Providence

REQUEST FOR PRACTITIONER APPLICATION / PRE-APPLICATION

Rev. 10.2024

Please complete this form, sign it, and e-mail to AKMedicalStaff@Providence.org

Facility or Facilities you wish to apply for privileges: ☐ PAMC (Anchorage) ☐ PKIMC (Kodiak Island) ☐ PSESH (St. Elias) ☐ PSMC (Seward) ☐ PVMC (Valdez)

Applicant's Name:	Degree	Applicant's Contact Phone #	Employment Type: ☐ Employed ☐ Contracted ☐ Locums ☐ Independent ☐ Fellowship Program

Applicant's E-Mail:	SSN:	Date of Birth:	Primary Practicing Specialty:	NPI Number:

Group you will be employed by OR affiliated with in Alaska:	If **Locums**, name of company?
Who will you share call coverage with?:	If **AHP**, who will be your supervising Physician?

Do you currently hold an active Alaska State License? ☐ **Yes** ☐ **No**	If no, have you applied for you Alaska State License? ☐ **Yes** ☐ **No**	Date licensing application was submitted:

Have you completed a 3-year Residency Program? ☐ **Yes** ☐ **No** **(N/A for AHP)**	Residency Training/Specialty:

Have you ever had Medical Staff or Allied Health Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this medical center, or health plan for reasons related to clinical competence or professional conduct? ☐ **Yes** ☐ **No**

Have you ever had your medical license revoked, restricted, or suspended by any state licensing agency? ☐ **Yes** ☐ **No**

Do you have a current, unrestricted (non-exempt) DEA registration and state-controlled substance license (PDMP)? ☐ **Yes** ☐ **No**

Are you board certified in your primary specialty by a board recognized by the ABMS, AOA, or applicable AHP certifying agency? ☐ **Yes** ☐ **No**,

If NO, are you board admissible and will become board certified within 5 years of training completion? ☐ **Yes** ☐ **No**

Have you ever been excluded from Medicare, Medicaid or any healthcare program as identified on the Government Services Agency "Excluded Parties Listing System" or the Health and Human Services Officer of the Inspector General "Excluded Individual Search"? ☐ **Yes** ☐ **No**

I represent that the information provided on this pre-application is accurate, complete, and fairly represents my training and current expertise. I understand and agree that any misrepresentation, misstatement, or omission from this application request whether intentional or not may constitute cause to not be provided an application as requested. I understand that in the event of discovery of such an event, or if I do not meet the minimum criteria of the facility requested, I will not be provided an application and I will not be entitled to any hearing or appeal rights that are contained in the Hospital or Medical Staff Bylaws, Policies, or other regulations. I understand that with the information I have provided above, basic steps to understand my training and background may be checked to further determine my eligibility for medical staff membership and privileges at the requested Providence Health and Services facility(ies), prior to my submitting a full application. If I currently have privileges at a facility that holds a Credentials Information Sharing Agreement with, I authorize such facility to release information covered in the Credentials Information Sharing Agreement to. I formally request an application for membership and privileges and certify that I am currently competent to perform the privileges selected above based on my training, recent experience and within the scope of my professional licensure. I agree that I am responsible to provide all necessary documentation, as deemed required by the facility(ies), in support of the application for membership and privileges I will receive. I attest to know of no health condition or inability to perform that, without reasonable accommodation that would impair my ability to competently perform the privileges I may be granted.

Signature: _____ Date: _____

Consent and Release for:

Providence

PHS CENTRALIZED VERIFICATION SERVICE

Attestation and Consent & Release from Liability

Note:

The Regional Medical Staff Services Dept at Providence Alaska Medical Center provides a Centralized Verification Service for the following facilities.

Please indicate all facilities you are applying to provide services at:

Yes PAMC: Providence Alaska Medical Center

Yes PKIMC: Providence Kodiak Island Medical Center

Yes PSMC: Providence Seward Medical Center

Yes PSESH: Providence St. Elias Specialty Hospital

Yes PVMC: Providence Valdez Medical Center

As an applicant, I understand I have the burden of producing adequate information for proper evaluation of my application. I agree to provide the hospital with updated and current information regarding all questions on this application form as such information becomes available and the hospital or its authorized representatives may request such additional information as necessary. I understand failure to produce information as requested will prevent my application form being evaluated and acted upon.

By applying or reapplying for appointment and clinical privileges, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment and/or clinical privileges. These conditions shall remain in effect for the duration of any term of appointment that I may be granted, and as applicable to third-party inquiries received after I leave the medical staff:

1. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue the Medical Center, its medical staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges or my qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Medical Center, the medical staff, their authorized representatives, or appropriate third parties.
2. I authorize the Medical Center, its medical staff, and their authorized representatives (i) to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for initial and continued appointment to the medical staff and (ii) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, I specifically authorize these third parties to release the information to the Medical Center, its medical staff, and their authorized representatives upon request.
3. I also authorize the Medical Center, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, and any government or regulatory agencies, including licensure boards who solicit such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges, participating provider status, other credentialing matter, or licensure or regulatory matter.

I acknowledge that (1) medical staff appointment and clinical privileges at this hospital are not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules and regulations and policies and procedures; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board of Directors, whose decision shall be final; (4) my responsibility to keep this application current by informing the hospital, through the CEO and/or designee of any change in the areas of inquiry contained herein, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical staff status at any other hospital. and (5) reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital, as evidenced by admission, treatment and continuous care and supervision of patients for whom I have responsibility, and acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by the hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to hospital and medical staff bylaws, rules and regulations, and policies, and upon final approval of the hospital board of directors.

If appointed and/or granted clinical privileges, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral, (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not credentialed to undertake the responsibility; (3) refrain from deceiving patients as to the identify of any practitioner providing treatment or services; (4) seek consultation whenever required or necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; (7) Participate in the Utilization Review and Quality Improvement activities of the hospital

VOLUNTARY CREDENTIALING CONTACT PERMISSION

As an applicant, I understand I have the burden of producing adequate information for proper evaluation of my application.

◯ **I hereby do not authorize** the Regional Medical Staff Services Dept at Providence Alaska Medical Center or its authorized representatives, to share and discuss my information with a credentialing contact. I understand that there may be delay in obtaining required information, as I will be the only person that is able to provide the requested information.

◯ **I hereby authorize** the Regional Medical Staff Services Dept at Providence Alaska Medical Center and its authorized representatives, to share and discuss my information, regardless of whether it is private, confidential, or privileged, from any source, if such information is reasonably related to the consideration of my appointment for medical/allied health staff membership or ongoing monitoring thereof with the following person/representative:

Name	Title	Email	Phone	Fax
_____	_____	_____	_____	_____

I understand that authorizing discussion of my credentialing information is not required and is a voluntary action.

I represent that all of the information provided in or attached to this application is accurate and complete.

Photocopies and/ or facsimile copies of this Authorization will serve the same purpose as the originally executed document.

Electronic Signature: Date & Time of Electronic Signature:

(Stamped or representative signatures unacceptable)