



## MEDICAL PRIVILEGES APPLICATION AND AGREEMENT

**PLEASE COMPLETE ALL SECTIONS AND RELEVANT CHECK BOXES**

PRACTITIONER INFORMATION			
<input type="checkbox"/> MD	<input type="checkbox"/> DO	<input type="checkbox"/> NP	<input type="checkbox"/> PA
<input type="checkbox"/> DPM	<input type="checkbox"/> DDS/DMD		
First Name		M.I.	Last Name
Home Address			
City		State	Zip Code
Phone No.		Cell No.	
Email			Tax ID No.
Date of Birth		State License No.	
NPI No.		DEA No.	
Are you Medicaid Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Medicaid Certification Date	
Are you Medicare Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Medicare Certification Date	

Group Name			
Practice Address			
City		State	Zip Code
Office Phone Number		Fax Number	

Alternate/Covering Practitioner			
Practice Address			
City		State	Zip Code
Office Number		Fax Number	

Name of Supervising Physician			
Practice Address			
City		State	Zip Code
Office Phone Number		Fax Number	

<b>EDUCATION</b>		
School		
Address		
City	State	Zip Code
Phone Number	Year Graduated	
<b>POST GRADUATE EDUCATION/TRAINING</b>		
School	Type of Education/Training	
Address		
City	State	Zip Code
Phone Number	Year Graduated	
<b>INTERNSHIP</b>		
Place of Internship	Type of Internship	Year Completed
Address		
City	State	Zip Code
<b>RESIDENCIES</b>		
Place of Residency	Year Completed	
Address		
City	State	Zip Code
Place of Residency	Year Completed	
Address		
City	State	Zip Code
<b>FELLOWSHIP TRAINING</b>		
Place of Fellowship	Year Completed	
Address		
City	State	Zip Code
<b>CERTIFICATION</b>		
Board Certification	Year	
Board Certification	Year	
Recertification <input type="checkbox"/> Yes <input type="checkbox"/> No	Board Eligibility <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Application: ____/____/____
Specialty		
Membership in Professional Societies/Organizations		

**HOSPITAL or FACILITIES – List all hospitals or facilities (in all states) you have been associated with over the past ten years. Provide dates of association.**

Hospital/Facility	Years of Association
Hospital/Facility	Years of Association
Hospital/Facility	Years of Association
Hospital/Facility	Years of Association

Have your privileges to practice ever been restricted, suspended, curtailed or discontinued at any of the above facilities?  Yes  No If answer is yes, please provide details of situation(s).

Are you involved in any pending malpractice professional actions or professional misconduct proceedings for your profession?  Yes  No If answer is yes, please provide details of situation(s).

**Physician Signature Log is required to verify signature(s) of all physicians, nurse practitioners and physician assistants as identified on all documentation in the medical record. Please print and sign your name, professional designation and initials:**

Name as it appears on Your professional license (please print)	Signature	Professional Designation	Initials

<b>MEDICAL RECORDS SYSTEM – POINT CLICK CARE</b>	<b>REQUIRED FOR ALL</b>
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**Tiger Text User Name**  
 Tiger Text is required for Secure Conversations if you service more than one organization with PointClick Care or if you prefer to receive all messages on your preexisting account. An information packet regarding setting up a Tiger Text account will be provided during training. A business email address is required for setup.

<b>Do you currently have a Tiger Text Account?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes please provide the email address associated with this account.</b>
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**Controlled Substances** are electronically prescribed through Point Click Care by using a 2 factor authentication. (Password and Token). Please select the appropriate answer.

<input type="checkbox"/> Yes - I already have a Point Click Care Token(Record the ID # from the back of your Token below so we can attached to Elderwood's Data Base).	<input type="checkbox"/> No - I do not have a Point Click Care Token and will need one assigned.	<input type="checkbox"/> N/A - I will not be prescribing controlled substances.
<b>Token Serial ID #:</b>		

**PCC Training Needs**  
 Elderwood offers medical providers basic Navigation and ePrescribing Training. Please select what type of training you require and what method of training you prefer. If you do prefer training, our Instructional Support Specialist will be contacting you once the credentialing process and security setup is complete.

<input type="checkbox"/> I do not require any training <input type="checkbox"/> I require basic navigation training <input type="checkbox"/> I require ePrescribing training	<input type="checkbox"/> I prefer self-learning materials <input type="checkbox"/> I prefer live training by Elderwood.
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**CODE OF CONDUCT AFFIRMATION STATEMENT****REQUIRED FOR ALL**

- I have received and reviewed a copy of the Companies Code of Conduct Principles, False Claims, and Deficit Reduction Act information, and compliance program overview. I have read, understand and acknowledge their contents and accept all the responsibilities they impose on my association with the company. I understand that I have the opportunity to ask questions and discuss any aspects of the Code of Conduct with the Compliance Officer or any member of the Companies management team if I am unsure of how the code applies in any situation.
  
- I specifically acknowledge my affirmative obligation to adhere to the principles and standards of the Code of Conduct, and to report in good faith and in accordance with the Codes provisions, any violations or suspected violations of which I become aware.

**HEALTH STATUS/MEDICAL SERVICES AGREEMENT****REQUIRED FOR ALL**

**TB Screening** Per facility policy, initial and annual TB screening is required for all medical professionals.

(Select one below)

- I have attached the negative results of a completed TST test with in the last 12 months.
- I have a history of a positive TST test and I have attached a negative Chest x-ray completed within the last 5 years.

**Influenza Vaccination** Per facility policy, if the annual influenza vaccination is not received, all medical professionals are required to wear a surgical mask during flu season.

- I have attached proof of my vaccination
- It is not flu season, and vaccination documentation is not required
- I am unvaccinated and agree to wear a surgical mask during flu season.

**Attestation**

- I attest that I am free of Illegal drug use, free of communicable disease and am capable of carrying out my duties with or without reasonable accommodation.
  
- I have received a written summary of the facility provider requirement for my profession
  
- I understand I am required to provide a current copy of the following:
  - § State professional registration certificate
  - § Controlled Substance Certificate
  - § Certificate of Professional Liability Insurance
  - § Surescripts Registration Receipt (if applicable)
  - § Current Board Certification (if applicable)
  - § Government issued Photo ID (Drivers license, passport, etc.)

I verify that the above information is true and accurate. I will comply with all applicable federal, state, and local laws or regulations, and facility policies that apply to providing medical services for a resident of Elderwood.

\_\_\_\_\_  
**Signature of Medical Professional/Consultant**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

Residents are admitted and treated at this facility without regard to race, color, national origin, creed, religion, age, sex, sexual preference, sponsor, blindness or other disability

**ELDERWOOD ADMINISTRATIVE SERVICES  
AUTHORIZATION FOR RELEASE OF CREDENTIALING INFORMATION  
and  
WAIVER OF CONFIDENTIALITY REGARDING MEDICAL CREDENTIALS**

I hereby authorize Elderwood Facilities, and its representatives to request and obtain all of my medical, school records and other pertinent information with respect to my performance in medical school, as an intern, resident or fellow, and in connection with my prior or current associations with or privileges at all health care facilities.

I also authorize Elderwood Facilities to consult with insurance companies who may have information bearing my competence, character and ethical qualifications. I authorize such health care facilities and insurance companies, their officers, employees, agents and representatives to release any information to any or all of the above mentioned facilities as will have bearing on my professional competence and character and my qualifications to perform the duties of the position for which I seek appointment privileges.

In connection with the release of such information, I hereby waive all rights as to confidentiality and I release all institutions, organizations and individuals who provide, receive and use such information, in good faith and pursuant to this application and to the request of Elderwood Facilities from liability or claim for damages in connection with that release of information. Such institutions, organizations, and persons providing, receiving, and using such information shall also be entitled to all the protection set forth in federal state and local laws and regulations regarding the release and use of information.

Pursuant to applicable provisions of the State Law, I hereby waive any liability on the part of any hospitals or facilities concerning information about my professional association or credentials.

A copy of this statement shall be as binding as the original.

\_\_\_\_\_  
**Applicants Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Applicants Name**