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 PAGE FOR MAILING ADDRESS AND CONTACT NAMES*.**

***NOTE**: **You must photocopy and mail the entire application and supporting documentation to each Healthcare facility/organization you have checked on Designation Page 1.** 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

MID-MICHIGAN UNIFORM CREDENTIALING APPLICATION FOR APPOINTMENT – DESIGNATION PAGE

I hereby make application for appointment, clinical privileges and/or membership and also authorize the use of this application by each healthcare facility (ies)/organization(s) I have identified on this Designation Page. 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____ Date:_________________________________

Printed Name:____

Eaton Rapids Medical Center	☐	Linda Lohmeier, Medical Staff Coordinator llohmeier@ermchealth.org **Eaton Rapids Medical Center** 1500 S Main St., Eaton Rapids, MI 48827 Phone: (517) 663-9446 Fax: (517) 663-2472
Sparrow Eaton Hospital	☐	Cindy Robison, Administrative Secretary #843 cindy.robison@sparrow.org **Sparrow Eaton Hospital** 321 E Harris St., Charlotte, MI 48813 Phone: (517) 543-1050, Ext. 1209 Fax: (517) 541-0036
McLaren GREATER LANSING	☐	Michelle Kelly, CPMSM, Supervisor (517) 975-7576 michelle.kelly@mclaren.org Deb Kowalski, Medical Staff Coordinator (517) 975-7575 deborah.kowalski@mclaren.org Medical Staff Services **McLaren Greater Lansing** 401 W Greenlawn Ave., Lansing, MI 48910-2819 Fax: (517) 975-7580
Lansing Genesis Surgery Centers	☐	Richard Smith, CEO rsmith@uspi.com Amy Hurst, Credentialing Coordinator ahurst@uspi.com **Lansing Genesis Surgery Center** 1707 Lake Lansing Road, Lansing, MI 48912 Phone: (517) 708-3334 Fax: (517) 708-3335
Michigan State University HealthTeam	☐	Sally Marquette, Credentialing Coordinator (517) 353-9783 Courtney Wiskochil, Credentialing Coordinator (517) 884-6756 Sue Dolby, Credentialing Manager (517) 432-6690 **MSU HealthTeam** MSUHealthTeamCredentialing@hc.msu.edu 804 Service Rd, Rm A 118 Clinical Center East Lansing, MI 48824-1315, Fax: (517) 432-6692
Michigan Surgical Center Excellence in Outpatient Care	☐	JoAnne Hudson, Office Support Coordinator jhudson@loeye.com **Michigan Surgical Center** 2075 Coolidge Rd., East Lansing, MI 48823 Phone: (517) 319-9025 Fax: (517) 319-0049
Physicians Health Plan	☐	PHP.credentialing@phpmm.org Network Services Department **Physicians Health Plan** PO Box 30377, Lansing, MI 48909-7877, Phone: (517) 364-8312 Fax: (517) 364-8412 *Affiliated entity with **Sparrow Health System***

1/09, 12/10, 1/11, 2/12, 4/12, 8/12, 4/13, 6/13, 8/13, 10/13, 1/14, 3/14

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 N.

2. If more space is needed, attach additional sheets and make reference to the question being answered.

3. **Incomplete applications may be returned and will delay processing time. Provide answers to all questions, if appropriate response is none or N/A, state "none" or "N/A"**

4. Please ATTACH CURRENT COPIES of the following documents to this application: (*note some items may be specific to certain sites only)*

____ 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/Residency and/or Fellowship **as applicable**
____ Residency and/or Fellowship Training Logs
____ Board Certification or Board eligibility Letter
____ PPD Status Validation within previous 12 months
____ Privilege Delineation Form
____ Current Driver's License
____ Original photo with signature – NOTARIZED (*see specific hospital requirements*)
_______CLIA (Clinical Laboratory Improvement Amendments) Certificate (if applicable)
_______(PHP ONLY) Letter from covering physician if not applying for admitting privileges

5. **Credentialing Application Fee(s)**

Eaton Rapids Medical Center (Make check payable to ERMC Medical Staff)	**$100.00**
Sparrow Eaton Hospital	**$150.00**
McLaren Greater Lansing (Make check payable to MGL Medical Staff Services)	**$250.00**
Lansing & Genesis Surgery Centers	**$100.00**
MSU HealthTeam	**No Fee**
Michigan Surgical Center	**No Fee**
Physicians Health Plan (PHP)	**No Fee**

6. **Anticipated Start Date at the above entities: ____**

SECTION B - PERSONAL INFORMATION - if appropriate response is none or N/A, state "none" or "N/A"

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 ______ 11. Listed ☐ Unlisted ☐ Home Fax ____________________

12. Email Address ___________________________ 13. Cell Phone ____________________

14. All current and prior city and states of residence ______________________________

15. Citizenship ____

16. If not a citizen of the United States, please indicate the status of your VISA at the present time. ________________

17. Languages spoken ____

18. Emergency Contact ____

19. Emergency Contact Work Phone ______________ 20. Emergency Contact Home Phone ______________

SECTION C – PROFESSIONAL DATA - if appropriate response is none or N/A, state "none" or "N/A"

1. Practice Specialty ____

2. Practice Subspecialty ____

3. Since Medical School, list all licenses:

State ____________ License Number ____________ Expiration Date ______________

State ____________ License Number ____________ Expiration Date ______________

4. DEA Registration # ______________________ Expiration Date ______________

5. NPI # ____

PRIMARY PRACTICE INFORMATION

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.

6. 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: ______________________________

1/09, 12/10, 1/11, 2/12, 4/12, 8/12, 4/13, 6/13, 8/13, 10/13, 1/14, 3/14

SECTION C – PROFESSIONAL DATA (Con't) - if appropriate response is none or N/A, state "none" or "N/A"

Primary Office Address ______________________________
Number and Street City State Zip Code

General Phone ____________ Ext.__________ Fax ____________

Private Phone ____________ Ext. __________ Answering Service ____________

TDD Service(please circle): YES NO If yes, TDD phone number: ________ PHI Fax #__________

Pager Number ______________ Cell Phone ______________

Office Manager/Contact ________ Phone ________ Email ________

Website address ______________________________

7. Academic Office

Address ______________________________
Number and Street City State Zip Code

Phone ____________ Ext. __________ Fax ____________

Office Manager/Contact ________ Phone ________ Ext ________

ADDITIONAL PRACTICE INFORMATION – if applicable please supply the same information as that under primary practice information on a separate sheet.

SECTION D – EDUCATIONAL DATA - if appropriate response is none or N/A, state "none" or "N/A"

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.

Type of Internship/Preceptorship ______________________________

Program Director ______________ Institution ______________

Phone ____________ Fax ________ Email ____________

Address ______________________________
Number and Street City State Zip Code

Date(s) from ________ to ____________Program Completed? ☐ Yes ☐ No
(mm/dd/yyyy) (mm/dd/yyyy)

1/09, 12/10, 1/11, 2/12, 4/12, 8/12, 4/13, 6/13, 8/13, 10/13, 1/14, 3/14

SECTION D – EDUCATIONAL DATA (Con't) - if appropriate response is none or N/A, state "none" or "N/A"

RESIDENCIES/FELLOWSHIPS
List in chronological order below all residencies/fellowships which you have begun or completed. If more that 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. ☐ Residency ☐ Fellowship *Specialty ______

Program Director ______ Institution ______

Phone ______ Fax ______ Email______

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. ☐ Residency ☐ Fellowship *Specialty ______

Program Director ______ Institution ______

Phone ______ Fax ______ Email______

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)

3. ☐ Residency ☐ Fellowship *Specialty ______

Program Director ______ Institution ______

Phone ______ Fax ______ Email______

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)

4. ☐ Residency ☐ Fellowship *Specialty ______

Program Director ______ Institution ______

Phone ______ Fax ______ Email______

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 E – BOARD CERTIFICATION DATA - if appropriate response is none or N/A, state "none" or "N/A"

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

Are you board eligible ☐ Yes ☐ No If yes, provide a copy of board eligible letter.

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 - if response is none or N/A, state “none” or “N/A”

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 four, please supply the same information on a separate sheet and attach.

1. Hospital/Institution ______________________

   Address ______________________
   Number and Street City State Zip Code

   Phone ______________ Fax ______________

   Department ______________ Chairperson ______________

   Date(s) from ________ to ________ Admitting privileges: ☐ Yes ☐ No
   (mm/dd/yyyy) (mm/dd/yyyy)

   Category: ______________ Reason for leaving: ______________

2. Hospital/Institution ______________________

   Address ______________________
   Number and Street City State Zip Code

   Phone ______________ Fax ______________

   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 (Con't) - if appropriate response is none or N/A, state "none" or "N/A"

3. Hospital/Institution ______

   Address ______
   Number and Street City State Zip Code

   Phone ______ Fax ______

   Department ______ Chairperson ______

   Date(s) from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Admitting privileges: ☐ Yes ☐ No

   Category: ______ Reason for leaving: ______

4. Hospital/Institution ______

   Address ______
   Number and Street City State Zip Code

   Phone ______ Fax ______

   Department ______ Chairperson ______

   Date(s) from ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Admitting privileges: ☐ Yes ☐ No

   Category: ______ Reason for leaving: ______

SECTION G – PROFESSIONAL WORK HISTORY - if appropriate response is none or N/A, state "none" or "N/A"

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 ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Contact Person______

   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 ______ (mm/dd/yyyy) to ______ (mm/dd/yyyy) Contact Person______

   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 ______

SECTION G – PROFESSIONAL WORK HISTORY (Con't) - if appropriate response is none or N/A, state "none" or "N/A"

UNACCOUNTED INTERVALS

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

______________________ Date(s) From __________ (mm/dd/yyyy) to __________ (mm/dd/yyyy)

______________________ Date(s) From __________ (mm/dd/yyyy) to __________ (mm/dd/yyyy)

______________________ Date(s) From __________ (mm/dd/yyyy) to __________ (mm/dd/yyyy)

SECTION H – PROFESSIONAL SANCTIONS – all questions must be answered

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 ☐ YES ☐ NO

   DEA Registration ☐ YES ☐ NO

   CLIA (CLINICAL LABORATORY IMPROVEMENT AMENDMENTS)

   Certification ☐ YES ☐ NO

   Academic Appointment ☐ YES ☐ NO

   Membership of any hospital staff ☐ YES ☐ NO

   Clinical Privileges ☐ YES ☐ NO

   Prerogatives/rights on any medical staff ☐ YES ☐ NO

   Other institutional affiliation or status ☐ YES ☐ NO

   Professional organization/society membership, fellowship or board certification ☐ YES ☐ NO

   Professional Office ☐ YES ☐ NO

   Professional Liability Insurance ☐ YES ☐ NO

   Private, State, or Federal health insurance programs

   For example, Medicare or Medicaid ☐ YES ☐ 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 – all questions must be answered

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, have you or do you participate in any of the following *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?

- Use illegal drugs YES ☐ NO ☐
- Consume alcohol YES ☐ NO ☐
- Prescribe drugs for yourself YES ☐ NO ☐
- Use chemical substances YES ☐ NO ☐

D. Have you ever been treated for substance abuse? YES ☐ NO ☐

SECTION J – PROFESSIONAL LIABILITY DATA - if appropriate response is none or N/A, state "none" or "N/A"

1. Name of current carrier: ____________ Dates from: ____________ (mm/dd/yyyy) to ____________ (mm/dd/yyyy)

Address: ____________ Number and Street City State Zip Code

Policy #: ____________ Phone: ____________ Fax: ____________

2. Has your current 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 two please supply the same information on a separate sheet and attach):

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

Address: ____________ Number and Street City State Zip Code

Policy #: ____________ Phone: ____________ Fax: ____________

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

Address: ____________ Number and Street City State Zip Code

Policy #: ____________ Phone: ____________ Fax: ____________

SECTION J – PROFESSIONAL LIABILITY DATA (Con't) – all questions must be answered

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): ______________________________ Date of Occurrence mddyyyy):____________________

Date Claim Filed (mmddyyyy):________________ Claim Settlement Date, if applicable mmddyyyy):___________________

Claim Status: ❑ Claim ❑ Suit ❑ Open ❑ Closed

Insurance Carrier Name: ________________________ Insurance Carrier Phone: _____________ Ext.______________

Insurance Carrier Address: ____
Number and Street City State Zip code

Policy Number: ______________________________ Settlement Amount: ______________________________________

Resolution Method: ❑ None ❑ Arbitration ❑ Dismissed ❑ Judgment for Defendant

❑ Judgment for Plaintiff ❑ Mediation ❑ Settled

Description of Allegations: ____

____ Were you the primary defendant? ❑ YES ❑ NO

Number of Co-defendants: ____________________ Your involvement in the case: _______________________________

____

Description of alleged injury to patient:

____

___________________________________ Did the alleged injury result in death? ❑ YES ❑ NO

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ❑ YES ❑ NO

SECTION K – PEER REFERENCES – ALL LINES MUST BE COMPLETE

PEER REFERENCES (must be a practitioner, i.e., MD/DO/DPM/DDS, in same specialty as you)

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. Name four (4) individuals who have personal knowledge of your current clinical abilities in your specialty area, 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: ______________________________ ❑ M.D. ❑ D.O. ❑ Other ________
   Medical Specialty: ______________________________
   Facility/Organization: ______________________________
   Mailing Address: ______________________________
   City/State/Zip: ______________________________
   Phone: ____________________ Fax: ____________________
   E-mail Address: ____________________

2. Name: ______________________________ ❑ M.D. ❑ D.O. ❑ Other ________
   Medical Specialty: ______________________________
   Facility/Organization: ______________________________
   Mailing Address: ______________________________
   City/Sate/Zip: ______________________________
   Phone: ____________________ Fax: ____________________
   E-mail Address: ____________________

3. Name: ______________________________ ❑ M.D. ❑ D.O. ❑ Other ________
   Medical Specialty: ______________________________
   Facility/Organization: ______________________________
   Mailing Address: ______________________________
   City/State/Zip: ______________________________
   Phone: ____________________ Fax: ____________________
   E-mail Address: ____________________

4. Name: ______________________________ ❑ M.D. ❑ D.O. ❑ Other ________
   Medical Specialty: ______________________________
   Facility/Organization: ______________________________
   Mailing Address: ______________________________
   City/Sate/Zip: ______________________________
   Phone: ____________________ Fax: ____________________
   E-mail Address: ____________________

SECTION L – PRACTICE DEMOGRAPHICS - if appropriate response is none or N/A, state "none" or "N/A"

1. Primary Admitting Hospital ____________________

2. Office Practice Hours:

Location	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Primary							
Secondary							

3. Explain what arrangements you have for 24 hour, 7 day a week coverage for your patients:
   ____
4. Emergency on-call number: ____________________
5. What is the waiting time to obtain an appointment in your office for Routine, Urgent, and Emergency Exams?
   Days, Weeks, Hours
   Routine ____________________ Urgent ____________________ Emergency ____________________
6. What, if any, limitations do you have on the age range of patients which you see? ____________________
7. Is your practice open to new patients at this time? ☐ YES ☐ NO
8. 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 ____________________

9. What are your other interests in practice, research etc? ____________________
   ____
10. Will you utilize/employ nurse practitioners, physician assistants, nurse midwives, physical therapists, occupational therapists, or other licensed professionals for the institutions at which you are applying? ☐ YES ☐ NO

    If YES, please attach a list with names and specialties.
11. Are you accepting Medicare Patients? YES ☐ NO ☐ 2.Medicaid Patients? Yes ☐ NO ☐

SECTION M – CONTINUING MEDICAL EDUCATION DATA
(NOT APPLICABLE FOR CURRENT RESIDENTS/FELLOWS)

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 N – APPLICANT'S CONSENT AND RELEASE (Must sign and date)

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
OR PHYSICIANS HEALTH PLAN

For those physicians applying to ***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:

<table>
<tr><td colspan="2">Name of organization</td><td>Tax identification number</td><td>Telephone number</td></tr>
<tr><td colspan="4">Street City State Zip code</td></tr>
<tr><td colspan="3">Type of organization</td><td>Size of organization</td></tr>
<tr><td>Percent of business owned/invested by practitioners or hospitals</td><td colspan="3">Percent of business owned/invested by applicant</td></tr>
<tr><td colspan="4">Nature of business interest (e.g., owner, partner, investor, employee)</td></tr>
</table>