

***MID-MICHIGAN  
UNIFORM  
CREDENTIALING  
APPLICATION  
FOR  
APPOINTMENT***

**MEMBERSHIP AND PRIVILEGES ARE NOT GUARANTEED SIMPLY BY SUBMITTING THIS APPLICATION TO ANY OF THE HEALTHCARE ORGANIZATIONS TO WHICH YOU ARE APPLYING. EACH HEALTHCARE ORGANIZATION UTILIZES THEIR OWN CREDENTIALING AND APPROVAL PROCESS. PLEASE SEE DESIGNATION PAGES FOR MAILING ADDRESS AND CONTACT NAMES.**

**Mid-Michigan Uniform Credentialing Application for Appointment  
Designation Page 1 of 2**

I hereby make application for appointment, clinical privileges and/or membership to the healthcare facility (ies)/organization(s) I have identified on Designation Page 1 and/or Designation Page 2. I also authorize the use of this application by each facility (ies)/organization(s) I have identified on Designation Page 1 and/or Designation Page 2. I understand that my application will be considered in accordance with the applicable credentialing policies, procedures and practices of each healthcare facility/organization as designated.

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**\*NOTE: You must photocopy and mail the entire application and supporting documentation to each Healthcare facility/organization you have checked on designation page 1 and 2.** Upon receipt of your application, each healthcare facility/organization will forward to you information specific to your membership/affiliation. Should you have any questions or require additional information, contact the appropriate representatives listed on Designation Page 1 and/or Designation Page 2.

	<b>Healthcare Facility/Organization</b>	<b>Mailing Address and contact:</b>
	<input type="checkbox"/> <b>Clinton Memorial Hospital</b>	<b>Clinton Memorial Hospital*</b> <b>Pat Quigley, Medical Staff Coordinator</b> <b>Medical Staff Office</b> <b>805 S. Oakland St.</b> <b>St. Johns, MI 48879</b> Phone (989) 227-3326, Fax (989) 227-3407 Email: <a href="mailto:pat.quigley@sparrow.org">pat.quigley@sparrow.org</a>
	<input type="checkbox"/> <b>Eaton Rapids Medical Center</b>	<b>Eaton Rapids Medical Center*</b> <b>Terri Rhoads, Medical Staff Coordinator</b> <b>1500 S. Main Street</b> <b>Eaton Rapids, MI 48827</b> Phone: (517) 663-9476, Fax: (517) 663-2472 Email: <a href="mailto:trhoads@ermchealth.org">trhoads@ermchealth.org</a>
	<input type="checkbox"/> <b>Genesis Surgery Center, L.L.C.</b>	<b>Genesis Surgery Center, L.L.C.*</b> <b>Sandra Sinclair</b> <b>3400 E. Jolly Road</b> <b>Lansing, MI 48910</b> Phone: (517) 272-1063, Fax: (517) 272-1685 Email:
	<input type="checkbox"/> <b>Hayes Green Beach Memorial Hospital</b>	<b>Hayes Green Beach Memorial Hospital*</b> <b>Paula VanDorpe, Professional Services 881</b> <b>321 E. Harris Street</b> <b>Charlotte, MI 48813</b> Phone: (517) 543-1050, Ext. 1206, Fax: (517) 541-0036 Email: <a href="mailto:pvandorpe@HGBhealth.com">pvandorpe@HGBhealth.com</a>
	<input type="checkbox"/> <b>Ingham Regional Medical Center</b>  <u><b>Affiliated Entities</b></u> <input type="checkbox"/> Mid-State Physicians, P.C. <input type="checkbox"/> McLaren Health Plan <input type="checkbox"/> Great Lakes Cancer Institute	<b>Ingham Regional Medical Center *</b> <b>Michelle Kelly, CPMSM,</b> <b>Cindy Stauffer, Medical Staff Coordinator</b> <b>Medical Staff Services</b> <b>401 W. Greenlawn Avenue</b> <b>Lansing, MI 48910-2819</b> Phone: (517) 334-2395, Fax: (517) 346-4865 Email: <a href="mailto:michelle.kelly@IRMC.org">michelle.kelly@IRMC.org</a> , <a href="mailto:cindy.stauffer@IRMC.org">cindy.stauffer@IRMC.org</a>

REVISED 2/06

**Mid-Michigan Uniform Credentialing Application for Appointment  
Designation Page 2 of 2**

	Healthcare Facility/Organization	Mailing address and contact:
	<input type="checkbox"/> <b>Lansing Surgery Center</b>	<b>Lansing Surgery Center*</b> <b>Sandra Sinclair</b> <b>1707 Lake Lansing Road</b> <b>Lansing, MI 48912</b> Phone: (517) 267-0033, Fax: (517) 267-0430
	<input type="checkbox"/> <b>MSU HealthTeam</b>	<b>Michigan State University *</b> <b>Patricia Bayer, Credentialing Coordinator,</b> <b>MSU HealthTeam</b> <b>D-128 W. Fee Hall</b> <b>East Lansing, MI 48824-1315</b> Phone: (517) 353-9783, Fax: (517) 432-1167 Email: <a href="mailto:Pat.Bayer@ht.msu.edu">Pat.Bayer@ht.msu.edu</a>
	<input type="checkbox"/> <b>Michigan Surgical Center</b>	<b>Michigan Surgical Center*</b> <b>JoAnne Hudson, Administrative Assistant</b> <b>2075 Coolidge Road</b> <b>East Lansing, MI 48823</b> Phone (517) 319-9025, Fax (517) 319-0049 Email: <a href="mailto:jhudson@loeye.com">jhudson@loeye.com</a>
  	<input type="checkbox"/> <b>Sparrow Health System</b> <b>Includes St. Lawrence Campus</b>  <input type="checkbox"/> <b>Sparrow Specialty Hospital</b> (St. Lawrence Campus LTACH)	<b>Sparrow Health System*</b> <b>Includes St. Lawrence Campus</b> <b>Jan Sipola, CPMSM (517) 364-2122</b> <b>Lola Leonard, CPMSM (517) 364-2085</b> <b>Chris Allen, CPCS (517) 364-2913</b> <b>Medical Staff Office</b> <b>P.O. Box 30480</b> <b>Lansing, MI 48909-7980</b> Fax: (517) 364-3896 Email: <a href="mailto:jan.sipola@sparrow.org">jan.sipola@sparrow.org</a> , <a href="mailto:chris.allen@sparrow.org">chris.allen@sparrow.org</a> , <a href="mailto:lola.leonard@sparrow.org">lola.leonard@sparrow.org</a>
	<input type="checkbox"/> <b>Physicians Health Plan (PHPMM)</b>  <i>Applicants have the right to be informed of the status of their application. Please contact PHPMM for more information and to determine what information can be reviewed.</i>	<b>Physicians Health Plan (PHPMM) *</b> <b>ATTN: Network Services Dept.</b> <b>Kathie Clarkin, Credentialing Coordinator</b> <b>Christa Sielski, Credentialing Coordinator</b> <b>P.O. Box 30377</b> <b>Lansing, MI 48909-7877</b> (517) 364-8312 Fax: (517) 364-8412 Email: <a href="mailto:Kathie.Clarkin@phpmm.org">Kathie.Clarkin@phpmm.org</a> , <a href="mailto:Christa.Sielski@phpmm.org">Christa.Sielski@phpmm.org</a> , <a href="mailto:Amy.Weller@phpmm.org">Amy.Weller@phpmm.org</a>

Mid Michigan Uniform Credentialing Application

SECTION A – INSTRUCTIONS

1. Please type or legibly print all information and sign the designation page and the applicant's consent and release in Section O.
2. If more space is needed, attach additional sheets and make reference to the question being answered.
3. Please ATTACH CURRENT COPIES of the following documents to this application:

- CV or Resume (mm/dd/yy)
- Federal Controlled Substance License (DEA), if applicable
- Michigan Controlled Substance License
- Michigan Physician/Dental/Podiatric License to Practice Medicine
- Professional Liability Insurance Certificate of Coverage from Insurance Carrier
- ECFMG Certificate (if Foreign Medical Graduate) and/or applicable USMLE Certificate
- Medical School Diploma
- Certificate of Internship
- Certificate of Residency
- Residency Training Logs
- Certificate of Fellowship
- Fellowship Training Logs
- Board Certification
- PPD Status Validation Within Previous 12 months
- Privilege Delineation Form
- Current Driver's License
- Original photo with signature - NOTARIZED
- CLIA (CLINICAL LABORATORY IMPROVEMENT AMENDMENTS) Certificate (if applicable)
- (PHPMM ONLY) Letter from covering physician if not applying for admitting privileges

4. Credentialing Application Fee(s)

- |  |          |
|--|----------|
| <input type="checkbox"/> Clinton Memorial Hospital                             | \$100.00 |
| <input type="checkbox"/> Eaton Rapids Medical Center                           | No Fee   |
| <input type="checkbox"/> Genesis Surgery Center, L.L.C.                        | No Fee   |
| <input type="checkbox"/> Hayes Green Beach Memorial Hospital                   | \$150.00 |
| <input type="checkbox"/> Ingham Regional Medical Center                        | \$250.00 |
| (Make check payable to IRMC Medical Staff Services)                            |          |
| <input type="checkbox"/> Lansing Surgery Center                                | No Fee   |
| <input type="checkbox"/> MSU HealthTeam  | No Fee   |
| <input type="checkbox"/> Michigan Surgical Center                              | No Fee   |
| <input type="checkbox"/> Sparrow Health System (Sparrow & St. Lawrence Campus) | \$250.00 |
| (Make check payable to SHS Medical Staff Development)                          |          |
| <input type="checkbox"/> Physicians Health Plan (PHPMM)                        | No Fee   |

5. Anticipated Start Date: \_\_\_\_\_

## SECTION B - - PERSONAL INFORMATION

1. \_\_\_\_\_ 2. Degree \_\_\_\_\_  
Last Name First Name Middle Initial
3. Date of Birth \_\_\_\_\_ 4. Birthplace \_\_\_\_\_ 5. Ethnicity (optional) \_\_\_\_\_
6. Social Security Number \_\_\_\_\_ 7. (Optional) \_\_\_\_\_ Male \_\_\_\_\_ Female
8. Other Legal Name(s) Used \_\_\_\_\_
9. Home Address \_\_\_\_\_  
Number and Street City State Zip Code
10. Home Phone \_\_\_\_\_  Listed  Unlisted 11. Home Fax \_\_\_\_\_
12. All current and prior city and states of residence \_\_\_\_\_
13. Citizenship \_\_\_\_\_
14. Languages spoken \_\_\_\_\_ 15. Email Address \_\_\_\_\_
- If not a citizen of the United States, please indicate the status of your VISA at the present time. \_\_\_\_\_
16. Contact in Case of Emergency \_\_\_\_\_
17. Contact Work Phone \_\_\_\_\_ 18. Contact Home Phone \_\_\_\_\_

## SECTION C - PROFESSIONAL DATA

1. Practice Specialty \_\_\_\_\_
2. Practice Subspecialty \_\_\_\_\_
3. Since Medical School, list all licenses:
- State \_\_\_\_\_ License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_
- State \_\_\_\_\_ License Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

### PRIMARY PRACTICE INFORMATION

Anticipated start date: \_\_\_\_\_

Local Practice Information. Out of area applicants should complete information based on existing arrangements in the Lansing area. Where local arrangements are not finalized and confirmed, put "N.A." after entry.

4. Nature of Practice:  Solo  Single Specialty Group  Multi-specialty Group

Corporation Name Affiliated with Federal Tax Identification Number \_\_\_\_\_

Federal Tax Identification Number \_\_\_\_\_

Remittance Address \_\_\_\_\_  
Number and Street City State Zip Code

Name of Group Members (or attach list) \_\_\_\_\_

Clinic name if different from corporation name: \_\_\_\_\_

**SECTION C – PROFESSIONAL DATA CONTINUED**

5. Primary Office Address \_\_\_\_\_  
Number and Street City State Zip Code

6. General Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 7. Fax \_\_\_\_\_

8. Private Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 9. Answering Service \_\_\_\_\_

10. TDD Service(please circle): YES NO If yes, TDD phone number: \_\_\_\_\_

11. Pager Number \_\_\_\_\_ 12. Cell Phone \_\_\_\_\_

13. Office Manager/Contact \_\_\_\_\_ 14. Phone \_\_\_\_\_ Ext. \_\_\_\_\_

15. Website address \_\_\_\_\_ 16. Billing Company Name \_\_\_\_\_

17. Billing Company Address \_\_\_\_\_  
Number and Street City State Zip Code

18. Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 19. Fax \_\_\_\_\_

20. Office Manager/Contact (if different) \_\_\_\_\_ 21. Phone \_\_\_\_\_ Ext. \_\_\_\_\_

22. Academic Office

Address \_\_\_\_\_  
Number and Street City State Zip Code

23. Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 24. Fax \_\_\_\_\_

25. Office Manager/Contact \_\_\_\_\_ 26. Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**ADDITIONAL PRACTICE INFORMATION** – if applicable please supply the same information as that under primary practice information

Anticipated start date: \_\_\_\_\_

27. Nature of Practice:  Solo  Single Specialty Group  Multi-specialty Group

Corporation Name Affiliated with Federal Tax Identification Number \_\_\_\_\_

Federal Tax Identification Number \_\_\_\_\_

Remittance Address \_\_\_\_\_  
Number and Street City State Zip Code

Name of Group Members \_\_\_\_\_

Clinic name if different from corporation name: \_\_\_\_\_

28. Secondary Address \_\_\_\_\_  
Number and Street City State Zip Code

29. General Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 30. Fax \_\_\_\_\_

31. Private Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 32. Answering Service \_\_\_\_\_

33. Pager Number \_\_\_\_\_ 34. Office Manager/Contact \_\_\_\_\_

35. Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 36. Billing Company Name \_\_\_\_\_

37. Billing Company Address \_\_\_\_\_  
Number and Street City State Zip Code

38. Phone \_\_\_\_\_ Ext. \_\_\_\_\_ 39. Fax \_\_\_\_\_

40. Office Manager/Contact (if different) \_\_\_\_\_ 41. Phone \_\_\_\_\_ Ext. \_\_\_\_\_

## SECTION D – EDUCATIONAL DATA

### MEDICAL/DENTAL/PODIATRIC EDUCATION (If attended more than one, attach a separate sheet.)

College/University \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Degree \_\_\_\_\_ Date(s) From \_\_\_\_\_ to \_\_\_\_\_ Year Graduated \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

### INTERNSHIP/PRECEPTORSHIP PROGRAMS

Describe below all internships that you have begun or completed. If more than one internship, please supply the same information on a separate sheet and attach. Please provide **complete** addresses.

Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Type of Internship/Preceptorship \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Program Completed?  Yes  No  
(mm/dd/yyyy) (mm/dd/yyyy)

### RESIDENCIES/FELLOWSHIPS

List in chronological order below all residencies/fellowships which you have begun or completed. If more than four residencies/fellowships, please supply the same information on a separate sheet and attach. Please provide **complete** addresses.

**\*Please Note: Your specialty program must be accredited by a body recognized by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association, The Commission on Dental Accreditation of the American Dental Association, or the American Podiatric Medical Association.**

1. Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Residency  Fellowship

\*Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code Country

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Program Completed?  Yes  No (Please explain)  
(mm/dd/yyyy) (mm/dd/yyyy)

2. Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Residency  Fellowship

\*Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code Country

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Program Completed?  Yes  No (Please explain)  
(mm/dd/yyyy) (mm/dd/yyyy)

**SECTION D – EDUCATIONAL DATA CONTINUED**

3. Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Residency  Fellowship

\*Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_

Number and Street City State Zip Code Country

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Program Completed?  Yes  No (Please explain)  
 (mm/dd/yyyy) (mm/dd/yyyy)

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4. Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Residency  Fellowship

\*Specialty \_\_\_\_\_ Program Director \_\_\_\_\_

Address \_\_\_\_\_

Number and Street City State Zip Code Country

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Program Completed?  Yes  No (Please explain)  
 (mm/dd/yyyy) (mm/dd/yyyy)

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**SECTION E – BOARD CERTIFICATION DATA**

Name of Board/Certifying Entity	Specialty	Initial Certification Date	Expiration Date	Recertification Date	Expiration Date
1.					
2.					
3.					

Have you applied for board certification other than those indicated above:  Yes  No

If yes, list board(s) and date(s): \_\_\_\_\_

If not certified, do you intend to apply?  Yes Specify timeframe: \_\_\_\_\_

No Specify reason: \_\_\_\_\_

Have you ever taken and not passed a medical board examination?  Yes  No

If yes, will you re-take?  Yes  No

## SECTION F – HOSPITAL/INSTITUTION AFFILIATIONS

### HOSPITAL/INSTITUTION STAFF MEMBERSHIPS

List the hospital(s) (**in chronological order**) at which you currently hold or have held staff membership and/or clinical privileges including your department assignments and staff category. If there are more than five, please supply the same information on a separate sheet and attach.

1. Hospital/Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Department \_\_\_\_\_ Chairperson \_\_\_\_\_

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Admitting privileges:  Yes  No  
(mm/dd/yyyy) (mm/dd/yyyy)

Category: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

2. Hospital/Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Department \_\_\_\_\_ Chairperson \_\_\_\_\_

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Admitting privileges:  Yes  No  
(mm/dd/yyyy) (mm/dd/yyyy)

Category: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

3. Hospital/Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Department \_\_\_\_\_ Chairperson \_\_\_\_\_

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Admitting privileges:  Yes  No  
(mm/dd/yyyy) (mm/dd/yyyy)

Category: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

4. Hospital/Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

Department \_\_\_\_\_ Chairperson \_\_\_\_\_

Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Admitting privileges:  Yes  No  
(mm/dd/yyyy) (mm/dd/yyyy)

Category: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

**SECTION F – HOSPITAL/INSTITUTION AFFILIATIONS CONTINUED**

5. Hospital/Institution \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_  
                    Number and Street                      City                      State                      Zip Code  
Department \_\_\_\_\_ Chairperson \_\_\_\_\_  
Date(s) from \_\_\_\_\_ to \_\_\_\_\_ Admitting privileges:  Yes  No  
                    (mm/dd/yyyy)                      (mm/dd/yyyy)  
Category: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

**SECTION G – PROFESSIONAL WORK HISTORY**

**CHRONOLOGICAL PROFESSIONAL HISTORY**

Please identify all professional employers, locum tenens, clinics, private or group practice, and/or military service, listing most recent first. Account for ALL intervals of time (including nonprofessional employers, etc) not included in Section F. List additional institutions on a separate sheet.

1. Organization/Practice Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Status: (Mark as applicable)  Owner  Employee  Subcontractor  Other  
Address \_\_\_\_\_  
                    Number and Street                      City                      State                      Zip Code  
Date(s) From \_\_\_\_\_ to \_\_\_\_\_ Contact Person \_\_\_\_\_  
                    (mm/dd/yyyy)                      (mm/dd/yyyy)  
Reason for discontinuing affiliation \_\_\_\_\_  
\_\_\_\_\_

2. Organization/Practice Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Status: (Mark as applicable)  Owner  Employee  Subcontractor  Other  
Address \_\_\_\_\_  
                    Number and Street                      City                      State                      Zip Code  
Date(s) From \_\_\_\_\_ to \_\_\_\_\_ Contact Person \_\_\_\_\_  
                    (mm/dd/yyyy)                      (mm/dd/yyyy)  
Reason for discontinuing affiliation \_\_\_\_\_  
\_\_\_\_\_

3. Organization/Practice Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Status: (Mark as applicable)  Owner  Employee  Subcontractor  Other  
Address \_\_\_\_\_  
                    Number and Street                      City                      State                      Zip Code  
Date(s) From \_\_\_\_\_ to \_\_\_\_\_ Contact Person \_\_\_\_\_  
                    (mm/dd/yyyy)                      (mm/dd/yyyy)  
Reason for discontinuing affiliation \_\_\_\_\_  
\_\_\_\_\_

## UNACCOUNTED INTERVALS

1. Since medical school graduation are there any unaccounted intervals (one month or more)? Please list below:

_____	Date(s) From _____	to _____
	(mm/dd/yyyy)	(mm/dd/yyyy)
_____	Date(s) From _____	to _____
	(mm/dd/yyyy)	(mm/dd/yyyy)
_____	Date(s) From _____	to _____
	(mm/dd/yyyy)	(mm/dd/yyyy)

## SECTION H – PROFESSIONAL SANCTIONS

1. Please answer each of the questions. **If the answer to any of these questions is YES, please provide full details on a separate sheet, and attach.**

A. Have any of the following ever been, or are any currently in the process of being, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, voluntarily *or involuntarily* relinquished while under investigation or in exchange for an investigation or action not being taken, or investigated?

Medical or other professional Registration/License in any state	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DEA Registration	<input type="checkbox"/> YES	<input type="checkbox"/> NO
CLIA (CLINICAL LABORATORY IMPROVEMENT AMENDMENTS) Certification	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Academic Appointment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Membership of any hospital staff	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Clinical Privileges	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Prerogatives/rights on any medical staff	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other institutional affiliation or status	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Professional organization/society membership, fellowship or board certification	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Professional Office	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Professional Liability Insurance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Private, State, or Federal health insurance programs For example, Medicare or Medicaid	<input type="checkbox"/> YES	<input type="checkbox"/> NO

B. Have you ever been convicted of a felony or misdemeanor (excluding civil infraction traffic offenses) or is a felony charge currently pending against you?

YES       NO

## SECTION I – HEALTH STATUS

1. If you answer YES to any of these questions, please provide a full explanation of the details on a separate sheet and attach.

A. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform all elements of the clinical privileges for which you have applied without a direct threat to the health and safety of others?  YES  NO

NOTE: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in monitoring programs for alcohol, drug dependency, mental conditions, medical limitation of activity workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.

B. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients?  YES  NO

C. Regarding **chemical substances**, within the last six months, have you or do you, use illegal drugs, consume alcohol, prescribe drugs for yourself; or use chemical substances to the extent that your ability to competently and safely perform the essential functions of a practitioner in your area of practice is or has been compromised?  YES  NO

D. Have you been treated for substance abuse in the past two (2) years?  YES  NO

## SECTION J – PROFESSIONAL LIABILITY DATA

1. Has your present professional liability insurance carrier excluded any specific procedures from your coverage?  YES  NO

**If YES, list the procedures which have been excluded and provide a full explanation on a separate sheet including the name of the carrier, the date and specific information concerning any limitation.**

2. Name of all previous carriers and dates (if more than three please supply the same information on a separate sheet and attach):

Name of carrier: \_\_\_\_\_ Dates from: \_\_\_\_\_ to \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Address: \_\_\_\_\_  
Number and Street City State Zip Code

Name of carrier: \_\_\_\_\_ Dates from: \_\_\_\_\_ to \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Address: \_\_\_\_\_  
Number and Street City State Zip Code

Name of carrier: \_\_\_\_\_ Dates from: \_\_\_\_\_ to \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

Address: \_\_\_\_\_  
Number and Street City State Zip Code

## LEGAL ACTIONS

1. Have you ever been denied professional liability coverage or has your policy been cancelled or denied renewal?  YES  NO

**If you answered YES to question 1, please provide a full explanation of the details on a separate sheet and attach.**

2. Within the past 10 years, have there been, or are there currently pending, any claims arising out of your care or supervision of care for a patient? (For this purpose, "claim" includes a lawsuit, arbitration, settlement or request for payment of damages).  YES  NO

**If you answered YES to question 2, please complete the information below. If additional space needed please attach a separate sheet with the same information below for each claim.**

Name of Patient (Plaintiff) \_\_\_\_\_

Claim  Suit Date of incident \_\_\_\_\_

Year Claim or Suit was filed \_\_\_\_\_ Year Claim or Suit was settled \_\_\_\_\_

Nature of Allegations \_\_\_\_\_

Status:  Pending  Dismissed  Settled, amount \_\_\_\_\_

Jury Decision (Describe) \_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_

Address of Insurance Carrier \_\_\_\_\_  
Number and Street City State Zip Code

Phone \_\_\_\_\_ Ext. \_\_\_\_\_

## SECTION K – PEER REFERENCES

### PEER REFERENCES

**None of the individuals may be related to you by family. Do not give names of your program directors as they will automatically be contacted.** (Typical resources: department chairman/service chief, practitioners in same specialty. Please provide complete addresses.) Name four (4) individuals who have personal knowledge of your current clinical abilities in your area specialty, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time and at least one must have had organizational responsibility for your performance.

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State Zip Code

E-mail Address \_\_\_\_\_ Specialty: \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_  
Number and Street City State Zip Code  
 E-mail Address \_\_\_\_\_ Specialty: \_\_\_\_\_

3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_  
Number and Street City State Zip Code  
 E-mail Address \_\_\_\_\_ Specialty: \_\_\_\_\_

4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_  
Number and Street City State Zip Code  
 E-mail Address \_\_\_\_\_ Specialty: \_\_\_\_\_

**SECTION L – HEALTH PLAN INFORMATION**

1. Are you accepting Medicare Patients?  YES  NO    2. Medicaid Patients?  Yes  NO  
 3. Medicare Provider Number \_\_\_\_\_ 4. Medicaid Provider Number \_\_\_\_\_  
 5. UPIN Number \_\_\_\_\_ 6. NPI Number \_\_\_\_\_

**SECTION M – PRACTICE DEMOGRAPHICS**

1. Office Practice Hours

Location	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Primary							
Secondary							

2. Explain what arrangements you have for 24 hour, 7 day a week coverage for your patients:  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Emergency on-call number: \_\_\_\_\_

4. What is the waiting time to obtain an appointment in your office for Routine, Urgent, and Emergency Exams?  
 Days, Weeks, Hours  
 Routine \_\_\_\_\_ Urgent \_\_\_\_\_ Emergency \_\_\_\_\_

5. What, if any, limitations do you have on the age range of patients which you see? \_\_\_\_\_

6. Is your practice open to new patients at this time?  YES  NO

**SECTION M – PRACTICE DEMOGRAPHICS CONTINUED**

7. Name of physicians(s) taking calls for you:

Physician _____	Office Phone _____	Home Phone _____
Physician _____	Office Phone _____	Home Phone _____
Physician _____	Office Phone _____	Home Phone _____
Physician _____	Office Phone _____	Home Phone _____

8. What are your other interests in practice, research etc? \_\_\_\_\_  
\_\_\_\_\_

9. Do you employ nurse practitioners, physician assistants, nurse midwives, physical therapists, occupational therapists, or other licensed professionals?  YES  NO If YES, please attach a list with names and specialties.

**SECTION N – CONTINUING MEDICAL EDUCATION DATA**

Please submit a listing of Continuing Medical Education (CME) courses attended – where, when, and the number of hours of CME credits obtained – on a separate sheet or copies of CME documents that are related to the clinical privileges you hold

**OR Sign the statement below:**

I hereby certify that I have completed CME (Category I) credit related to my scope of practice. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical Staff.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## SECTION O – APPLICANT’S CONSENT AND RELEASE

I, the undersigned, hereby apply for medical staff appointment, clinical privileges, and/or membership with the healthcare facility/organization(s) listed on the designation page. Copies of this application, including my signature below, are as valid as the original.

I understand and agree that as an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications and for resolving any doubts about my qualifications. I understand that my application will not be processed until it is deemed complete by the healthcare facility/organization. I have the responsibility to keep the application current by informing the healthcare facility/organization of any change in my professional liability insurance coverage, the filing of a lawsuit or other submission of a claim against me relating to my competency to practice my profession, any change in my medical staff status at another hospital, or any other material change or addition to the information provided in this application. I will provide the organization with updated current information regarding all questions on this application form as it becomes available. I will provide additional information that may be requested by the healthcare facility/organization or its authorized representatives. My failure to provide information requested, will prevent my application from being evaluated and acted upon.

I attest that the information included in this application is current, complete, accurate, true and fairly represents the current level of my qualifications for the clinical privileges requested. I understand that as a condition to making this application, any misrepresentation, misstatement, or omission from this application, whether intentional or not, may result in an automatic and immediate rejection of this application for appointment and clinical privileges or termination of any medical staff membership or clinical privileges granted before discovery of the misrepresentation, misstatement, or omission.

By applying for appointment and clinical privileges, I hereby:

- Agree to appear for an interview in regard to my application if requested;
- Authorize the healthcare facility/organization and their representatives to consult with administrators and members of other healthcare facilities/organizations with which I am or have been associated, malpractice carriers, or anyone else who may have information bearing on my qualifications;
- Agree to provide a photo with signature – notarized – to assist in verifying my identity and agree to the distribution of such photo for additional credentialing verification purposes;
- Consent to the inspection by the healthcare facility/organization and their representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications to carry out the clinical privileges requested.
- Authorize the healthcare facility/organization and their representatives to provide other healthcare facilities/organizations, licensing boards, associations, and others concerned with provider performance and the quality and efficiency of patient care with any information about me relevant to such matters.
- Agree that I have disclosed in my application all criminal convictions and any felony charges brought or pending against me. I further authorize the healthcare facility/organization and its representatives to request, and any individual, company, firm, corporation or public agency, including law enforcement agencies, to divulge, any criminal records or information, verbal or written, pertaining to me, including information or data received from other sources.

I hereby release from liability to the fullest extent permitted by law all representatives of the healthcare facility/organization and its Medical/Professional Staff for their acts performed and statements made in good faith and without malice within its scope as a review entity. I hereby release from liability any and all third parties who in good faith, and without malice, provide information to the facility/organization concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior or any other matter that might have an effect on my competence, on patient care or on the orderly operation of any hospital or healthcare facility/organization.

I agree to:

- Abide by the bylaws, rules and policies of the healthcare facility/organization
- Abide by the medical staff bylaws, rules and policies and the rules and policies of the department and/or clinical service to which I am assigned
- Adhere to recognized principles governing the practice of medicine, participate in continuing education program which relate, at least in part, to the privileges granted to me by the healthcare facility/organization, and document such participation when requested to do so;
- Provide for care for my patients consistent with the standard of practice of my profession, accept committee assignments, accept administrative consulting assignments and participate in staffing emergency room service areas in my specialty on a reasonably agreed upon basis if requested to do so;
- Comply with applicable local, Michigan and federal law, including abstaining from the division of fees or remuneration for referrals under any guise whatsoever;
- Maintain a constructive interest and cooperate in advancing the healthcare facility/organization as a quality healthcare facility/organization; and;
- Seek consultation by physicians of appropriate clinical experience as needed or requested.

I acknowledge that medical staff appointment and clinical privileges at the healthcare facility/organization are not a right of every licensed professional who makes application for the same.

I understand that:

- My application will be evaluated in accordance with prescribed procedures defined in the medical staff bylaws and rules;
- All medical staff recommendations relative to my application are subject to the ultimate action of the healthcare facility/organization Board;
- If appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the healthcare facility/organization Board;
- Reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the healthcare facility/organization, acceptable performance of all responsibilities, as well as the other factors deemed relevant by the healthcare facility/organization. Reappointment and continued clinical privileges shall be granted only on formal application, according to medical staff bylaws and rules, and upon final approval of the healthcare facility/organization Board.
- I have received and had an opportunity to read a copy of the medical staff bylaws and rules of the healthcare facility/organization and such policies and directives as are applicable to appointees to the medical staff, and acknowledge I shall be bound by the terms thereof, any subsequent modifications or amendments thereof and any other established written policies of the healthcare facility/organization, which are consistent with the bylaws and rules, whether or not I am granted membership and privileges; and
- The provisions of the medical staff bylaws relating to confidentiality and release from liability are express conditions of my application for, and acceptance of, medical staff membership and the continuation of such membership and to my exercise of privileges.

\_\_\_\_\_  
Print or Type Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

APPENDIX A

**APPLICATION TO:  
McLAREN HEALTH PLAN  
MID-STATE PHYSICIANS  
OR PHYSICIANS HEALTH PLAN**

For those physicians applying to **Mid-State Physicians, McLaren Health Plan, or Physicians Health Plan**, please answer the following question:

Do you or does a member of your family own or have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, or other business dealings with the provision of ancillary health services, equipment or supplies, or an employment relationship or ownership interest in any health insurer or health plan?

YES     NO

If YES, please provide the following information:

Name of organization	Tax identification number	Telephone number	
Street	City	State	Zip code
Type of organization	Size of organization		
Percent of business owned/invested by practitioners or hospitals	Percent of business owned/invested by applicant		
Nature of business interest (e.g., owner, partner, investor, employee)			