Attachment H

# REAPPOINTMENT ADDENDUM

**TO THE TEXAS DEPARTMENT OF INSURANCE (TDI)**
**STANDARDIZED CREDENTIALING APPLICATION**

## SECTION ONE - PERSONAL INFORMATION

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Mobile/Cellular Phone Number: | Pager Number: | Answering Service Number: |
| Preference(s) for Being Contacted After Hours: | | |

## SECTION TWO – PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

| | |
|---|---|
| 1. Current Type of Policy: | o Occurrence<br>o Claims-Made |
| 2. Has an insurance carrier refused to renew your policy, placed limitations on your scope of coverage, excluded any specific procedures or area of practice from your coverage or terminated coverage? | o Yes o No |
| 3. Have you been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty? | o Yes o No |
| **If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.** | |
| 4. Have any open claims previously listed on your last reappointment application been dismissed? **If yes, please complete and submit Attachment G of the TDI Application for each claim.** | o Yes o No |

5. ***Beyond what you documented in the TDI application***, list insurance carriers for ***all other*** professional liability policies you have had within the past three (3) years including all pertinent information requested. If more space is needed, attach an additional sheet.

Insurance Company: _____
Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

Insurance Company: _____
Mailing Address: _____
Policy Number: _____ Dates of Coverage: _____

## SECTION THREE – PROFESSIONAL WORK HISTORY

The TDI Application requests an explanation for any gaps in work history greater than six (6) months. Explain below ***ALL GAPS THIRTY (30) DAYS OR GREATER*** within the last two (2) years**. If additional space is needed, please supply the information as an attachment.**

| Gap Dates: | Explanation: |
|---|---|
| Gap Dates: | Explanation: |

| SECTION FOUR – HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS | |
|---|---|
| 1. Have you withdrawn an application for appointment, reappointment or clinical privileges or failed to seek reappointment or renewal of membership or privileges for any reason, or resigned before a decision was made by a hospital's or heath care facility's governing board? | o Yes o No |
| 2. Has your appointment, staff category, scope of clinical privileges, employment, or the nature of your medical practice changed at any hospital or other healthcare institution within the last two (2) years? | o Yes o No |
| 3. Have your clinical privileges or membership at any hospital or other healthcare institution been voluntarily or involuntarily limited, reduced, excluded, denied, suspended, revoked, restricted, surrendered, relinquished, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have investigations or proceedings toward any of those ends been instituted or recommended by any hospital or other healthcare entity, Medical Staff committee, or governing board? | o Yes o No |
| **If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.** | |
| **SECTION FIVE – ADDITIONAL INFORMATION** | |
| 1. Have any investigations or disciplinary actions been initiated or are there current pending challenges against you by any state licensure board? | o Yes o No |
| 2. Has your license to practice been involuntarily or voluntarily denied, limited, suspended, revoked, relinquished or surrendered or have you ever been subject to any disciplinary actions, by a state licensing board? | o Yes o No |
| 3. Have you voluntarily or involuntarily obtained or been required to obtain additional education or training, proctoring, supervision, or consultation as a result of peer review of quality assurance/improvement or utilization review activities by any type of healthcare entity? | o Yes o No |
| 4. Have you been disciplined, excluded from, suspended, reprimanded, sanctioned, censured, investigated, disqualified, declared an ineligible person or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other private, federal or state governmental health care plans or programs, or are there any such actions pending? | o Yes o No |
| 5. Have you been convicted of, pled guilty to, pled nolo contendere to, received deferred adjudication, or been formally charged with a felony or misdemeanor (including DUI) other than minor traffic violations? | o Yes o No |
| 6. Have you been named as a defendant in any criminal proceedings? | o Yes o No |
| 7. Have you been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you been subject to civil money penalties under the Medicare or Medicaid program? | o Yes o No |
| 8. Have your Federal DEA and/or Controlled Substances Certificate(s), registrations or authorization(s) in any state, been voluntarily or involuntarily denied, limited, suspended, revoked, restricted, denied renewal, or relinquished, or are any such challenges currently pending?<br>If so, which registration number and state? | o Yes o No |
| 9. Has your membership in any medical/professional society or association been voluntarily or involuntarily challenged, denied, limited, suspended, revoked or relinquished, or are there any actions currently pending that would affect your membership in any medical/professional society? | o Yes o No |
| **If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.** | |
| **SECTION SIX – HEALTH STATUS** | |
| 1. Within the past two (2) years, have you been diagnosed with or received treatment for a physical, mental, chemical dependency or emotional condition? | o Yes o No |
| 2. If yes, would such a condition impair your current ability to provide patient care or fulfill the essential functions of membership or participation in any healthcare institution? | o Yes o No |
| 3. Are you currently or have you been under a monitoring or rehabilitation contract/agreement for any health condition including substance abuse, mental or emotional illness, or disruptive behavior? | o Yes o No |

| | |
|---|---|
| **If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment**. | |
| 3. Required Immunization: Influenza Date of vaccination: _____<br>4. Required Immunization: TdaP Date of vaccination: _____<br><br>**To obtain an exemption form, contact the Medical Staff Office** | |
| 5. Recommended Immunization: MMR o By History o Vaccination<br>6. Recommended Immunization: Hepatitis B o By History o Vaccination<br>7. Recommended Immunization: Varicella o By History o Vaccination | |
| **SECTION SEVEN – CONTINUING MEDICAL EDUCATION** | |
| Continuing Education (CE) is required in accordance with licensing and/or certification requirements.<br><br>**Please mark <u>ONE</u> of the following selections as it pertains to you:**<br><br>**[ ]** I hereby attest that I am in compliance with the CE requirements of the applicable licensure and/or certification board. I attest that, upon request, I can and will provide documentation of such compliance. I acknowledge that my failure to produce the requested documentation could result in disciplinary action up to and including removal as an Allied Health Professional. **OR**<br><br>**[ ]** I hereby attest that I am not in compliance with the CE requirements of the applicable licensure and/or certification board. | |

## Application Distribution

Application is being made to the following facilities (check all that apply):

[ ] Hendrick Medical Center
[ ] ContinueCare Hospital at Hendrick Medical Center
[ ] Texas Midwest Surgical Center
[ ] Stephens Memorial Hospital, Breckenridge, Texas

## APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this application and addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing.

APPLICANT'S SIGNATURE _____ DATE _____

APPLICANT'S PRINTED NAME _____