Attachment H

HENDRICK MEDICAL CENTER
INITIAL APPOINTMENT 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:
Anticipated Start Date:		

SECTION TWO - EDUCATION INFORMATION	
1. Were all of your postgraduate training programs accredited by one of the following entities? If yes, check applicable entity below: o Accreditation Council for Graduate Medical Education or Royal College o American Osteopathic Association o American Dental Association o Council on Podiatric Medical Education	o Yes o No
2. Did you complete all your internship/residency/fellowship training programs?	o Yes o No
If you answered no, please explain. If additional space is needed, supply the information as an attachment.	

SECTION THREE - PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY	
1. Current Type of Policy:	o Occurrence o Claims-Made
2. Has your insurance carrier ever 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 ever 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, supply the information as an attachment.	
4. Have you EVER had any malpractice actions that are pending, settled, arbitrated, mediated, or litigated?	o Yes o No
If you have answered yes to question 4, please complete and submit attachment G of the TDI application for each claim.	

5. ***Beyond what you documented in the TDI application,*** list insurance carriers for ***all other*** professional liability policies for the past ***ten (10) years*** including all pertinent information requested. **If additional space is needed, please supply the information as an attachment.**

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

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

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

SECTION FOUR – PROFESSIONAL WORK HISTORY

The TDI application only requests work history for the past five (5) years. ***Beyond what you documented in the TDI application***, please provide ***ALL OTHER*** professional work history since completion of training, including clinics, medical centers, surgical centers, solo practices, self-employment, employment or any practice from which you received an income in the space provided below. **If additional space is needed, please supply the information as an attachment.**

Name and Nature of Affiliation:		**Dates of Affiliation:**		
		From: / /		To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				
Name and Nature of Affiliation:		**Dates of Affiliation:**		
		From: / /		To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				
Name and Nature of Affiliation:		**Dates of Affiliation:**		
		From: / /		To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				

The TDI application requests an explanation of any time gaps greater than six (6) months. ***If not already provided in the TDI application***, explain below ***ALL*** time gaps in work history ***30 DAYS OR GREATER*** including any gap in any internship/residency/fellowship training or during any teaching appointment. **If additional space is needed, please supply the information as an attachment.**

Gap Dates:	Explanation:
Gap Dates:	Explanation:

SECTION FIVE – HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS	
1. Have you ever withdrawn an application for appointment, reappointment or clinical privileges or failed to seek reappointment or renewal of medical staff membership or privileges for any reason, or resigned from the Medical Staff 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 ever changed at any hospital, other healthcare institution or training program?	o Yes o No
3. Have your clinical privileges or Medical Staff membership at any hospital, other healthcare institution or training program ever 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, other healthcare entity, training program, 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, supply the information as an attachment.	

SECTION SIX – ADDITIONAL INFORMATION	
1. Have any investigations or disciplinary actions ever 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 ever 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 ever 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 ever 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 are plans or programs, or are there any such actions pending?	o Yes o No
5. Have you ever been convicted of, pled guilty to, pled nolo contendere to, received deferred adjudication, or formally charged with a felony or misdemeanor (including DUI) other than minor traffic violations?	o Yes o No
6. Have you ever been named as a defendant in any criminal proceedings?	o Yes o No
7. Have you ever been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever 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, ever been voluntarily or involuntarily denied, limited, suspended, revoked, restricted, denied renewal, or relinquished, or are any such challenges currently pending? If so, which registration number and state?	o Yes o No
9. Has your membership in any medical/professional society or association ever 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, supply the information as an attachment.	

SECTION SEVEN – HEALTH STATUS

1. Have you ever 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 medical staff membership or participation in any healthcare institution?	o Yes o No
3. Are you currently or have you ever 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, supply the information as an attachment.

4. Required Immunization: Influenza Date of vaccination: _____ 5. Required Immunization: TdaP Date of vaccination: _____ **To obtain an exemption form, contact the Medical Staff Office**	
6. Recommended Immunization: MMR o By History o Vaccination 7. Recommended Immunization: Hepatitis B o By History o Vaccination 8. Recommended Immunization: Varicella o By History o Vaccination	

SECTION EIGHT– STATEMENT OF CONTINUING MEDICAL EDUCATION

The Texas Medical Board requires physicians to complete at least 48 credit hours of continuing medical education (CME) per 24-month period. At least half of the required CME credits must be formal, Category I or IA courses related to the privileges you currently hold. At least two of the Category I or IA hours must involve the study of medical ethics and/or professional responsibility. Professional responsibility includes but is not limited to courses in: Risk Management, Domestic Abuse or Child Abuse.

Please mark <u>one</u> of the following selections as it pertains to you:

[ ] I hereby attest that I am in compliance with the CME requirements of the applicable Texas licensure board (**48 hours** (MD), **24 hours** (DDS) or **50 hours** (DPM) of CME (Category I and Category II) credits every 24 months). 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 from the medical staff; **OR**

[ ] I hereby attest that I have completed residency/fellowship training within 6 months of this application; such training satisfies my CME requirements; **OR**

[ ] I hereby attest that I have passed a licensure board certification exam within 3 years of this application; such certification satisfies my CME requirements. Maintenance of certification will not suffice; **OR**

[ ] I hereby attest that I am **<u>not</u>** in compliance with the CME requirements of the applicable Texas licensure board, nor do I qualify for the residency/fellowship or board certification exemptions listed above.

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 _____

PHOTO

A CURRENT PHOTOGRAPH IS REQUIRED FOR ALL NEW APPLICANTS, THEREFORE, WE MUST RECEIVE A CURRENT, DINSTINGUISHABLE PHOTO BEFORE WE CAN PROCEED WITH THE PROCESSING OF YOUR APPLICATION.

(Please do not staple the photograph.)

ATTACH
PHOTO
HERE
(AT LEAST 2” X 2”)