



GREATER ARIZONA CENTRAL CREDENTIALING PROGRAM

326 E. Coronado Road
Phoenix, Arizona 85004-1576
Telephone: (602) 256-0705
Fax: (602) 256-2763

MARICOPA
COUNTY
MEDICAL
SOCIETY

Instructions for Completing the Initial Application

- | Complete all areas on the application
- | Do not leave any blanks
- | Incomplete applications WILL be returned
- | Print completed application, sign pages 15, 16, 17 and 14, if applicable
- | Send with readable copies of:
 - o Arizona professional license
 - o All other current state licenses
 - o DEA certificates
 - o Malpractice insurance certificate
 - o Degree(s) and post graduate training certificates
 - o Military release certificate (DD214)
 - o Board certification (certificate, status letter)
 - o Continuing Medical Education certificates
 - o TB attestation documentation
 - o Current curriculum vitae
 - o One current photo
 - o Criminal background check forms, if applicable
- | Non-Refundable check made payable to GACCP for \$160.00 for each hospital (except St. Joseph's - see below) to which you are applying.

Facilities requiring criminal background checks:

- o Maryvale (Medical Center) Hospital

If you are applying to any of the facilities listed above, please complete, sign and include pages 20 and 21

IMPORTANT NOTICE

St. Joseph's Hospital and Medical Center Applicants

As of January 1, 2002 fees connected with the verification process are to be paid directly to GACCP and included with completed application. Please remit \$285.00, the total amount due for St. Joseph's.

If you are currently a member or become a member of the Maricopa County Medical Society within 30 days of our receipt of your GACCP application, you will receive a reduction in the form of a partial rebate of your GACCP application processing fee.

I AM APPLYING TO THE FOLLOWING HOSPITAL(S) AND HAVE ENCLOSED THE APPROPRIATE FEE

- | | |
|--|--|
| <input type="checkbox"/> Arizona Heart Hospital | <input type="checkbox"/> St. Joseph's Hospital Medical Center ** |
| <input type="checkbox"/> Arrowhead Hospital | <input type="checkbox"/> Trillium Specialty Hospital - East Valley |
| <input type="checkbox"/> Kindred Hospital - Phoenix/Scottsdale | <input type="checkbox"/> Trillium Specialty Hospital - West Valley |
| <input type="checkbox"/> Maryvale Hospital Medical Center | <input type="checkbox"/> Valley of the Sun Rehabilitation Hospital |
| <input type="checkbox"/> Phoenix Baptist Hospital & Medical Center | <input type="checkbox"/> West Valley Hospital Medical Center |

****AN ADDITIONAL FEE OF \$125.00 MUST BE RETURNED WITH THE APPLICATION WHEN APPLYING TO ST. JOSEPH'S HOSPITAL MEDICAL CENTER**

THE FOLLOWING HOSPITALS REQUIRE YOU TO COMPLETE A PRE-APPLICATION BEFORE WE CAN PROCESS YOUR APPLICATION. YOU MUST CONTACT THE FACILITY AND COMPLETE THEIR PRE-APPLICATION PROCESS

- Casa Grande Regional Medical Center (520) 381-6347
- Hualapai Mountain Medical Center

Printed Name _____ Date _____

Signature _____

GREATER ARIZONA CENTRAL CREDENTIALING PROGRAM



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PHOENIX, ARIZONA 85004-1576
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FAX: 602-256-2763

MARICOPA
COUNTY
MEDICAL
SOCIETY

INITIAL APPLICATION FOR MEDICAL STAFF OR HEALTH CARE ENTITY

Date
APPLICATION SENT: _____
APPLICATION RECEIVED: _____
VERIFICATION COMPLETED: _____

Application will be returned if not complete.

Incomplete addresses will delay file.

DO NOT leave any blank spaces. "See CV" is not acceptable, if not applicable mark N/A.

Please PRINT (using black ink) or type. *If using a Highlighter, use yellow ONLY

DO NOT use white out. INITIAL ALL CHANGES.

Copies of all required attachments must be legible.

(PLEASE INDICATE SPECIALTY AREA(S) IN WHICH YOU ARE REQUESTING PRIVILEGES)

- | | |
|---|---|
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Physical Medicine and Rehab |
| <input type="checkbox"/> Allergy and Immunology | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> Pain Management | <input type="checkbox"/> Psychiatry and Neurology |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Child Psychiatry |
| <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Neurology and / or Child Neurology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Toxicology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Interventional Radiology |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Endocrinology and Metabolism | <input type="checkbox"/> Cardiothoracic Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Colon & Rectal Surgery |
| <input type="checkbox"/> Hematology | <input type="checkbox"/> General Surgery |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Neurological Surgery |
| <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Oral & Maxillofacial Surgery |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Otolaryngology |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Pediatric Surgery |
| <input type="checkbox"/> Obstetrics and Gynecology | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Gynecology Only | <input type="checkbox"/> Surgical Assist |
| <input type="checkbox"/> Gynecology Oncology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Maternal/Fetal Medicine | <input type="checkbox"/> Vascular Surgery |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pediatrics | |
| <input type="checkbox"/> Neonatal-Perinatal | |
| <input type="checkbox"/> Sub Specialty _____ | |

I. PERSONAL DATA

Confidential and only used in the event of an emergency.

- a) Name: _____
(Last) (First) (Middle) (Title)
- b) List other names you have used: _____ Sex: F M
- c) Home: _____
(Street Address) (City) (State) (Zip)
- d) Home Phone #: _____ e) Name of Spouse: _____
- f) Date of Birth: _____ g) Place of Birth: _____ h) Citizenship: _____
- i) Foreign Language(s): _____ Speak Write j) UPIN #: _____
(Assigned by Medicare)
- k) NPI #: _____ l) SSN: _____ m) Tax ID#: _____
- n) Primary Taxonomy Code: _____

II. CURRENT PRACTICE INFORMATION

a) Primary Office

Corporate/Group Name: _____ Office Manager: _____

(Street Address)

(City) (State) (Zip Code)

Phone: _____ Fax #: _____ Email: _____

Answering Service: _____ Pager: _____ Cell Phone: _____

b) Other Locations

(Street Address) (City) (State) (Zip)

(Street Address) (City) (State) (Zip)

(Street Address) (City) (State) (Zip)

If additional space is needed - please attach a separate sheet

c) Address to which all correspondence should be sent (IF DIFFERENT FROM Primary Office Address):

(Street Address / P.O. Box Number)

(City) (State) (Zip Code)

Phone: _____ Fax #: _____ Email: _____

d) Associates (Name of Physicians): _____

e) Covering Physicians: _____

f) Do you sponsor / employ any Allied Health Practitioners? _____ If yes, list names, category (i.e. NP, PA):
(Yes/No)

III. FUTURE PRACTICE INFORMATION

Complete this section if you are in the process of moving from the location listed as your current primary office.

Not leaving Current Practice

a) Corporate/Group Name: _____ b) Office Manager: _____

c) Anticipated Start Date: _____

d) Address: _____
(Street Address)

(City) (State) (Zip Code)

e) Phone: _____ f) Fax #: _____ g) Email: _____

h) Answering Service: _____ i) Pager: _____ j) Cell Phone: _____

k) Address to which all correspondence should be sent (IF DIFFERENT FROM Primary Office Address):

(Street Address / P.O. Box Number)

(City) (State) (Zip Code)

Phone: _____ Fax #: _____ Email: _____

l) Associates (Name of Physicians): _____

m) Covering Physicians: _____

n) Do you sponsor / employ any Allied Health Practitioners? _____
(Yes/No)

If yes, list names, category (i.e. NP, PA): _____

IV. LICENSE(S)

List in what states or provinces you have applied for or been granted license or registration.
If license not issued, so state. Attach legible copy of current license(s).
If additional space is needed, complete addendum page.

a) State: _____	License #: _____	Date Issued: _____	Date Expired: _____
b) State: _____	License #: _____	Date Issued: _____	Date Expired: _____
c) State: _____	License #: _____	Date Issued: _____	Date Expired: _____
d) State: _____	License #: _____	Date Issued: _____	Date Expired: _____
e) State: _____	License #: _____	Date Issued: _____	Date Expired: _____

Explain any licenses not issued:

This completes my license information Yes No

V. EDUCATION

List all medical, osteopathic, dental or podiatric schools attended. Attach copy of Degree(s).
See Page 5 for Post Graduate education.

a) College or University: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? Yes No

b) College or University: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? Yes No

c) College or University: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? Yes No

d) College or University: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

From: _____ To: _____ Degree Earned: _____
Month Year Month Year

Continue with additional education? Yes No

VI. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

Please attach copy of ECFMG Certificate (if applicable)

Does Not Apply

ECFMG Certification #: _____ Date Issued: _____

VII. POSTGRADUATE TRAINING

List all facilities where you received training. Applicant must disclose every training program initiated, whether completed or not, and all completed programs. ATTACH COPIES OF CERTIFICATES.

a) Check one: Internship Residency Fellowship Specialty: _____

Facility: _____
(Name)

(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? Yes No

b) Check one: Internship Residency Fellowship Specialty: _____

Facility: _____
(Name)

(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? Yes No

c) Check one: Internship Residency Fellowship Specialty: _____

Facility: _____
(Name)

(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? Yes No

d) Check one: Internship Residency Fellowship Specialty: _____

Facility: _____
(Name)

(Street Address) (City) (State) (Zip)

From: _____ To: _____ Program Director: _____
Month Year Month Year

Completed: _____ If no, please explain: _____
Yes/No

Continue with additional training? Yes No

VIII. MILITARY/PUBLIC HEALTH SERVICE

Please attach copy of DD214 / Statement of service U.S. Public Health

Does Not Apply

In the previous 15 years, have you served or are you currently serving Yes No

U.S. Military Reserves Public Health Service

If yes, which Branch: _____

From: _____ To: _____ Type of discharge: _____
Month Year Month Year

IX. EMPLOYED FACULTY POSITION

Please list all positions held during previous 15 years.

Does Not Apply

a) Institution: _____
(Name)

Department: _____

Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

Position Held: _____ From: _____ To: _____
Month Year Month Year

Reason for Leaving: _____

Continue with additional employed faculty positions? Yes No

b) Institution: _____
(Name)

Department: _____

Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

Position Held: _____ From: _____ To: _____
Month Year Month Year

Reason for Leaving: _____

Continue with additional employed faculty positions? Yes No

X. PRACTICE HISTORY

Please list all positions held during the previous 15 years, in chronological order. Leave no time period unaccounted. Information should include private practice (solo, group) and any paid employment. If additional space is needed please complete addendum page.

New physician, no previous practice

a) Practice/Employer Name: _____

Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? Yes No

b) Practice/Employer Name: _____

Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? Yes No

c) Practice/Employer Name: _____

Address: _____
(Street Address) (City) (State) (Zip)

Phone: _____ Fax: _____

From: _____ To: _____ Position Held: _____
Month Year Month Year

Name and title of person who can verify this information: _____

Address (if different from above): _____

Reason for leaving: _____

Continue with additional practice history? Yes No

XI. TIME GAPS

You must account for time gaps less than 90 days (3 months). Time gaps greater than 90 days (3 months) must be accounted for by you and verified in writing by someone other than yourself. You must account for all time gaps that occurred during the previous 15 years.

I have no time gaps

a) From: _____ To: _____ Explain:
Month Year Month Year

Name and address of person to contact for verification of time gap greater than 3 months.

(Name) (Phone) (Fax)

(Street Address) (City) (State) (Zip)

Continue with additional time gap information? Yes No

b) From: _____ To: _____ Explain:
Month Year Month Year

Name and address of person to contact for verification of time gap greater than 3 months.

(Name) (Phone) (Fax)

(Street Address) (City) (State) (Zip)

Continue with additional time gap information? Yes No

c) From: _____ To: _____ Explain:
Month Year Month Year

Name and address of person to contact for verification of time gap greater than 3 months.

(Name) (Phone) (Fax)

(Street Address) (City) (State) (Zip)

Continue with additional time gap information? Yes No

d) From: _____ To: _____ Explain:
Month Year Month Year

Name and address of person to contact for verification of time gap greater than 3 months.

(Name) (Phone) (Fax)

(Street Address) (City) (State) (Zip)

Continue with additional time gap information? Yes No

XII. STAFF MEMBERSHIPS

Please list ALL facilities to which you have applied during the previous 15 years.
If additional space is needed, please complete addendum page.

I have never applied or held staff membership in any healthcare facility during the previous 15 years

a) **PRIMARY HOSPITAL AFFILIATION** _____
(Hospital Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

b) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

c) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

d) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

e) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

f) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

g) Healthcare Facility Name: _____
(Name)

(Street Address) (City) (State) (Zip)
Date of staff membership: From: _____ To: _____
Month Year Month Year
Continue with additional staff memberships? Yes No

XIII. BOARD CERTIFICATION

List any and all Specialty Boards. Attach copy of certificate(s) or Documentation of Board Status.

a) Are you Board Certified? Yes No If yes, complete questions 1 through 3

1) Name of Board: _____ Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

b) Are you certified in a sub-specialty? Yes No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: _____ Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

c) Are you certified in an additional sub-specialty? Yes No If yes, complete questions 1 through 3

1) Sub-Specialty Board Name: _____ Board Name

2) Date Certified: _____ Date Recertified, if applicable: _____
Month Year Month Year

3) Identify each date you sat or will sit for Board Exam: _____

d) If you are not Board certified, indicate current status: _____

Name of Board: _____ Board Name

Identify dates you sat for exam:

Or will sit:

Date: _____ Passed Exam Failed Exam Date: _____

Date: _____ Passed Exam Failed Exam Date: _____

Date: _____ Passed Exam Failed Exam Date: _____

e) Not Pursuing

XIV. DRUG ENFORCEMENT ADMINISTRATION REGISTRATION (DEA)

Please attach legible copy of current registration.

DEA Number: _____ Expiration Date: _____

DEA Pending

I do not have a DEA

XV. CONTINUING MEDICAL EDUCATION

Attach copies of CME certificates and/or provide a listing of all credits received.

Hospitals require documentation of CME hours related to privileges requested, except for practitioners who have completed training within the past year.

N/A, I completed training within the past year

Number of continuing medical education hours awarded to you during the past calendar year: _____ hours.

XVI. PROFESSIONAL LIABILITY INSURANCE

Please list current professional liability insurance information. You must provide information on all professional policies under which you may be covered. List ALL policies under which you've been insured for the previous fifteen (15) years. Please attach a copy of current certificate of insurance

CURRENT CARRIERS

a) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____
(Street Address) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ To: _____ Retro Date: _____
Month Year Month Year Month Year

Amount of coverage currently in effect: \$ _____ per occurrence/per aggregate.

Continue with additional insurance information? Yes No

b) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____
(Street Address) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ To: _____ Retro Date: _____
Month Year Month Year Month Year

Amount of coverage currently in effect: \$ _____ per occurrence/per aggregate.

Continue with additional insurance information? Yes No

PRIOR CARRIERS

a) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____
(Street Address) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ To: _____
Month Year Month Year

Continue with additional insurance information? Yes No

b) Name of Policyholder: _____ Policy #: _____

Name of Insurance Carrier: _____

Mailing Address: _____
(Street Address) (City) (State) (Zip)

Phone Number: _____ Fax Number: _____

Dates of Coverage: From: _____ To: _____
Month Year Month Year

Continue with additional insurance information? Yes No

XVII. PEER REFERENCES

List four licensed, independent practitioners who can attest to your current clinical competency, ethical character, health status and ability to work cooperatively with others. **Two of the four must be in your specialty.** None of the practitioners should be related to you by family or current/ pending professional partnership/financial arrangement (**NOT AN ASSOCIATE**). Practitioners listed as a reference must be local if you have been in Arizona for more than 6 months. Observations by peer reference must be within the last 2 years for current competency.

a) Name: _____ Specialty: _____

(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____ E-mail Address: _____

b) Name: _____ Specialty: _____

(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____ E-mail Address: _____

c) Name: _____ Specialty: _____

(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____ E-mail Address: _____

d) Name: _____ Specialty: _____

(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____ E-mail Address: _____

XVIII. OTHER PERTINENT INFORMATION

- a) Are you currently under investigation or have you been subject to disciplinary or corrective action such as admonition, reprimand, probation, non-provisional supervision, suspension, termination, revocation or reduction of privileges by any healthcare facility or professional organization? Yes No IF YES, EXPLAIN:

- b) Have you ever voluntarily withdrawn / terminated your healthcare facility application / membership? Yes No
Have you ever voluntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility? Yes No
IF YES, EXPLAIN:

- c) Have you ever involuntarily withdrawn / terminated your healthcare facility application / membership? Yes No
Have you ever involuntarily experienced a limitation, reduction, or loss of clinical privileges at any healthcare facility? Yes No
IF YES, EXPLAIN:

- d) Have you ever been or are you currently the subject of an investigation, suspension or sanction from participating in any private, federal or state health insurance program (e.g., Medicare, Blue Cross)? Yes No IF YES, EXPLAIN:

- e) Have you ever been convicted of a felony? Yes No
Have you ever been convicted of a misdemeanor? Yes No IF YES TO EITHER QUESTION, EXPLAIN:

XIX. LICENSURE

- a) Are you currently under investigation or has any license or registration entitling you to practice your profession in any jurisdiction been censured, challenged, investigated, denied, suspended, limited, placed under stipulation or probation, revoked or been voluntarily/involuntarily relinquished? Yes No IF YES, EXPLAIN:

- b) Have you ever been issued an advisory letter or a letter of concern/reprimand? Yes No IF YES, EXPLAIN:

XX. DEA

- a) Has your narcotics registration ever been limited, suspended, revoked, or voluntarily/involuntarily relinquished or is it currently being challenged/investigated? Yes No N/A IF YES, EXPLAIN:

XXI. PROFESSIONAL LIABILITY INSURANCE

- a) Have you ever been denied liability insurance, in whole or in part, or has your policy ever been canceled, involuntarily restricted, denied renewal, or rated up because of the nature or volume of claims against you? Yes No IF YES, EXPLAIN:

- b) Does your malpractice coverage exclude you from providing any specific procedure(s) or practicing portions of your specialty for which you are requesting privileges? Yes No IF YES, EXPLAIN:

- c) Have you ever practiced without professional liability insurance? Yes No IF YES, EXPLAIN:

- d) In the previous 15 years, have there been or are there currently pending malpractice claims, suits, settlements, judgments, arbitration proceedings, or complaints filed involving your professional practice? Yes No
IF YES TO THIS QUESTION YOU MUST COMPLETE THE ATTACHED CONFIDENTIAL INFORMATION REPORT FOR EACH INCIDENT.

CONFIDENTIAL INFORMATION REPORT

Does not apply

If you have answered "YES" to question (d) in Section XXI - Professional Liability Insurance (page 13), you must furnish the following information regarding each lawsuit or complaint. Attach a copy of the complaint and your response. **It is your responsibility to provide documentation verifying your response (i.e., statement from an attorney, court records, etc.).** You may choose to have your attorney complete this form, however, **your signature is required.**

Month / Year of Incident? _____ Where incident occurred? _____

Nature of Incident? (Complaint, Allegation)

Disposition of Claim Dropped Dismissed Pending Settled, Amount ? _____

With Prejudice Without Prejudice

Verdict for you, Amount? _____ Verdict for plaintiff, Amount? _____

Represented by Legal Counsel for this claim / malpractice lawsuit? Yes No

If yes, give the name and address of counsel. Name: _____

(Street Address)

(City)

(State)

(Zip)

Phone Number: _____ Fax Number: _____

Insurance Company that provided coverage for this claim?

Company Name: _____

(Street Address)

(City)

(State)

(Zip)

Telephone Number: _____ Policy Number: _____ Claim Number: _____

Other comments:

Practitioner Signature: _____ Date: _____

Name: _____
(Please Print)

XXII. HEALTH STATUS

a) Do you have a chronic or recurring illness, mental or physical disability that might limit or affect your ability to perform privileges requested? Yes No IF YES, EXPLAIN:

b) Are you currently or have you in the past been dependent on or treated for alcohol or drugs? Yes No IF YES, EXPLAIN:

c) Are you currently taking medication or undergoing treatment or therapy that is likely to affect your ability to perform privileges requested? Yes No IF YES, EXPLAIN:

TB ATTESTATION FORM

The Arizona Department of Health Services (DHS) requires each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis at least once every 24 months or more often as required by the hospital's infection control committee. This evidence of freedom from infectious pulmonary tuberculosis can be established by; (a) a report of a negative Mantoux skin test; (b) a report of a negative chest X-ray; or (c) if the medical staff member has had a positive Mantoux skin test, another physician's statement that he or she is free from infectious pulmonary tuberculosis.

DHS will accept a medical staff or allied health member's attestation that he or she is free from infectious pulmonary tuberculosis and can provide one of the types of evidence listed above upon request. If a medical staff or allied health member signs this attestation and cannot produce this evidence upon request, DHS has indicated that it will report the physician to AMB/OBEX or the appropriate licensing board.

I attest that I was evaluated for infectious pulmonary tuberculosis in _____, 20 ____ .

I can provide the following evidence to demonstrate that I am free from infectious pulmonary tuberculosis:

- A report of a negative Mantoux skin test;
- A report of a negative chest X-ray; or
- Although I had a positive Mantoux skin test, I have another physician's statement that I am free from infectious pulmonary tuberculosis.

Practitioner Signature: _____ Date: _____

Print Name: _____

RELEASE AND STATEMENT OF APPLICANT

GACCP and all Healthcare Entities receiving this information will treat all information submitted in this application as confidential and protected under Arizona state statutes.

Please read carefully before signing

I understand and acknowledge that, as an applicant to those healthcare entities indicated in this application, it is my responsibility to provide sufficient information upon which a proper evaluation of my qualifications including my current licensure, relevant training and/or experience, current competence, health status, character and ethics can be based. I hereby pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for the care of my patients to any practitioner not qualified to undertake that responsibility. I further understand and acknowledge that the Maricopa County Medical Society's Greater Arizona Central Credentialing Program (GACCP), acting as agent for the healthcare entities, will verify the information in this application. I further understand that healthcare entities may also independently investigate my qualifications. By submitting this application, I agree to such verification and to the information exchange activities of GACCP and the healthcare entities. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations, and code of conduct of the healthcare entities and their medical staffs and agree to be bound by them. I understand and acknowledge that completing this application does not entitle me to membership or privileges at any of the healthcare entities and that GACCP shall have no responsibility or liability with respect to healthcare entities' membership decisions. I further understand and agree that GACCP is solely responsible for the information which it provides to healthcare entities and that healthcare entities shall have no responsibility or liability for the completeness or accuracy of this information insofar as it was provided by GACCP or verified by GACCP.

Verification of Application. I hereby authorize all individuals, institutions, and entities, (past, present, and future) including all professional liability insurers with whom I have had or currently have professional liability insurance (including past and present claims history), who have knowledge concerning my qualifications and other information requested in this application to consult with, and release relevant information and/or records to the healthcare entities, their medical staffs and agents, specifically including but not limited to GACCP.

I further authorize the use of the pictures provided by me for internal/ external purposes.

Authorization of Release. I understand and agree that the authorizations given by me herein shall be irrevocable for a period of twenty-four (24) months. A photocopy of this waiver shall be as effective as the original when so presented.

All information provided by me in this application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial of appointment or for summary dismissal from the healthcare entities. I further release from liability and from any restrictions as to confidentiality and/or privacy, all representatives of GACCP, the hospitals, healthcare entities, their boards and medical staffs, and further release all medical schools, licensing boards, specialty societies and all other entities and individuals providing information from liability for their acts performed in connection with the gathering and exchange of information as consented to above.

I agree to update this application while it is being processed, should there be any change in the information provided that could affect this application or its outcome.

I hereby agree that the exclusive remedy for any decision or recommendation made pertaining to this application for appointment or in any other peer review proceeding shall be to seek review of the correctness of the decision or recommendation, that no claim for alleged monetary damages will be brought on account thereof, and that no action at law or inequity will be brought until after all appeal rights available under the healthcare entities' medical staff bylaws/contracts have been exercised and completed.

I agree to notify GACCP and the healthcare entities within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against me. I further agree to notify GACCP and the healthcare entities thirty (30) days prior to any change in malpractice insurance coverage.

Name: _____
(Please Print)

Date: _____ Signature: _____

MEDICARE ATTESTATION STATEMENT

NOTICE TO PRACTITIONERS

"Medicare, and/or other federally funded program payments to healthcare entities are based on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws."

I acknowledge that I have read the above statement.

Name: _____
(Please Print)

Date: _____

Signature: _____

ADDENDUM

LICENSES (continued from page 3)

f) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
g) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
h) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
i) State: _____ License #: _____ Date Issued: _____ Date Expired: _____
j) State: _____ License #: _____ Date Issued: _____ Date Expired: _____

Explain any licenses not issued:

PRACTICE HISTORY (continued from page 7)

d) Practice/Employer Name: _____
Address: _____
(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____
From: _____ To: _____ Position Held: _____
Month Year Month Year
Name and title of person who can verify this information: _____
Address (if different from above): _____
Reason for leaving: _____
Continue with additional practice history? Yes No

e) Practice/Employer Name: _____
Address: _____
(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____
From: _____ To: _____ Position Held: _____
Month Year Month Year
Name and title of person who can verify this information: _____
Address (if different from above): _____
Reason for leaving: _____
Continue with additional practice history? Yes No

f) Practice/Employer Name: _____
Address: _____
(Street Address) (City) (State) (Zip)
Phone: _____ Fax: _____
From: _____ To: _____ Position Held: _____
Month Year Month Year
Name and title of person who can verify this information: _____
Address (if different from above): _____
Reason for leaving: _____
Continue with additional practice history? Yes No

ADDENDUM

STAFF MEMBERSHIPS (continued from page 9)

h) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

i) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

j) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

k) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

l) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

m) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

n) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Continue with additional staff memberships? Yes No

o) Healthcare Facility Name: _____
(Name)

(Street Address)

(City)

(State)

(Zip)

Date of staff membership: From: _____ To: _____
Month Year Month Year

Social Security Number

□	□	□	—	□	□	—	□	□	□	□	□
---	---	---	---	---	---	---	---	---	---	---	---

Date of Birth - used for identification purposes only

□	□	—	□	□	—	□	□	□	□
MONTH			DATE			YEAR			

First Name	Middle Name	Last Name
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Other Names Used (maiden names, AKA names, etc.)

Current Residential Address

City	State	Zip Code
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List each **CITY**, **STATE** and **ZIP CODE** (if known) where you have lived during the past seven years:

City	State	Zip Code	From Date	To Date	<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Driver's License Number	State of Issue
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FCRA NOTICE AND ACKNOWLEDGMENT
IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

NOTICE REGARDING BACKGROUND INVESTIGATION

Greater Arizona Central Credentialing Program (GACCP) ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include, but is not limited to: employment and education verifications; social security number verification; criminal and civil court records; personal interviews; driving records; and/or any other public records or any other information bearing on my character, general reputation, personal characteristics and trustworthiness. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report.

The report will be generated by Universal Background Screening (4000 North Central Avenue, Suite 1000, Phoenix, AZ 85012, 1-877-263-8033) or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing Employer to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by Employer by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION (above) and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT (separate document) and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law.

Signature

Date

Printed Name

Social Security Number (SSN)