PLEASANTDALE
AMBULATORY CARE

61 D Main Street • West Orange • NJ 07052 • Tel: (973) 324-2280 • Fax: (973) 324-2285

Dear Physician:

Thank you for your interest in joining the staff at the Pleasantdale Ambulatory Care, LLC. In addition to the completed and signed application, we also require clear copies of the following documents to complete the credentialing process:

- **Current N.J. Medical or Podiatric License (signed)**
- **Current CDS License (signed)**
- **Current DEA License**
- **Current Malpractice Coverage Declarations Page**
- **Curriculum Vitae**
- **Specialty Board Certificate or Board Eligibility Letter**
- **ECFMG certificate (if applicable)**
- **Valid Photo ID (driver's license, U.S. passport, hospital ID, etc.)**
- **Medical School Diploma**
- **Internship & Residency Certificates**
- **Most Current PPD/Mantoux/TB results – within 1 year**
- **MMR titers (if born after 1957) and Hepatitis Immunity**
- **CME credits for the past two years**
- **Current ACLS certification (Anesthesiology only)**
- **Delineation of Privileges (attached)**

If you have any questions or concerns during the application process, please feel free to contact me @ 973-324-2280.Thank you for your anticipated cooperation in this matter and we look forward to working with you soon.

PLEASE MAIL
DOCUMENTS TO:
Pleaseantdale Ambulatory Care, LLC
61 D Main Street
West Orange, NJ 07052
Attn: Credentialing Coordinator

Date Received_____

APPLICATON FOR APPOINTMENT TO THE MEDICAL STAFF

_____

Last Name First Name Middle Degree Specialty

_____

Primary Office Address Street City State Zip Telephone/Fax

_____

Residence Address Street City State Zip Telephone/Fax

PERSONAL PROFILE

Date of Birth_____ Place of Birth_____ Soc.Sec.No._____

Citizenship/Status _____Sex ___Marital Status_____Language_____

Medicaid No. _____Medicare No. _____UPIN No. _____NPI No._____

E-Mail Address _____Beeper No._____ECFMG No._____

Cell Phone No._____ Best Time/Number to be contacted _____

EDUCATION PROFILE
(In Chronological Order)

COLLEGE/ UNIVERSITY	Name	Address	Degree	Date of Graduation

MEDICAL SCHOOLS	Name	Address	Degree	Date of Graduation
	Name	Address	Degree	Date of Graduation

IF YOU ARE A FOREIGN MEDICAL GRADUATE, DO YOU HAVE AN E.C.F.M.G CERTIFICATE?
[ ] YES [ ] NO

INTERSHIPS AND/OR RESIDENCIES

Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director

FELLOWSHIPS OR OTHER TRAINING

Institution		Address	
Your Title	Inception Date	Completion Date	Program Director
Institution		Address	
Your Title	Inception Date	Completion Date	Program Director

TEACHING APPOINTMENTS

Location_____

Type/Area_____ Title_____

Starting Date_____ Completion Date_____

Location_____

Type/Area_____ Title_____

Starting Date_____ Completion Date_____

HOSPITAL MEMBERSHIP (List past and present hospital staff memberships. Indicate category/status for each hospital listed. Included time period for each hospital listed.)

1. Hospital_____ Category_____

   Address_____

   Department Chairman_____

   Reason for Leaving_____

2. Hospital_____ Category_____

   Address_____

   Department Chairman_____

   Reason for Leaving_____

3. Hospital_____ Category_____

   Address_____

   Department Chairman_____

   Reason for Leaving_____

SURGICAL CENTER AFFLIATIONS: (List past and present surgical center memberships. Indicate category status for each ASC listed. Include the time period for each facility.)

1. Surgical Center_____ Category_____

   Address_____

   Reason for Leaving_____

2. Surgical Center_____ Category_____

   Address_____

   Reason for Leaving_____

3. Surgical Center_____ Category_____

   Address_____

   Reason for Leaving_____

LICENSURE – Please forward copies of valid licenses and photo ID/Driver's License

State Date Issued License # Date of Expiration [ ] By Examination [ ] Reciprocity [ ]

State Date Issued License # Date of Expiration [ ] By Examination [ ] Reciprocity [ ]

Federal DEA Registration # Date of Expiration

New Jersey CDS Registration # Date of Expiration

Professional Liability: Please request your malpractice insurance carrier to name Pleasantdale Ambulatory Care, LLC as a certificate holder. Copy of Certificate of Insurance must show coverage amount and expiration date of the policy.

Insurance Carrier_____Limit of Coverage_____

Special Competence Certification
Please Circle any you are certified in **CPR BCLS ACLS ATLS PALS NONE** (And submit copy(ies) of same)

Specialty Board Certification (Please submit copy of your certification)

1. Are you Board Certified Yes [ ] No [ ] Name of Specialty Board Year Certified

2. Are you Board Admissible Yes [ ] No [ ] Name of Specialty Board Schedule of Exam

PROFESSIONAL SOCIETIES

Name:_____

Address:_____

Name:_____

Address:_____

References: Supply the names of at least three (3) professional references. The named individuals must have personal knowledge, gained through clinical interaction, of your professional practice over a reasonable period of time. At least one of the references must be in the same professional discipline and one must have had organizational responsibility for your performance.

Name:_____ Specialty:_____

Address:_____
Telephone No.

Name:_____ Specialty:_____

Address:_____
Telephone No.

Name:_____ Specialty:_____

Address:_____
Telephone No.

HEALTH STATUS

Are you currently experiencing any health problems in which would make you incapable of performing all responsibilities that the Medical Staff requires? **Yes [ ] No [ ]**

Are you currently taking any medication that may affect either your clinical judgment or motor skills? **Yes [ ] No [ ]**

Are you currently under any limitations concerning your activities or workload? **Yes [ ] No [ ]**

Please read and sign this statement if it is correct:
"I know of no current personal health problems such as a communicable disease, substance abuse, and physical disability or mental disorder that will interfere with my ability to practice my medical/dental specialty. I further attest to the veracity of my response."

X_____ _____
Signature Date

NOTE: Please attach completed Health Status Verification form included in the package.

PROFFESSIONAL HISTORY

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OF PAPER.

a) Have you been named as a defendant in any criminal proceeding? **Yes [ ] No [ ]**

b) Has your membership or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked or not renewed at any hospital or health care facility? **Yes [ ] No [ ]**

c) Have you voluntarily requested limitation, reduction, or restriction of clinical privileges, or have you voluntarily resigned your appointment at any other hospital or Institution? **Yes [ ] No [ ]**

d) Has your license to practice your profession in any jurisdiction ever been voluntarily or involuntarily limited, suspended, revoked, denied, subject to probationary conditions or relinquished, or have challenges or proceedings toward any of those ends ever been instituted? **Yes [ ] No [ ]**

e) Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, suspended, reduced, relinquished or not renewed; or have proceedings toward any of those ends ever been instituted? **Yes [ ] No [ ]**

f) Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid)? **Yes [ ] No [ ]**

g) Has your present malpractice insurance carrier excluded any specific procedures from your coverage? **Yes [ ] No [ ]**

h) Have any malpractice suits been filed against you in the last 10 years? **Yes [ ] No [ ]**

i) Have any judgments or settlements been made against you in malpractice cases? **Yes [ ] No [ ]**

j) Has any restrictions, limitation or supervision been required by any other state agency other than New Jersey? **Yes [ ] No [ ]**

DECLARATION

I, the undersigned, attest that I have to the best of my knowledge and judgment truthfully answered every question on this application. I fully understand that any deliberate mis-statement of the truth to any question on this application will constitute cause for immediate denial of my appointment or cause for my summary dismissal from the Medical Staff of Pleasantdale Ambulatory Care, LLC.

In making this application for appointment to the Medical Staff of this Surgical Center, I acknowledge my obligation to provide continuous care and supervision of my patients. I acknowledge receipt of, have read and agree to abide by the current Bylaws, Rules and Regulations of the Medical Staff and the governing body of Pleasantdale Ambulatory Care, LLC.

. I further agree to be bound by the terms thereof if I am granted membership and clinical privileges.

By applying for appointment to the Medical Staff I hereby sign my willingness to appear for interviews in regard to my application. I hereby authorize the Pleasantdale Ambulatory Care, LLC.

, its medical staff and their representatives to consult with administrators and members of the medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all documents, including medical records at other hospitals, that may be relevant to any evaluation on my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its medical staff, and good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff membership and clinical privileges, and hereby consent to the release of such information.

I understand and agree that I, as an applicant for medical-dental staff membership and privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

I specifically pledge that I will not receive from or pay to another physician, either directly, any part of a fee received for professional services.

X _____ _____

Signature of Applicant

APPOINTMENT/REAPPOIMTMENT INFORMATION

CLAIMS/LIGATION HISTORY

PLEASE PROVIDE THE FOLLOWING INFORMANTION: **TOTAL**

Pending Professional Liability Claims or Litigation _____

Professional Liability Claims or Litigation settled with Payment of Indemnity _____

Claims Closed without Indemnity Payment _____

PLEASE PROVIDE DETAILS AS OUTLINED BELOWED IF APPLICABLE:

Name of Case:_____

Date of Loss:_____

Docket Number:_____

Indemnity Paid:_____

Brief Summary:_____

Practitioner Name: _____
Type/Print Name

_____
Signature

_____
Date

Dear Insurance Carrier:

Please be advised that practitioner_____has presented documentation of malpractice coverage through your company.

_____practices at the Pleasantdale Ambulatory Care, LLC ambulatory surgery center and is subject to the Bylaws, Rules and Regulations of the Medical Staff, which require that the practitioner carry appropriate liability insurance coverage.

This letter is to request that you make the necessary arrangements to notify the above facility (ies) immediately should there exist any lapse, termination or exhaustion of policy limits, in order that we may take appropriate action to protect the interest of Pleasantdale Ambulatory Care, LLC. Also needed is a malpractice claims history for our credentialing process.

Sincerely,

Susan Smith
Administrator

I,_____hereby authorize_____insurance carrier, to provide Pleasantdale Ambulatory Care, LLC with a certificate of insurance for my professional liability coverage on an annual basis. In the event of any material change in, cancellation of, or failure to renew said policy, I also authorize the above named company to give written notice to Pleasantdale Ambulatory Care, LLC. I hereby release from liability such insurance company and its representatives that provide this information and agree to hold them harmless from any action by me for their acts.

_____ _____

Signature of Insured Date

_____

Please Print or Type Name

REQUEST FOR VERIFICATION OF FITNESS

***Please fill out top portion of this page, including your personal physician's name and address**

MAIL FORM TO: _____

_____

_____

I hereby authorize and consent to the release of personal and confidential information pertaining to my medical and/or physical history from the physician listed above.

Applicant's Signature: _____ Date: _____

Applicant's Name (please print or type): _____

FOR PERSONAL PHYSICIAN USE ONLY

The above individual has applied or applied for medical staff privileges at Pleasantdale Ambulatory Care, LLC.

. It is a requirement of the Federal Tort Claims Act liability coverage that each licensed or certified individual appointed to the staff be deemed fit to provide services at the center(s) and will become part of the above applicant's permanent file. Your assistance is greatly appreciated.

Please provide the following information:

I certify that the above individual is/has been under my care as a patient. It is my professional opinion as his or her physician that the individual is:

☐ Fit to provide services at Pleasantdale Ambulatory Care, LLC without limitation
☐ Fit to provide services at Pleasantdale Ambulatory Care, LLC under the following conditions:

☐ Not fit to provide services at Pleasantdale Ambulatory Care, LLC

_____ _____

Signature of Physician Date

_____

Name Printed

_____

Address

_____

Phone

PLEASE COMPLETE THIS FORM & RETURN IN THE ENVELOPE PROVIDED

HEALTH STATUS VERIFICATION

I have examined_____and have found him/her to be free from any health impairment that would pose a potential risk to patients and hospital personnel or which might interfere with performance if his/her duties.

Signature:_____

Print Name:_____

Date:_____

NOTE TO APPLICANT: TO BE COMPLETED BY A PHYSICIAN OTHER THAN YOURSELF.

PLEASANTDALE
AMBULATORY CARE

PHYSICIAN DATA/ CONTACT SHEET

Physician Name: _____

Practice Name: _____

City, State, Zip: _____

Office Phone Number: _____

Office Fax Number: _____

Physician Cell Phone: _____

Physician Pager Number: _____

Physician E-Mail Address: _____

Office Manager Name: _____

Office Manager Phone Number/Extension: _____

Office Manager E-Mail Address: _____

Surgical Schedule Name: _____

Surgical Scheduler Phone Number/Extension: _____

Surgical Scheduler E-Mail Address: _____

AUTHORIZATION AND CONSENT

Applicant_____

By applying for appointment or reappointment to the Medical Staff, hereby indicate my willingness to appear for interviews in regard to my application, and I hereby authorize Pleasantdale Ambulatory Care, LLC, its Medical Staff and their representatives to consult with others who may have information bearing on my competence and qualifications, including hospital executive and members of the Medical Staff of other hospitals or institutions with whom I have been associated, past and present malpractice insurance carriers, and any other individuals who may have information bearing upon my competence, character and ethical qualification. I hereby consent to the inspection by Pleasantdale Ambulatory Care, LLC, its Medical Staff and its representatives of all records and documents that may be material to an evaluation of my professional qualifications, ethics and competence to carry out the clinical privileges requested, as well as my medical qualifications for staff membership. I understand that as part of this inspection, PAC may obtain information from other agencies verifying eligibility to participate in federal and other governmental programs, either as part of my credentialing or at any time while I am a Member of the Medical Staff. Information obtained may include the status, background and circumstances of my participation in any federal, state, or other governmental payer program and may include information concerning, my application to, participation in or disqualification from any such program.

By my signature below, I acknowledge that I have read and I understand the foregoing disclosure. I hereby release from liability any and all individuals and organizations who provide information to Pleasantdale Ambulatory Care, LLC, and its Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for Medical Staff appointment or reappointment and clinical privileges, and I consent to the release of such information to Pleasantdale Ambulatory Care, LLC , and its Medical Staff may have concerning me, as long as such release of information is done in good faith and without malice, and I release from liability Pleasantdale Ambulatory Care, LLC, and its Medical Staff and their employees and agents for doing so.

Date_____ Signature **X**_____

Print Name:_____

PHYSICIAN ACKNOWLEDGEMENT

"Notice to all Physicians: Medicare payments to the surgery center is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested by the patient's attending physicians 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 Law."

X _____

Signature-Full Name

_____

Typed or Printed Name

_____

Date of Signature

BYLAWS ATTESTATION

I hereby acknowledge receipt of the Bylaws, Rules and Regulations of the Medical Staff of

Pleasantdale Ambulatory Care, LLC

_____

Signature of Applicant

_____

Print Name

_____

Department

_____

Date