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Outpatient Medical Center, Inc.
"Caring For You Is What We Do"

APPLICATION FOR CLINICAL STAFF APPOINTMENT & CLINICAL PRIVILEGES

GENERAL INSTRUCTIONS: The time that it takes to complete credentialing, verifications, and a privileging decision at a monthly Board of Directors meeting, is largely dependent on how soon the provider submits all information needed. We advise you to submit requested information as soon as possible so that the remaining part of the process is not delayed. Additional instructions below:

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. Government issued picture identification/Passport
   B. Current Curriculum Vitae (CV) or Resume
   C. Evidence of clinical education with copies of degrees/certifications
   D. Current license(s) to practice
   E. Narcotics (DEA and CDS) registration certificate
   F. Evidence of board certifications (if applicable)
   G. ECFMG certificate (if applicable)
   H. Proof of current Basic Life Support/CPR training
   I. Professional liability insurance policy and certificate of current coverage (if applicable)
   J. Health Attestations (one from yourself and another from your Physician)
   K. Complete personal immunization record

3. Contact OMC's Credentialing and Privileging Coordinator at 318-357-2071 or email HR@outpatientmedical.org should you have any questions.

I. PERSONAL IDENTIFICATION DATA

Last Name	First Name	Middle Name

Date of Birth: ______________________ Social Security#: ____ - ____ - ____

Home Address: ____

____

Phone: ______________________ (☐ home, ☐ cell or ☐ other: _________)

Email Address: ____

Other Address: ____

____

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

If not, please provide evidence of your legal ability to work in the United States:

____

II. PROFESSIONAL DATA

Please provide the following identifying numbers (if applicable):

National Provider Identifier:____________________ Federal DEA: __________________

Unique Physician Identification No:_______________ State CDS:____________________

Medicaid Provider No: ________________________ Medicare Provider No: ___________

LA License No:______________________________

A. Complete the Following General Practice Information Questions:

1. Clinical Specialty/Subspecialty: ____
2. Other interests in practice, research, etc.:__________________________________

____

B. Complete the Following Specific Practice Questions:

Question		
Have any disciplinary actions been initiated or are any pending against you by any state licensure board?	☐ **YES**	☐ **NO**
Has your license to practice in any state ever been (voluntarily or involuntarily) denied, limited, suspended or revoked?	☐ **YES**	☐ **NO**
Have you ever been voluntarily or involuntarily suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program?	☐ **YES**	☐ **NO**
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?	☐ **YES**	☐ **NO**
Has your narcotics registration certificate ever been voluntarily or involuntarily investigated, limited, suspended or revoked?	☐ **YES**	☐ **NO**
Is your narcotics registration certificate currently being investigated or challenged?	☐ **YES**	☐ **NO**
Have you ever been named as a defendant in any type of criminal proceeding?	☐ **YES**	☐ **NO**

NOTE: If your answer "Yes" to the questions above, provide a full explanation of the details on a separate sheet and attach.

III. EDUCATIONAL DATA - 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			
Teaching Appointment			
Other			

IV. INSTITUTIONAL AFFILIATIONS - 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/Address of Institution: ____

____

Department: ____________________ Chairperson/Supervisor: _______________________

Dates From: ____________________ To: __________________

Name/Address of Institution: ____

____

Department: ____________________ Chairperson/Supervisor: _______________________

Dates From: ____________________ To: __________________

Name/Address of Institution: ____

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Department: ____________________ Chairperson/Supervisor: ________________________

Dates From: ________________________ To: ________________________

Complete the Following Affiliation Questions:

Question		
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?	☐ **YES**	☐ **NO**
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?	☐ **YES**	☐ **NO**
Have you ever been the subject of disciplinary proceedings at any hospital or health care facility?	☐ **YES**	☐ **NO**
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?	☐ **YES**	☐ **NO**

NOTE: If your answer "Yes" to the questions above, provide a full explanation of the details on a separate sheet and attach.

V. PROFESSIONAL ASSOCIATIONS

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

Name: ____

Address: ____

____

From: ________________ To: ______________

Complete the Association Question:

Have you ever been denied membership or renewal thereof or been subject to disciplinary proceedings in any professional organization? ☐ **YES** ☐ **NO**

NOTE: If yes, please provide a full explanation of details on a separate sheet and attach.

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

______________________________	______________
Name of Specialty Board	Date

Complete Specialty Board questions:

Have you ever been examined by any specialty board, but failed to pass the examination? ☐ **YES** ☐ **NO**

If not certified, have you applied for the certification examination? ☐ **YES** ☐ **NO**

Have you been accepted to take the certifications examination? ☐ **YES** ☐ **NO**

Date of next required re-certification examination (if applicable): ____________

NOTE: If yes, please provide a full explanation of details on a separate sheet and attach.

VI. PROFESSIONAL LIABILITY DATA

Complete questions regarding Liability Insurance:

Do you currently have professional liability coverage?	☐ **YES** ☐ **NO**
Has your professional liability coverage ever been voluntarily or involuntarily terminated, or have you ever been denied such coverage?	☐ **YES** ☐ **NO**
Has your present professional liability insurance carrier excluded any specific procedures from your coverage?	☐ **YES** ☐ **NO**

NOTE: If yes, please provide a full explanation of details on a separate sheet and attach.

Complete questions regarding Malpractice Claims and Legal Actions:

During the past five years have you been informed of any professional liability claims (not yet suits) being made against you?	☐ **YES** ☐ **NO**
Have any professional liability suits ever been filed against you?	☐ **YES** ☐ **NO**
Have any professional liability suits been filed against you which are presently pending?	☐ **YES** ☐ **NO**
Have any verdicts, judgments or settlements been made in any professional liability case in which you have been involved?	☐ **YES** ☐ **NO**

NOTE: 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. CLINICAL REFERENCES - Provide at least 3 professional references, and their contact information, who are familiar with your ability to practice as a licensed provider. Your references must have the same credentials as you or, if a Nurse Practitioner, it may be a Physician.

Reference #1:

Name: ____

Address: ____

Phone: ____________________ Email: ____________________

Reference #2:

Name: ____

Address: ____

Phone: ____________________ Email: ____________________

Reference #3:

Name: ____

Address: ____

Phone: ____________________ Email: ____________________

OUTPATIENT MEDICAL CENTERS, INC.
Provider Request for Specific Privileges

Thank you for considering Outpatient Medical Center. Part of your application for clinical privileges involve your specific request for types of privileges that fall within OMC's scope of services as a Federal Qualified Health Center (FQHC). Granting clinical privileges is based upon your education, clinical training, experience, demonstrated current competence, documented results of patient care, and other quality reviews deemed appropriate.

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:

Please select a category below that applies to your request for privileges:

☐ **General** – Applied when a physician, dentist, or nurse practitioner is a graduate of an approved school and has demonstrated skills in a general medicine or dentistry practice.

☐ **Residency/Board Certification** – Applies when a physician or dentist had additional residency training and/or board certified in a specialty area.

☐ **Specialty Credentials** – Applied when a physician or dentist has knowledge or skill in medicine or a specialized area. As appropriate, the CMO will review these additional privileges to assure within the scope and healthcare needs of OMC patients.

I believe the selection above applies to my request.

Signature:____________________________ Date: _____________

NOTE: On the next page, complete the LIP Request for Privileges that applies to your credentials. Please note there is one for Medical/Primary Care, another for Behavioral Health/Counseling, and another for Dentistry. Only complete the one form that applies to you.

Medical / Primary Care

Request for Privileges

Requested Privilege	Provider's Initials	CMO's Initials
1. Takes a complete history and review of systems of patients (medical oral interview)		
2. Performs thorough patient care examinations pertinent to the reason for the visit		
3. Diagnose illness in patients of all ages (if scope is family practice)		
4. Order laboratory and radiology tests		
5. Refer patients to specialists when appropriate.		
6. Develop evidence-based treatment options.		
7. Prescribe pharmaceuticals, other medications, and treatment regimens to treat identified and documented medical conditions.		
8. Provides appropriate health education and guidance to include discussing potential side effects of medication/treatment with patients/guardians and ensure that all allergy information is up-to-date before prescribing medication/treatment.		
Other:		

I attest that my request above are consistent with my knowledge, abilities, skills, licensure, certifications, and my physical/cognitive abilities:

Provider Signature ____ **Date**____________

Approved:

Chief Medical Officer Signature ______________________________ **Date** ___________

Behavioral Health / Counseling
Request for Privileges

Requested Privilege	Provider's Initials	CMO's Initials
1. Assess mental health needs of patients		
2. Refer for treatment patients with chronic and severe mental illness and or substance abuse.		
3. Provide crisis counseling and make appropriate treatment referrals.		
4. Assess nonclinical psychosocial needs of patients and make appropriate referrals to community agencies.		
5. Match patients to the appropriate treatment modality.		
6. Provide psychosocial counseling for patients (primarily for the treatment of depressive disorders, anxiety disorders and adjustment to illness.) Substance Use Disorder, ADD/ADHD		
7. Provide couples counseling as appropriate.		
8. Provide family counseling as appropriate.		
9. Provide case management and counseling to pregnant women.		
10. Medication compliance and supportive counseling for patients with stable diagnosis of a severe or chronic mental health diagnosis.		
Other:		

I attest that my request above are consistent with my knowledge, abilities, skills, licensure certifications, and my physical/cognitive abilities:

Provider Signature ____ **Date**______________

Approved:

Chief Medical Officer Signature _________________________________ **Date** _____________

Dentistry

Request for Privileges

Requested Privilege	Provider's Initials	CMO's Initials
1. Take, evaluate and record dental histories.		
2. Perform physical examinations required to evaluate dental problems.		
3. Perform standard dental examinations.		
4. Order appropriate laboratory studies, x-rays, and other special examinations.		
5. Collect specimens for dental Pathologic examinations.		
6. Analyze and interpret data, formulate diagnoses and problem lists and establish plans for the management of dental problems.		
7. Treat dental problems within his/her scope of competence and exercise judgment on problems requiring consultation, referral or evaluation.		
8. Initiate consultation requests to specialists and other health professionals including physicians, dietitians, etc.		
9. Counsel patients on dental problems, use of mediations, expected effects of treatment diet and other dental maintenance matters.		
10. Perform dental health maintenance for well patients.		
11. Manage common dental problems encountered in primary care clinics.		
12. Educate appropriate groups on dental matters and use of community resources.		
13. Manage selected chronic dental illnesses.		
14. Prescribe medications as determined by the Health Center's formulary		
Other:		

I attest that my request above are consistent with my knowledge, abilities, skills, licensure, certifications, and my physical/cognitive abilities:

Provider Signature ____ **Date**_____________

Approved:

Chief Medical Officer Signature _________________________________ **Date** ____________