

Affinity Health System
Request for Additional Privileges

Name _____

I would like to request the following additional privilege(s):

Privilege	# Done in past 2 years at any facility

In the last two years, have any of the following items been denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily or involuntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| * YES | NO | N/A | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | BOARD CERTIFICATION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | STATE LICENSE TO PRACTICE YOUR PROFESSION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DEA REGISTRATION OR OTHER NARCOTIC LICENSE |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HOSPITAL OR OTHER HEALTH CARE FACILITY STAFF MEMBERSHIP OR PRIVILEGES |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PROFESSIONAL ORGANIZATION MEMBERSHIP |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | MEDICARE, MEDICAID, OR OTHER GOVERNMENT PROGRAM PARTICIPATION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HMO, PPO, OR OTHER PREPAID HEALTH PLAN PARTICIPATION |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | STATE DRIVER'S LICENSE |

In the last two years, have you been employed as a practitioner by a military service, a hospital, an HMO or any other health care organization, where your employment was terminated by the employer?

* YES NO

In the last two years, have you been convicted of a crime (exclude minor traffic offense), or are you currently subject to a pending charge or under indictment for an alleged crime? *Note: Pending charges or convictions are not an absolute bar and will be considered only if there is a substantial relationship to the contracted job duties or if bondability is at issue.*

* YES NO

In the last two years, have you had any Medicare/Medicaid sanctions?

* YES NO

In the last two years, have judgments or settlements been made against you in professional liability cases?

* YES NO

In the last two years, have you been denied malpractice insurance coverage, or has your malpractice insurance coverage been terminated by action of any insurance carrier?

* YES NO

In the last two years, have any malpractice suits or claims been filed against you that are presently pending?

* YES NO

In the last two years, has any malpractice claim settlement or personal grievance of any type, not involving litigation or arbitration, been paid by you or paid on your behalf?

* YES NO

Are you currently a habitual user of drugs, alcohol or illegal chemicals?

* YES NO

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Are you currently or have you in the last two years had any physical, emotional or mental disability that impairs or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and is required by the Bylaws, Rules and Policies of the healthcare provider(s) at which you seek continued professional staff appointment? (When answering this question, please consider all types of physical, emotional or mental disability, including substance abuse).

* YES NO

Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose any significant health and safety risk to your patients?

* YES NO

If you answered any of the preceding questions "yes," could accommodations be made to allow you to perform the privilege(s) requested? If so, please describe those accommodations on a separate sheet

* YES NO

***If the answer is yes to the above questions, please explain on a separate sheet.**

**Please attach to this application appropriate proof of training
for each privilege requested.**

APPLICANT'S SIGNATURE: All information submitted by me in this application or later submitted on request is correct and complete to the best of my knowledge and belief.

Name

Date

RECOMMENDATION:

Request approved.

Request approved with the following conditions, exceptions or limitations:

Request denied. Reasons for denial:

Department Chair Signature Date

Date

Credentials Committee
Approval Date

MEC/PGC
Approval Date

Board of Directors
Approval Date

Orig: 07/2006
Rev: 06/2009

Please return to: Medical Staff Services
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Menasha, WI 54952
Fax: (920) 720-1906