Outpatient Medical Centers, Inc.
Providing Quality Healthcare To All

APPLICATION FOR CLINICAL STAFF APPOINTMENT & CLINICAL PRIVILEGES

GENERAL INSTRUCTIONS:

1. If more space is needed, attach additional sheets and make reference to the questions being answered.
2. If you have not previously submitted copies of the following documents, please attach them to this application:
   a. Current license(s) to practice medicine
   b. Narcotics (DEA) registration certificate
   c. Professional liability insurance policy and certificate of current coverage from insurance carrier
   d. ECFMG certificate (if international medical graduate)
   e. Evidence of board status (if applicable)
   f. Curriculum vitae (resume)
   g. Government issued picture identification/Passport

I. PERSONAL IDENTIFICATION DATA

________________ ________________ ____________
Last Name First Name Middle

Date of Birth: ____________ Social Security #: ____________

Office Address: ________________________

____

____

Phone: ________________________

Home Address: ________________________

____

____

Phone: ________________________

Are you a citizen of the United States? ☐ YES ☐ NO

If no, please indicate the present status of your visa ________________

II. PROFESSIONAL DATA

Please provide the following identifying numbers (if applicable).

NPI: ______________________ UPIN: ________________

Federal DEA: ______________________ State CDS: ______________

Medicaid Provider #: ____________________

Medicare Provider #: ____________________

A. General Information

1. Clinical Specialty/Subspecialty: ________________________________

2. Other interests in practice, research, etc.:

____

____

B. Practice Information

Please answer each of the following questions. If you answered "yes" to any of the questions, please provide full explanation of the details on a separate sheet.

□ Y □ N Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

□ Y □ N Has your license to practice in any state ever been (voluntarily or involuntarily) denied, limited, suspended or revoked?

□ Y □ N Have you ever been voluntarily or involuntarily suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program?

□ Y □ N Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?

□ Y □ N Has your narcotics registration certificate ever been voluntarily or involuntarily investigated, limited, suspended or revoked?

□ Y □ N Is your narcotics registration certificate currently being investigated or challenged?

□ Y □ N Have you ever been named as a defendant in any type of criminal proceeding?

III. EDUCATIONAL DATA

A. Please list name and address of school/institution, degree obtained, and year of completion.

	Name and Address	Degree Obtained	Year of Completion
Undergraduate			
Medical/Dental			
Other Prof. Training			
Internship			
Residencies			
Fellowship			
Teaching Appointment			
Other			
Other			

IV. INSTITUTIONAL AFFILIATIONS

A. List in chronological order all institutional affiliations since completion of post-graduate education. This includes all hospitals, corporations, military assignments or government agencies. Complete addresses must be included. If more space is needed, attach additional sheets.

____
Name of Institution

____
Complete Address

____________________ Dates: ________ ________
Department From To

____
Chairperson/Supervisor

____
Name of Institution

____
Complete Address

____________________ Dates: ________ ________
Department From To

____
Chairperson/Supervisor

B. Has your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily relinquished, suspended, diminished, revoked, refused, limited or not renewed at any hospital or other health care facility? _____

C. Have you ever voluntarily or involuntarily withdrawn your application for appointment, reappointment and conical privileges or resigned from the medical staff before a decision was made by a hospital's or health care facility's governing board? ______

D. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility? ________

E. Has any health care entity ever reported any malpractice payment made for your benefit, any licensure action or any adverse disciplinary action concerning you to the National Practitioner Data Bank? _____

If your answer to B, C, D, or E listed above is "yes", please provide a full explanation of the details on a separate sheet and attach.

V. PROFESSIONAL ASSOCIATIONS

A. Membership in Professional Societies (local, state or national)

1. Name: ______________________________

   Address: ______________________________

   ____

   From: ______________ To: ____________

2. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? _________
   If yes, please provide a full explanation of details on a separate sheet and attach.

B. Name(s) of specialty boards by which you are certified:

______________________________ ____________
Date

1. Have you ever been examined by any specialty board, but failed to pass the examination? ____________
   If yes, please provide details.

2. If not certified, have you applied for the certification examination? ________

3. Have you been accepted to take the certifications examination? __________

4. Date of next required re-certification examination (if applicable) _________

VI. PROFESSIONAL LIABILITY DATA

A. Insurance

1. Do you currently have professional liability coverage? ☐ YES ☐ NO
   If yes, please attach a copy to this application.

2. Has your professional liability coverage ever been voluntarily or involuntarily terminated or have you ever been denied such coverage? ☐ YES ☐ NO

If yes to #2, explain: ____

3. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? ☐ YES ☐ NO

B. Malpractice Claims and Legal Actions

1. During the past five years have you been informed of any professional liability claims (not yet suits) being made against you? ☐ YES ☐ NO

2. Have any professional liability suits ever been filed against you? ☐ YES ☐ NO

3. Have any professional liability suits been filed against you which are presently pending? ☐ YES ☐ NO

4. Have any verdicts, judgments or settlements been made in any professional liability case in which you have been involved? ☐ YES ☐ NO

If the answer to any of the above questions is yes, please provide a full explanation of the details on a separate sheet and attach. If litigation was involved, the explanation must include the name of the court in which any suit was filed, the parties, caption and docket number of the case, and the name and address of the attorney defending you. Also furnish a description of the claim made against you and the outcome of the litigation. If no litigation was involved, identify the claimant and his/her attorney. Describe the claim, when it arose, what the final disposition was and the name and the address of the attorney defending you.

VII. REFERENCES

List at least two professional references and one character reference, and as many more as you like, not including relative, current partners or associates in practice. Provide current, complete addresses. References will be evaluated according to the extent of their direct clinical observation of your work, your judgment, your ethical character, your ability to work with others and their knowledge of you.

Name: ______________________________ Telephone: ____________________

Address: ____

Name: ______________________________ Telephone: ____________________

Address: ____

Name: ______________________________ Telephone: ____________________

Address: ____

OUTPATIENT MEDICAL CENTERS, INC.

APPLICATION FOR CLINICAL PRIVILEGES

General

Granting, reviewing, and changing of clinical privileges for the staff of the Outpatient Medical Centers, Inc., will be in accordance with OMC, Inc. policy. Assignments of such clinical privileges are based upon education, clinical training, experience, demonstrated current competence, documented results of patient care, and other quality review and monitoring deemed appropriate.

The principle of "documented competency' will prevail. Primary care medicine is a dynamic and comprehensive field. Adult medicine, pediatric care, prenatal care, .surgical care, critical care, and mental health care are integral components of OMC's continuity of care. As a result, privileges in these areas are identified to pertain to primary care specialties of pediatrics, internal medicine, family practice, general practice, and obstetrics/gynecology.

The privileges for the Outpatient Medical Centers, Inc. will be granted in the following three classes. Please check the one in which you would like apply:

☐	**LEVEL ONE (GENERAL)**	**Site:**
This class includes privileges for uncomplicated, basic procedures and clinical application of cognitive skills. Physicians applying for privileges in this class will be graduates of approved medical/osteopathic schools who are properly licensed, and who have demonstrated skills in appropriate general medicine practice.		
☐	**LEVEL TWO (RESIDENCY/BOARD CERTIFICATION)**	**Site:**
Privileges in this class include Level One privileges, as well as privileges for those procedures and cognitive skills involving more serious medical problems and which normally are taught in residency programs. This may include procedures and clinical application of cognitive skills appropriate to the care in prenatal, surgical, psychiatric, and critical care units. Physicians requesting privileges in this class will have met the criteria in Level One, and will also have either completed training in a residency program and/or will be Board Certified, or will have documented experience, demonstrated abilities and current competence in primary care medicine.		
☐	**LEVEL THREE (ADVANCED PROCEDURES)**	**Site:**
Privileges in this category include privileges in Classes I and II. Additional privileges may be granted to physicians who have acquired added experience and/or training, and who have special skills and knowledge in specified areas of medicine. As appropriate, the Medical Director will review these additional privileges.		

IT SHOULD BE NOTED THAT, EVEN THOUGH A PHYSICIAN IS ASSIGNED TO ONE OF HE THREE CLASSES, HE OR SHE MIGHT ALSO ELECT TO APPLY FOR INDIVIDUAL PRIVILEGES THAT MAY BE CONSIDERED TO BE IN A HIGHER CLASS.