APPLICATION FOR STAFF APPOINTMENT

SECTION I. PROVIDER INFORMATION

FROM:
TO: Dental Department Director
SUBJ: DENTAL DEPARTMENT STAFF APPOINTMENT AND CLINICAL PRIVILEGES
ENCL: (1) Clinical Privileges Request
(2) Personal and Professional Information Form

I request that I be granted (check appropriate subparagraph):

a. Staff appointment and clinical privileges as requested in enclosure #1.

b. Renewal of staff appointment and clinical privileges as requested in enclosure #1 with no changes.

c. Renewal of staff appointment and clinical privileges as requested in enclosure #1 with changes as indicated.

I certify that (complete subparagraph a or b & c, d, & e):

a. I possess the necessary skills and expertise to justify granting of clinical privileges in the areas requested.

b. I possess the necessary skills and expertise to justify continuation of my clinical privileges.

c. I have read and agree to abide by the Guidelines for Professional Care of the Dental Department, the Exposure Control Manual, and current corporate and departmental and clinical directives.

d. I have no mental or physical conditions that would limit my clinical abilities.

e. To the best of my knowledge, I am not currently under any investigation for activities of practice implying or involving potential malpractice or misconduct.

Signature:_____ Date:_____

PERSONAL AND PROFESSIONAL INFORMATION SHEET

Directions: Please answer every item on this form (indicate NA as not applicable). A "Yes" answer must be fully explained in the "Remarks" section or on a separate attached sheet of paper (indicate by number and section the question(s) being addressed.

1. Personal

A. General Information

Name: _____
Last First Middle

SSN: _____

Date of Birth: _____

Specialty: _____

Address: _____

Town: _____ State: _____ Zip:_____

Telephone: _____

B. Medical Information	YES	NO
1. Do you have any physical handicap or condition that could limit your clinical practice?	_____	_____
2. Do you currently or have you in the past ever had an alcohol dependency?	_____	_____
3. Are you currently involved in the unlawful use of controlled substances?	_____	_____
4. Are you currently, or have you been under extended mental health therapy?	_____	_____

2. Professional

A. Education

a. Dental School, Residency Training

Name and Location of School or Program	Dates From	To	Degree or Certificate

b. Continuing Professional Education: Please list continuing professional education courses which you have taken within the past two years

Title of Course	Dates From	To	# CDE Hours

Please use additional paper and attach if necessary

B. Professional Organization Memberships:

C. Articles Published/ Professional Presentations, Lectures:

D. Academic Appointments:

Name of School/Institution	Position	Dates From	To

E. Licensure:

State	Number	Dates From	To

F. Professional Positions:

Name of Institution and Location	Dates From	To

G. Practice Information:

	YES	NO
1. Has your license to practice in any jurisdiction ever been suspended or revoked?		
2. Has your narcotics (DEA or state) ever been suspended or revoked?		
3. Have you ever been denied staff appointment or had privileges suspended, revoked, limited or not renewed?		
4. Have you ever been the subject of a malpractice claim?		
5. Have you ever been a defendant in a felony case?		

H. Please attach copies of the following documents if not previously submitted to the Personnel Department.

1. Current State, Federal, etc. professional licensure
2. Certification of qualifying degree and/or completion of professional school or other specialty program
3. Copy of current Curriculum Vitae
4. Board Certification (if applicable)

5. Prior professional staff appointments and privileges granted

6. Continuing professional education documents

7. Additional applicable documents

I. Other Information:

Include any additional information that you wish to bring to the attention of the Credentials Committee in establishing the extent and scope of your clinical privileges.

Privacy Act Statement:

The above information is requested for use in the establishment of staff appointment and the extent of clinical privileges; disclosure of the information is voluntary; failure to provide information may result in the denial of a staff appointment or clinical privileges, or in the limitation of your clinical privileges.

Signature Date

SECTION II. ENDORSEMENTS

Dental Department Director

__ Recommend as requested

__ Not recommended: enter reason in Section IV

__ Recommended with modification as shown in Section IV

_____

Signature of Dental Department Director Date

SECTION III BOARD OF DIRECTORS' ACTION

__ APPROVED __ DISAPPROVED: enter reason in Section IV

_____

Signature of Executive Director Date

SECTION IV: REMARKS