CAMP LOWELL SURGERY CENTER

Application for Appointment/Reappointment*
Allied Health Practitioner

*(If reappointment, please skip to Section B if there are no changes to Section A and remember to print last, first, and middle name on the top line below.)

A. Personal Information:

1. Name and Locations:

(Please print) Last	First	Middle	Social Security Number

Home Address – No. and Street	City	State	Zip	Phone

Office Address – No. and Street	City	State	Zip	Phone

2. Education:

School Name	Location	Degree
School Name	Location	Degree

B. License and Certifications:

Professional License No. (State) _____ Expiration Date: _____

1.	BLS	☐ Yes	☐ No	Expiration Date: _____
2.	ACLS	☐ Yes	☐ No	Expiration Date: _____
3.	PALS	☐ Yes	☐ No	Expiration Date: _____
4.	DEA (as applicable)	☐ Yes	☐ No	Expiration Date: _____
5.	Other	☐ Yes	☐ No	Expiration Date: _____

C. Hospital Affiliations:

Hospital Name	Hospital Name
Hospital Name	Hospital Name
Residency Program Specialty	Year

Disciplinary Actions:

Have any of the following ever been, or are any currently in the process of being, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If "yes", please provide full explanations on a separate sheet.

Certification license in any state	☐ Yes ☐ No
Professional registration/license	☐ Yes ☐ No
Privileges at any hospital or ambulatory surgical center	☐ Yes ☐ No
Professional society membership	☐ Yes ☐ No
Professional liability insurance	☐ Yes ☐ No
Have you ever been involved with Medicare/Medicaid or any other Type of professional sanction?	☐ Yes ☐ No
Have there been any felony charges brought against you in the past?	☐ Yes ☐ No

If "yes", please provide full explanation on a separate sheet, including resolution of charges.

D. Liability Insurance:

Company: _____

Coverage Limit: _____ Expiration Date: _____

Note: Please attach copy of policy

Have judgments of settlements been made against you in professional liability cases, or are there any pending?	☐ Yes ☐ No

If "yes", attach a separate sheet with details.

E. Affidavit:

I agree to abide by the Medical Staff By-laws and guidelines set forth in the Policies and Procedures of the Surgery Center. All information submitted by me in this application is true to the best of my knowledge and belief. I certify that I am in good health and have the physical and mental capabilities to carry out my duties and responsibilities in the role as an Allied Health Practitioner.

I hereby release from liability all representatives of the Surgery Center and its Medical Staff for their acts performed in good faith and without malice in connection with the evaluation of my application and credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information to the Surgery Center and its Medical Staff in good faith, and without malice concerning licensure, education and training, experience, current competence, physical and mental health status, ability to cooperate with others, malpractice claims, ethical qualifications, and other qualifications for appointment.

I hereby consent to the release of such information.

_____

Name (please print)

_____ _____

Signature Date