K'IMA:W MEDICAL CENTER

BEHAVIOR HEALTH APPLLICATION

February 15, 2022
P.O. Box 1288 535 Airport Rd, Hoopa, CA 9546
530 625-4261 fax 530 625-5171

SECTION ONE-PERSONAL INFORMATION

Name: _____
First Middle last

Other names by which you have been known: _____
Home Address : _____
No & Street City State Zip Code

Home Telephone: _(____)_____ Cell Phone: (____)_____

Primary Office Address: _____
(If applicable) No & Street City State Zip Code

Primary Office Telephone: _(___)_____
(If applicable)

Email Address: _____@_____ Fax number (___)_____
Address to which correspondence should be sent: _____
Date of Birth _____/_____/_____ Gender: _____ Place of Birth: _____
Social Security Number: _____-_____-_____ Citizenship: _____
If not an American Citizen, Status and Visa Number: _____

SECTION TWO – EDUCATION

Graduate Professional Schools, List all completed or not

Degree, Title or Licensure: _____

School Name:_____ Degree Awarded _____
Mailing Address: _____
No. & Street City St Zip Code

Dates Attended: From _____to _____ Graduation Date: _____

School Name:_____ Degree Awarded _____
Mailing Address: _____
No. & Street City St Zip Code

Dates Attended: From _____to _____ Graduation Date: _____

School Name:_____ Degree Awarded _____
Mailing Address: _____
No. & Street City St Zip Code

Dates Attended: From _____to _____ Graduation Date: _____

SECTION THREE – LICENSURE

List all current professional licenses

State	Type	Number	Initial date of issue	Expiration Date

Specialty: _____ Board Certified: Yes ❑ No ❑
Board Name: _____ Date of Initial Certification: _____
Date of most recent certification: _____ Expiration: _____

SECTION FOUR – CERTIFICATIONS AND REGISTRATIONS

List all current certifications and registrations

Federal DEA: _____ _____ _____
Number Date Issued Expiration Date

NPI Number: _____ Additional Number if any: _____

CPR CLASSIFICATIONS:

- ❑ CPR Exp date: _____
- ❑ BLS Exp date: _____
- ❑ ACLS Exp date: _____
- ❑ ATLS Exp date: _____
- ❑ NALS exp date: _____
- ❑ PALS exp date: _____
- ❑ Health Care Provider Exp date: _____

SECTION FIVE – DENTAL AFFILIATIONS

Facility Name: _____

Address: _____
No. & Street City State Zip

Dates of appointment (month/yr) From: _____ to _____

Reason for discontinuance: _____

Facility Name: _____

Address: _____
No. & Street City State Zip

Dates of appointment (month/yr) From: _____ to _____

Reason for discontinuance: _____

Facility Name: _____

Address: _____
No. & Street City State Zip

Dates of appointment (month/yr) From: _____ to _____

Reason for discontinuance: _____

SECTION SEVEN - PROFESSIONAL LIABILITY INSURANCE

Submit current face sheet of policy

Present Carrier's Name: _____

Address: _____
No. & Street City State Zip

Policy Number: _____ Coverage Amount: _____

Dates of Coverage: (MM/DD/YYYY) From_____ to (MM/DD/YYYY) _____

Prior Carrier's (during the past five years)

Address: _____
No. & Street City State Zip

Policy Number: _____ Coverage Amount: _____

Dates of Coverage: (MM/DD/YYYY) From_____ to (MM/DD/YYYY) _____

Have you ever been denied professional liability insurance or has your coverage ever been canceled?
❑ Yes ❑ No

Within the last five (5) years, have there been final judgements 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 judgements where no liability was assigned to you.

Name of insurance carrier _____ Policy number _____
Nature and substance of claim_____
Date and place at which claim arose: _____
Amounts paid, if any, and date and manner of disposition, judgement, settlement _____
_____
Date and reason for final disposition, if no judgement or settlement_____
_____

SECTION EIGHT - CURRENT PROFESSIONAL PRACTICE

Primary Practice: _____

Address: _____
No ^ Street City State Zip

Phone Number: _____ Fax Number: _____

SECTION NINE - 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 & Street City State Zip

2 Name: _____

Mailing Address: _____
No & Street City State Zip

2 Name: _____

Mailing Address: _____
No & Street City State Zip

SECTION TEN - 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, place on probation, not renewed or relinquished for disciplinary reasons? All yes answers require a full explanation on a separate page.

Dental License in any state ❑ Yes ❑ No Other professional registration/license ❑ Yes ❑ No

Federal DEA Registration ❑ Yes ❑ No Professional Society Membership ❑ Yes ❑ No

Board Certification ❑Yes ❑ No Participation in the Medicare/Medicaid Program ❑Yes ❑No

Have you ever been convicted for a felony? ❑ Yes ❑ No

Additional information: 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

4 Have you ever had your privileges revoked? ❑Yes ❑No

5 Have you ever been sued for malpractice? ❑Yes ❑No

6 Involuntary license or Dental staff resignations, suspensions, disciplinary actions or denials? ❑Yes ❑ No

Notes for yes answers above:

_____

_____

_____

_____

SECTION ELEVEN - 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 is or omissions from this application may constitute cause For denial of my application for staff membership or participation.

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

Name (print) _____

Signature: _____

Date: _____

SECTION TWELVE -