorize KMC, its Medical Staff and their representatives to consult with my prior associated and others who may have information bearing on my professional competence, character, ethical qualification and ability to work cooperatively with others and authorize my prior associates and others to release such information when consulted as part of my application;
- ☐ agree that any information so provided shall not be required to be disclosed to me if the third party providing such information does so on the condition that it be kept confidential;
- ☐ authorize any current or previous insurer to release any and all information it may have regarding any claims made against me, the status of such claims, and the probable outcome;
- ☐ extend absolute immunity to and release from liability all representatives of KMC and Medical Staff, for their acts performed in good faith and in connection with evaluating my credentials and qualifications in connection with my application for staff appointment and clinical privileges;
- ☐ acknowledge that I have received, or been given access to and, and have read the Bylaws of the Medical Staff and Governing Board, and any other manuals and policies relevant to the application process and generally to clinical practice at the KMC, and agree to be bound by the terms whether or not my application is granted;
- ☐ pledge to maintain an ethical practice, to provide for continuous care of my patients, and to refrain from delegating the responsibility of care of my patients to any practitioner not qualified to undertake the responsibility;
- ☐ acknowledge that the information I have provided in this application is complete and accurate to the best of my knowledge and agree that the above provisions are in addition to any agreement, understanding, or releases provided by law or contained in any application or request form;
- ☐ acknowledge that I have read, understand, and voluntarily agree to all the conditions stated above.

SIGNATURE*:**_____DATE*:**_____