Attachment H

HENDRICK HEALTH
ALLIED HEALTH PROFESSIONALS
ADVANCED PRACTICE PROVIDERS
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:	Sponsoring Physician(s):	

SECTION TWO - EDUCATION INFORMATION	
1. Were all of your training programs accredited by one of the following entities? If yes, check applicable entity below: ☐ Certified Registered Nurse Anesthetist: (Certifying Board and/or Association) Current active licensure by the Board of Nursing with recognition as an Advanced Practice Registered Nurse. Current active certification by the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA). ☐ Clinical Nurse Specialist: (Certifying Board and/or Association) Current active licensure by the Board of Nursing with recognition as an Advanced Practice Registered Nurse. Certification, as appropriate, to the area of advanced or specialized practice by the American Nurses Credentialing Center or an equivalent body. ☐ Nurse Practitioner: (Certifying Board and/or Association) Current active licensure by the Board of Nursing with recognition as a Advanced Practice Registered Nurse. Certification, as appropriate, to the area of advanced or specialized practice by the American Nurses Association or an equivalent body.	○ Yes ○ No

☐Physician Assistant: (Certifying Board and/or Commission) Graduate from Accreditation Review Commission for the Physician Assistant (ARC-PA) educational program, or one of its predecessor organizations. Current active certification by the National Commission on Certification of Physician's Assistants (NCCPA).	
☐Psychologist (Certifying Board and/or Commission) Current active certification and licensure to practice psychology independently. Possession of an earned doctorate degree in psychology from an accredited institution.	
☐Surgical First Assistant (Certifying Board and/or Commission) Graduate of a CST or ORT program, or possession of a professional license. Successful completion of a first assistance course. Specialties include: ☐Registered Nurse First Assistant (RNFA) ☐Certified Surgical Technologist, Certified First Assistant (CST CFA) ☐Licensed Vocational Nurse, Certified First Assistant (LVN CFA) ☐Assistant at Surgery, Certified (AS-C)	
2. Did you complete all your training programs?	◯Yes ◯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:	◯ Occurrence ◯ 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?	◯ Yes ◯ No
3. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty?	◯ Yes ◯ 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?	◯ Yes ◯ No
If you have answered yes to question 4, please complete and submit attachment G of the TDI application for each claim.	

5. List insurance carriers for all 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. If not already provided on the TDI application, please provide ***ALL*** professional work history since completion of training, including clinics, medical center, solo practices, self-employment, employment or any practice from which you received an income beyond what you documented in the TDI application 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. 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, failed to seek reappointment, 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?	◯ Yes ◯ No
2. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your clinical practice ever changed at any hospital or other healthcare institution?	◯ Yes ◯ No
3. Have your clinical privileges or membership at any hospital or other healthcare institution ever been: a. voluntarily or involuntarily limited, reduced, excluded, denied, suspended, revoked, restricted, surrendered or relinquished; or b. denied for renewal or subjected to probationary or other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected).	◯ Yes ◯ No ◯ Yes ◯ No
4. Related to Question 3. a. and b. above, have investigations or proceedings toward any of those ends been instituted or recommended by any hospital or other healthcare entity, medical or Allied Health Professionals Staff or committee, or governing board?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ No
6. Have you ever been named as a defendant in any criminal proceedings?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ No
9. Has your membership in any 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 professional society?	◯ Yes ◯ No
10. Have you ever worked at Hendrick Medical Center?	◯ Yes ◯ No
11. Have you ever been involuntarily terminated from employment?	◯ Yes ◯ No
12. Have you ever been subject to any type of disciplinary action while employed?	◯ Yes ◯ No
13. Have you ever been involved in nursing peer review or any other professional peer review?	◯ Yes ◯ 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 which could impair your current ability to provide patient care or fulfill the essential functions of Allied Health Professionals Staff membership or participation in any healthcare institution?	◯ Yes ◯ No
2. 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?	◯ Yes ◯ No

If you answered yes to any of these questions, please explain. If additional space is needed, supply the information as an attachment.

3. Required Immunization: Influenza Date of vaccination: _____
4. Required Immunization: TdaP Date of vaccination: _____

5. Recommended Immunization: MMR 6. Recommended Immunization: Hepatitis B 7. Recommended Immunization: Varicella	◯ By History ◯ Vaccination ◯ By History ◯ Vaccination ◯ By History ◯ Vaccination	

SECTION EIGHT – CONTINUING MEDICAL EDUCATION

Hendrick Medical Center requires Continuing Education (CE) in accordance with licensing and/or certification requirements.

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

☐ 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**

☐ I hereby attest that I am not in compliance with the CE requirements of the applicable licensure and/or certification board.

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.)