Request for Appointment

Welcome!

Thank you for your interest in performing cases at North Florida Surgery Center.

Please complete the enclosed **Application for Privileges** and **Authorization For Release of Information**. When submitting your packet please ensure to include a copy of your:

- Curriculum vitae
- Florida Medical License
- DEA License
- Driver's License
- BLS, ACLS, PALS (if applicable)
- Declaration's page of professional liability insurance policy
- Board Certification(s)
- Professional School/Residency/Fellowship Certificates
- Immunization Record (Hep B, PPD specifically)

Once your **Application for Privileges** is approved, you will receive an additional packet noting available block time scheduling and an on-boarding checklist to ensure we have all the items you need to perform cases.

Sincerely,

Jessica Sorsby, MSA, CASC
Administrator

Jill Weeks, RN, BSN, MSN
Administrative Director

Melissa Roberson, RN, DON
Director of Nursing

Application for Privileges

Instructions: Information must be typed or printed. All questions must be answered and forms must be signed where indicated. Please initial the bottom of each page of this application. If more space is needed, please attach additional sheets and reference the questions being answered. If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.

Identifying Information

Last Name	Jr, Sr, etc	First Name	Middle Name	SSN
				___-___-___

List other name(s) by which you have been known:

Last Name(s)	First Name(s)		

Primary Professional Group and Address	Years Associated (YYYY-YYYY)

City	State	Zip	

Telephone Number	Fax Number	Email Address

Home Address	Home Phone Number	

City	State	Zip	Alternate Phone Number

Date of Birth	Place of Birth	Citizenship	

Physician Providing Coverage	Phone Number	Cell Phone	Email

Medicare Unique Provider ID Number	NPI Number	Medicaid Number	Fax Number

Specialty requesting Privileges for:

- ☐ Ophthalmology
- ☐ Pain Management
- ☐ Orthopedics
- ☐ Podiatry
- ☐ Plastic Surgery
- ☐ ENT
- ☐ Neurosurgery
- ☐ General
- ☐ Other: _____

Medical Licensure/Certification

State License Number | Original Date of Issue (MM/DD/YYYY) | Expires (MM/DD/YYYY)

Controlled Substances Certification Number (Your State Name) | Expires (MM/DD/YYYY)

DEA Registration Number | Expires (MM/DD/YYYY)

Other State Medical Licenses – Past & Present

State License Number | Original Date of Issue (MM/DD/YYYY) | Do you currently practice in this state? Y or N

Pre-Medical Education

College/University | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Medical Education

College/University | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Other Professional Education

College/University | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Internship

College/University | Degrees/Honors

Address | Date of Graduation (MM/DD/YYYY)

City | State | Zip

Internship program successfully completed? If no, attach an explanation……..Yes ___ No ___

__ Rotating __ Straight; if Straight. list specialty: _____

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. Yes / No

__ If more than one internship, check here and attach additional information including responses to the above items specific to the additional internship.

Residency Programs

_____ _____
Name of Institution Program Director

_____ _____
Address Dates Attended (MM/DD/YYYY)

_____ _____ _____
City State Zip

_____ Program Successfully Completed? Yes ___ No ___
Type of Residency *If no, attach an explanation

Training, Fellowships, Preceptorships & Post Graduate Education

_____ _____
Name of Institution (1) Supervisor

_____ _____
Address Dates Attended (MM/DD/YYYY)

_____ _____ _____
City State Zip

_____ Program Successfully Completed? Yes ___ No ___
Type of Fellowship *If no, attach an explanation

Were you subject of any disciplinary actions during your attendance at this institution? Yes ___ No ___
*If yes, attach an explanation

_____ _____
Name of Institution (2) Supervisor

_____ _____
Address Dates Attended (MM/DD/YYYY)

_____ _____ _____
City State Zip

_____ Program Successfully Completed? Yes ___ No ___
Type of Fellowship *If no, attach an explanation

Were you subject of any disciplinary actions during your attendance at this institution? Yes ___ No ___
*If yes, attach an explanation

Hospital & University Affiliations

Name of Institution (1) _____ Membership Status (Active, etc) _____

Address _____ Dates Affiliated (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Do you currently have privileges at this institution?..... Yes ___ No ___

If yes, please list the type of privileges granted (e.g. Provisional, limited, conditional) _____

Name of Institution (2) _____ Membership Status (Active, etc) _____

Address _____ Dates Affiliated (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Do you currently have privileges at this institution?..... Yes ___ No ___

If yes, please list the type of privileges granted (e.g. Provisional, limited, conditional) _____

Name of Institution (3) _____ Membership Status (Active, etc) _____

Address _____ Dates Affiliated (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Do you currently have privileges at this institution?..... Yes ___ No ___

Name of Institution (4) _____ Membership Status (Active, etc) _____

Address _____ Dates Affiliated (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Do you currently have privileges at this institution?..... Yes ___ No ___

If yes, please list the type of privileges granted (e.g. Provisional, limited, conditional) _____

Previous Group/Medical Practice

Name of Organization (1) _____ Type of Organization _____

Address _____ Dates Practicing (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Name of Organization (2) _____ Type of Organization _____

Address _____ Dates Practicing (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Name of Organization (3) _____ Type of Organization _____

Address _____ Dates Practicing (MM/DD/YYYY) _____

City _____ State _____ Zip _____

Certification

Certified by American Board of (Specialty) _____ Certification # _____ Dates of Certification _____

Certified by American Board of (Specialty) _____ Certification # _____ Dates of Certification _____

Subspecialty Board Status (Name of Board) _____ Certification # _____ Dates of Certification _____

If Not Certified, Give Present Status _____ Date _____ Date of Exam _____

Professional Societies, Awarded Fellowships (e.g., ACS, ACP)

List all memberships past, present, or pending in professional societies.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Professional Peer References

List three professional references familiar with the applicant's qualifications during the three (3) years immediately preceding this application. One professional reference must be from the Chief of the department of service where the applicant last furnished professional services.

Last Name (1) _____ First Name _____ Middle Name _____ Degree _____ Title _____ Prof Relationship _____ Specialty _____ Years Known _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Last Name (2) _____ First Name _____ Middle Name _____ Degree _____ Title _____ Prof Relationship _____ Specialty _____ Years Known _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Last Name (3) _____ First Name _____ Middle Name _____ Degree _____ Title _____ Prof Relationship _____ Specialty _____ Years Known _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Professional Liability

Insurance Carrier _____ Policy Limits _____ Per Occurrence ($) _____ Aggregate ($) _____

Address _____ City _____ State _____ Zip _____

Policy # _____ Agent _____ Eff Date (MM/DD/YYYY) _____ Exp Date (MM/DD/YYYY) _____

Type of Coverage……..……Claims Made ___ Occurrence ___

Have any professional liability lawsuits been filed against you during the past ten years (including those closed?)… Y__ N__

Are there any now still pending?..... Y __ N __

Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases? Y __ N __

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?..... Y __ N __

Have you ever been denied professional insurance, or has your policy ever been canceled?..... Y __ N __

*If yes to any of the above, please explain on a separate sheet.

Professional Sanctions

1.	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?	Yes No
2.	Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency that licenses providers?	Yes No
3.	Have you lost any board certification(s), and/or failed to rectify (may not apply)?	Yes No
4.	Have you been examined by a Capital Certifying Board but failed to pass (may not apply)?	Yes No
5.	Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) or any other practitioner data bank?	Yes No
6.	Has your federal DEA number and/or state-controlled substances license been restricted, limited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	Yes No
7.	Have you, or any of your hospital or ambulatory surgery center privileges and/or memberships been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation, or non-renewed?	Yes No
8.	Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?	Yes No
9.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?	Yes No
10.	Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs?	Yes No
11.	Have Medicare, Medicaid, CHAMPUS, PRO authorities, and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	Yes No
12.	Have you been denied membership and/or been subject to probation, reprimand, sanction, or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	Yes No
13.	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, health care entity, or health care plan prior to a final decision to avoid a professional review or an adverse decision?	Yes No
14.	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	Yes No
15.	Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse?	Yes No
16.	Have you had a refusal or cancellation of professional liability coverage?	Yes No

*If yes to any of the above, please explain on a separate sheet.

Health Status

1.	Do you have a medical condition, physical defect, or emotional impairment which is any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	Yes No
2.	Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	Yes No

Chemical Substance of Alcohol Abuse

1.	Are you currently engaged in illegal use of any legal or illegal substances?	Yes No
2.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	Yes No

Attestation

By applying for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and I authorize the "Organization", its medical staff, and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the "Organization", its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the "Organization" and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individual sand organizations who provide information to the "Organization" or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions the "Organization" may have concerned me as long as such release of information is done in good faith and without malice, and I hereby release from liability and hold harmless the "Organization" and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at North Florida Surgery Center, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of the "Organization", as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards". I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the "Organization" of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial or appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as the original.

_____ _____

Signature of Applicant Date

_____

Print Name

Temporary Privileges

- ☐ Appointment recommended to the category of _____ staff with the following clinical privileges:
  - As Requested,
  - As Requested with the following changes:
    - _____
      _____
      _____
      _____
- ☐ Appointment not recommended

_____ _____
Executive Director Date

_____ _____
Medical Director Date

Medical Executive Committee

- ☐ Appointment recommended to the category of _____ staff with the following clinical privileges:
  - As Requested,
  - As Requested with the following changes:
    - _____
      _____
      _____
      _____
- ☐ Appointment not recommended

_____ _____
Medical Executive Committee Member Date

Board of Directors

- ☐ Appointment recommended to the category of _____ staff with the following clinical privileges:
  - As Requested,
  - As Requested with the following changes:
    - _____
      _____
      _____
      _____
- ☐ Appointment not recommended

_____ _____
Board of Directors Member Date