Credentialing & Privileging
Reappointment Application

May 13, 2015

Dear Provider,

Thank you for being a part of Contra Costa Regional Medical Center and Health Centers staff. Every two years providers must be reappointed to the medical staff. Applications are sent out six months prior to your birth month and are to be completed and returned to the Medical Staff Office within 45 days. The reappointment process involves three-steps to evaluate a practitioner's continued eligibility and competency for clinical privileging.

Step 1: Applicant completes and returns application packet along with all requested documentation.

Step 2: Application will be reviewed and processed by our credentialing staff to make sure all information is complete and accurate.

Step 3: The complete and verified application will be presented at the monthly Credentials Committee, Medical Executive Committee, and Board of Supervisors meetings for review and approval.

The recredentialing process can take up to 12 weeks to verify, review, and obtain final approval. To help expedite the process, your application should be without blanks or missing documentation. If anything is missing, the process will be delayed and could mean assessment of accruing late fees or termination of your privileges.

Application Documentation:

Please ensure that the application form is complete, including names and full current addresses, phone and fax numbers of all schools, training facilities, hospital affiliations and references. Please also attach all required documentation. Incomplete applications will be returned to you and may result in a delay in the credentialing process.

- Application Documents that must be complete and submitted include the following:
  _____ Completed Application (Including signed *Attestation Statements* and *Information Release* (Pgs. 5-6 in application))

  _____ Signed and Dated CCRMC Release Forms

  _____ Completed Privilege Request Packet

  _____ Professional Liability Claims History (Addendum B)

  _____ Continuing Medical Education Credits (CMEs) for prior two years (written in app or certificates provided)
- Please also submit the following with your application:
  _____ Updated Curriculum Vitae (CV) (If Applicable)

  _____ Copy of Valid State Medical License

  _____ Current Drug Enforcement Administration (DEA) registration (if applicable)

  _____ Copy of any Diploma/Certificates if within last 2 years (medical school, residency, fellowship, etc.)

  _____ Proof of professional liability insurance (if not insured by the county policy)

  _____Clinical Activity Log (No/Low Volume Providers Only: all clinics, admissions, and procedures from prior two years)

  _____Check Payable to CCRMC Medical Staff (Nonrefundable: $200.00 for Active/$100.00 for Courtesy/Affiliate)

I. IDENTIFYING INFORMATION:

Full Name: ____
Last First MI Title (MD, DO, NP, etc.)

Is there any other name under which you have been known? Name(s): ____________________

Home Mailing Address: ____
City State Zip

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Pager Number: ____________________

Primary Email: ____________________

Work Email: ____________________

Hiring Agency/Private Practice/Locums/etc. (if applicable): ____________________

Contact Name: ____________________ Email: ____________________

Contact Phone: ____________________ Fax: ____________________

Mailing Address: ____
City State Zip

II. STAFF CATEGORY: Please indicate which facility and staff category you are applying for.

Please indicate in which department(s) and at what location(s) you are currently working:

Department(s): ____________________ Specialty: ____________________

Facility/Program Name	Check All That Apply
Antioch Health Center	
Bay Point Family Health Center	
Brentwood Health Center	
Concord Health Center	
CCRMC (County Hospital)	
Detention Facilities	
Martinez Health Center	
Miller Wellness Center	
North Richmond Center for Health	
Pittsburg Health Center	
Planned Parenthood	
Public Health	
West County Health Center	
Willow Pass Wellness Center	
West County Mental Health	
East County Mental Health	
Central County Mental Health	
First Hope Program	
Wright Institute	
Other Facility (please list):	

Staff Category Descriptions (please indicate which applies):

☐ **Active Staff:** These members regularly use the hospital and/or health centers for care of patients (usually more than 16 hours per week). These members are usually more active, can vote in hospital matters and pay higher reappointment dues.

☐ **Courtesy Staff:** These members occasionally use the hospital and/or health centers for care of patients (usually less than 16 hours per week). These members are less active, cannot vote, and pay slightly lower reappointment dues.

☐ **Allied Health:** These members include: Nurse practitioners (NPs), Midwifes (CNMS, CPMS, & LMS), Physicians assistants (PAs) and Optometrists.

☐ **No/Low Volume:** These providers are on active medical staff at another facility and treat most of their patients there. They provide specialty/subspecialty services at CCRMC/Health Centers in the role of consultants or experts who are specifically tasked to care for a defined subset of patients.

III. BOARD CERTIFICATION (Attach additional sheets if necessary). Check here if nothing has changed: ☐

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties or American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date of Original Certification:	Date of Expiration/Recertification:

Have you applied for board certification other than those indicated above? ____ Yes _____ No

If so, list board(s) and date(s): ____________________

If not certified, describe your intent for certification, if any, and date of eligibility for certification:____________________

____

IV. OTHER CERTIFICATIONS (E.G. PALS, BLS, FLUOROSCOPY, RADIOGRAPHY, ETC.) (Attach additional sheets if necessary).

Type:	**Number:**	**Certification date:** _____/_____/_____	**Exp. Date:** ____/_____/_____
Type:	**Number:**	**Certification date:** ____/_____/_____	**Exp. Date:** ____/_____/_____

V. PROFESSIONAL LIABILITY (List all carriers within past 2 years. Attach additional sheets if necessary).

Current Insurance Carrier: ____________________

Policy Number: ____________________ Dates of Coverage: ______/______ to ______/______

Per Claim Amount: ____________________ Aggregate Amount: ____________________

Insurance Carrier: ____________________

Policy Number: ____________________ Dates of Coverage: ______/______ to ______/______

Insurance Carrier: ____________________

Policy Number: ____________________ Dates of Coverage: ______/______ to ______/______

VI. CONTINUING MEDICAL EDUCATION (CMEs)

Courses must relate to your practice and will be reviewed toward granting privileges. CCRMC requires 50 CMEs for medical physicians, 36 for psychiatrists, and 30 for NPs/CNMs for the prior two years or double those amounts for the prior four. Please either write courses below or attach relevant certificates.

Course/Conference:	Date:	Number of Credits:

VII. PEER REFERENCE (For No/Low Volume Providers)

If you qualify as a no /low volume provider (see description on page 2) please provide one peer reference, preferably from your specialty, not including relatives, current partners or associates in practice.

** References must be from individuals who are currently directly familiar with your work and have observed such work within the past year either via clinical observation or through close working relations.

Name of Reference: ____
Last First Title

Specialty: ______________________ Time Frame Observed: _____/_____ to _____/_____

Home Mailing Address: ____
City State Zip

Phone: ______________________ Email: ______________________

VIII. CURRENT AFFILIATIONS & WORK HISTORY (Attach additional sheets or CV if necessary).

Please list all institutions where you have had hospital privileges during the past two years. This includes hospitals, surgery centers, corporations, military assignments, government agencies, etc. Please provide the current contact information for the institution medical staff office or personnel office.

A. Current Affiliation(s)

Primary Institution Name: ____

Department: ______________________ Staff Status: ______________________

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

Institution Name: ____

Department: ______________________ Staff Status: ______________________

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

Institution Name: ____

Department: ______________________ Staff Status: ______________________

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

B. Previous/Other Affiliation(s)/Position(s)

Institution Name: ____

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

Institution Name: ____

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

Institution Name: ____

Dates of Affiliation: _____/_____ to _____/_____ Phone: ______________ Fax: ______________

Mailing Address: ____
City State Zip

I. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes" or your answer to L is "no" please attach a full description on a separate sheet of paper.

Question	Answer
A. Has your license to practice medicine, your Drug Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes ☐ No ☐
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide service or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any public program, or is any such action pending?	Yes ☐ No ☐
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subjected to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes ☐ No ☐
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes ☐ No ☐
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes ☐ No ☐
F. Has your membership or fellowship in any local, county, state, regional, national or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes ☐ No ☐
G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes ☐ No ☐
H. Have you ever been convicted of any crime (other than minor traffic violations)?	Yes ☐ No ☐
I. Do you presently use any drugs illegally?	Yes ☐ No ☐
J. Have any judgements been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes ☐ No ☐
K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes ☐ No ☐
L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of Contra Costa Regional Medical Center and Clinics, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes ☐ No ☐

I hereby affirm that the information submitted and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions or misrepresentations may result in denial of my application or termination of my privileges, employment, or physician participation agreement.

Print Name: ___________________________ Practitioner Signature: ___________________________ Date: _____/_____/_____

(Stamped Signature Not Accepted)

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (*credentialing information*) by and between "this Healthcare Organization" and other healthcare organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities and business and individuals acting as their agents (collectively, 'healthcare organizations') for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgement ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[3] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including "this Healthcare Organization", engaged in quality assessment, peer review and credentialing on behalf of "this Healthcare Organization", and all person and entities proving credentialing information to such representative of "this Healthcare Organization", from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in "this Healthcare Organization", to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedure with respect to my participation in "this Healthcare Organization" as may be required by state and federal law and regulation, including but no limited to, California Business and Professions Code Section 809 et. seq, if applicable.

I understand and agree that I, as an applicant, 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.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a healthcare organization, I agree to notify "this Healthcare Organization" immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify "this Healthcare Organization" in writing, promptly and no later than fourteen (14) days from the occurrence of any of the following: (i) recipient of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentation may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name: ________________________________ Practitioner Signature: ____________________________ Date: _____/_____/_____

(Stamped Signature Not Accepted)

[3] the intent of this release is to apply at minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

Last Updated 5/13/2015
Approved by Committees *PENDING*

CHECK HERE IF NONE: ☐

CALIFORNIA PARTICIPATING PHYSICIANS
ADDENDUM B
PROFESSIONAL LIABILITY ACTION EXPLANATION

This addendum is submitted to: **Contra Costa Regional Medical Center** herein, this Healthcare Organization[1]

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in this past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this form prior to completing and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Full Name: ____
Last First MI

Mailing Address: ____
City State Zip

II. CASE INFORMATION

City, County and State Where Lawsuit Filed: ______________________

Court Case Number (if known): ______________

Date of Alleged Incident Serving as Basis for Suit: ____/____/____

Date Suit Filed: ____/____/____

Sex of Patient: ____ Male ____ Female

Age of Patient: ________

Location of Incident:
☐ Hospital ☐ My Office ☐ Other Doctor's Office ☐ Surgery Center ☐ Other: ______________

Your Relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.): ______________

Allegation Description: ____

Is/was there an insurance company or other liability protection company or organization providing coverage defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company or other liability protection company:

Insurer Name: ______________________ Contact Name: ______________

Phone: ______________ Fax: ______________ Claim ID ______________

Mailing Address: ____
City State Zip

If you would like us to contact your attorney regarding any of the above, please provide name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization.

Attorney Name: ______________________ Phone Number: ______________
Attorney Name: ______________________ Phone Number: ______________

[1] As used in the *Information Release* section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

III. LAWSUIT/ARBITRATION STATUS

☐ Lawsuit/Arbitration still ongoing, unresolved

☐ Judgement rendered and payment was made on my behalf

Amount paid on my behalf $________________

☐ Judgement rendered and I was found not liable

☐ Lawsuit/Arbitration settles and payment made on my behalf

Amount paid on my behalf $________________

☐ Lawsuit/Arbitration settled, no judgement rendered, and no payment on my behalf

Please provide a legible summary the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed attach additional sheet(s). Please include:

1. Condition and diagnosis at time of incident
2. Dates and description of treatment rendered, and
3. Condition of patient before treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to "this Healthcare Organization" in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the application. In order for participating healthcare organizations to evaluate my application or participation in and/or my continued participation in those organizations, I hereby give permission to release to "this Healthcare Organization" information about my medical malpractice insurance coverage and claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on page 1 of this document to discuss any information regarding this case with "this Healthcare Organization."

Print Name: ________________________ Practitioner Signature: ________________________ Date: _____/_____/_____
(Stamped Signature Not Accepted)