



Spokane County Medical Society

104 South Freya Street, Orange Flag Building, Suite 114, Spokane, WA 99202 (509) 325-5010

Application for Membership in the Spokane County Medical Society and/or Hospital Medical Staff Membership

GENERAL INFORMATION AND INSTRUCTIONS TO APPLICANT:

1. As a service to our members, the Spokane County Medical Society provides administrative coordination of all hospital medical staff applications in the County. This centralized service to applicant physicians and hospitals is simple and more efficient than individual applications. The Society acts as a data collection base only and draws no conclusions with regard to the information received. Each hospital and the Medical Society maintain their own individual credentials committees for review and evaluation of each application.
2. If you are applying for hospital medical staff privileges at any of the hospitals in Spokane, complete and return this form as soon as possible. Indicate all hospitals to which you intend to apply. These hospitals will be notified of your intention and each will forward to you, under separate cover, a copy of their constitution and by-laws, staff delineation form or other documents required by that institution.
3. Membership in the Spokane County Medical Society is not required for staff privileges in any of the hospitals nor is hospital staff membership required for Medical Society application.
4. Fees: a filing fee of \$375.00 must accompany the application. Checks should be made payable to the Spokane County Medical Society.
5. Copies of the following documents are required by all hospitals and the Spokane County Medical Society. If they are not available when submitting your application, please forward them to our office when they become available.
 - a. Washington State License (WARNING: New licensing applications can take up to 6 months to process.)
 - b. Federal DEA Registration listing Spokane address
 - c. Malpractice Insurance Face Sheet
 - d. Board Certification
 - e. Curriculum Vitae
 - f. Current Photo ID – a State Driver's License, State Identification Card or Passport
6. Enclose two black and white photographs (at least 2" x 3"), with your application. When you join the Spokane County Medical Society, you are entitled to a free photo during your first year of membership. They will be used in the Pictorial Directory of Physicians and for a press release we prepare for the newspaper. *Please call the Medical Society for details.*
7. The Spokane County Medical Society is using the Washington Practitioner Application. Please follow the instructions on page one. In addition, supplemental pages ii – iv must also be completed. They include additional instructions and information necessary for Hospital Staff membership, Medical Society membership and the required signatures.
8. All sections must be completed. If a particular section is inapplicable to you, mark the box **DOES NOT APPLY**. If additional room is needed under any section, please complete information on a separate sheet of paper.

Incomplete applications will be returned for completion prior to processing. Failure to complete this application in full may lead to a delay in obtaining hospital privileges.

We must have documentation for all time periods following your graduation from medical school. Complete mailing addresses are required and all dates must include month and year.

Please include a copy of your C.V. with your application.

SPECIAL INSTRUCTIONS FOR THE WASHINGTON PRACTITIONER APPLICATION

- A. Page two, section III, the Primary Practice location should be your practice in Spokane. Under effective date, please list the date you will begin practicing in Spokane. Your current practice location, if not in Spokane, should be listed under the Secondary Practice location.
- B. Page six, section XVI, Military, Hospitals and Other Institutional Affiliations, please list all current and previous hospital affiliations (including military duty stations). **DO NOT LIST** hospitals which you only rotated through as part of your training.
- C. Page nine, section XVIII, Peer References, please include physicians who have had extensive experience in observing and working with you. At least one reference should be from your current practice location. If you are a recent graduate of a Residency or Fellowship program, include the name of your Chief of Residency or Director of Medical Education.
- D. Page ten, section XX, Professional Liability, list your Spokane insurance carrier as the Current Insurance Carrier, followed by your previous carriers.
- E. On a separate sheet of paper please furnish the following:
 - 1. Continuing Medical Education – List all post graduate activities which you have attended or for which you have received credit in the past two (2) years. (The WSMA and AMA forms are acceptable.)
 - 2. Bibliography – Furnish a list of scientific papers or essays you have written (including reprints).

SUPPLEMENTAL INFORMATION	
Spokane Home Address: (if not listed on the Washington Practitioner Application)	City:
	State: Zip Code:
Spokane Home Phone: (if not listed on the Washington Practitioner Application) _____	
Effective Date of Spokane Home Address and Phone: _____	
Marital Status:	Name of Spouse:
Practice Limited To: _____	
Will you or your group provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MILITARY EXPERIENCE	
Branch of Service:	Dates of Service (To – From Month & Year)
Rank:	
TRAINING ACCREDITATION	
Is your residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please specify accreditation organization: _____	
Is your fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please specify accreditation organization: _____	

APPLICATION FOR HOSPITAL STAFF MEMBERSHIP

(Not mandatory for Medical Society membership)

I hereby apply for membership on the medical staff of the following indicated hospitals:

- Deaconess Medical Center Sacred Heart Medical Center Valley Hospital & Medical Center
 Holy Family Hospital St. Luke's Rehabilitation Institute

I fully understand that any significant misstatements in, or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of the hospital or hospitals indicated above, I agree to read the bylaws of the hospital(s) and the bylaws, rules and regulations of the medical staff of the hospital(s) and I agree to be bound by the terms thereof without regard as to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the medical staff. I further agree to abide by such hospital and staff rules and regulations as may be from time to time enacted.

By applying for appointment to the medical staff, I hereby signify my willingness to appear for interviews in regard to my application, authorize the hospital(s), its medical staff(s) and their representatives to consult with administrators and members of medical staff of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection now and in the future by the hospital(s) and its representatives of all records and documents, including medical records, at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out now and in the future the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I understand that the credentialing process may include a criminal background check in all jurisdictions.

I hereby release from liability all representatives of the hospital(s) and its medical staff(s) for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and any reevaluation of my qualifications; I hereby release from any liability any and all individuals and organizations who provide information to the hospital(s) or its medical staff(s) in good faith and without malice concerning my professional competence, medical ethics, character and other qualifications for staff appointment and clinical privileges, or reappointment or delineation of privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by the hospital(s) indicated above or its medical staff(s), to other hospitals, medical associations and other interested persons on request regarding any information the hospital(s) and the medical staff(s) may have concerning me as long as such release of information is done in good faith and without malice. I hereby release from liability the hospital(s) and its representative(s) for so doing.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I further acknowledge that I am familiar with the principles and standards of The Joint Commission (TJC) and will cooperate with the hospital in acquiring and maintaining TJC accreditation for the hospital. I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee-splitting. In complying with this principle, I understand that I am also not to collect fees for others referring patients to me or permit other physicians, surgeons or dentists to collect fees for me, or to make joint fees or permit any associate of mine to do so.

I particularly agree to subject my clinical performance to, and faithfully participate in, the hospital's quality assurance programs as the same shall from time to time be in effect, and I agree to hold members of the medical staff and other authorized representatives of the hospital engaged in these quality activities free of all liability for their actions performed in good faith in connection therewith. I understand that similar provisions are contained in the medical staff bylaws, and I acknowledge that I have read these provisions and have no objections to them.

I will comply with each hospital's policies and procedures related to the use and disclosure of patient care information, specifically following guidelines established by the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

Each hospital agrees to maintain the security, confidentiality, privacy, and integrity of all health care information received for or from the applicant as required by applicable federal, state, and local laws and regulations, including but not limited to HIPAA.

Print Name:	
Signature:	Date:
Note: This signature is for hospital staff membership only. Signature is required on the Authorization Statement on the next page also.	

APPLICATION FOR MEDICAL SOCIETY MEMBERSHIP

(Not mandatory for Hospital Staff membership)

I hereby apply for membership in the Spokane County Medical Society/Washington State Medical Association

In consideration of the Spokane County Medical Society processing my application for membership, I grant permission and consent for you to obtain information from all hospital affiliations regarding staff privilege and actions relating thereto: former medical society affiliations, specialty organizations, the American Medical Association and the Washington State Medical Association; and medical schools and other organizations providing medical training, including internships and residencies.

I agree to furnish the Society with all information relative to any claim or action filed against me for malpractice, and I authorize and consent for you to obtain from any insurance malpractice carrier any and all information regarding insurance coverage, premiums, claims, and actions against me.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualifications to all hospitals and medical discipline boards who request such information.

I hereby release, and hold harmless from any liability or loss, the Spokane County Medical Society, its officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from my liability any and all individuals and organizations who, in good faith and without malice, provide information to the Medical Society, or to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the Spokane County Medical Society, its officers, agents, employees, and members for the delivery of information to any third party as authorized herein, provided such delivery occurs prior to the acknowledged receipt, in the office of the Spokane County Medical Society, of a written notice of revocation of this release.

I do not practice or claim to practice any school or system of sectarian medicine or healing, nor will I do so in the future.

I promise to conform to and abide by the Constitution and Bylaws of the Spokane County Medical Society and Washington State Medical Association as they now stand or as they may be amended by these societies from time to time.

I fully understand that any significant mis-statements in, or omissions from this application constitute cause for denial of membership in the Spokane County Medical Society. All information submitted by me in this application is true to my best knowledge and belief.

Print Name:	
Signature:	Date:
Note: This signature is for Medical Society membership only. Signature is also required on the Authorization Statement below.	

AUTHORIZATION STATEMENT

Spokane County Medical Society may provide credentialing services to preferred provider organizations, health maintenance organizations, insurance carriers, health care service contractors and others. I hereby authorize the Spokane County Medical Society to communicate and/or release information regarding my professional credentials and other information about me which has a bearing on my professional competence, character and ethical qualifications to any such organization or any other organization with a legitimate interest in my credentials and professional qualifications. I further agree to hold Spokane County Medical Society harmless for releasing information as authorized herein. I also release from any liability any and all individuals and organizations who provide information in good faith and without malice concerning my professional competence, medical ethics, character and other qualifications for staff appointment and clinical privileges, or reappointment or delineation of privileges, and I hereby consent to the release of such information.

I further authorize the Spokane County Medical Society to communicate and or obtain information regarding my professional credentials from hospitals, professional liability insurance companies, the National Practitioner Data Bank and other persons or organizations with a legitimate interest.

Print Name:	
Signature:	Date:
Note: This signature is required for both hospital staff and Medical Society membership.	

Revised 1/1/2006

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 11 and 13. Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

I. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *Please do not use abbreviations.* **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

II. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)		First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:				
Home Mailing Address:			City:	
			State:	Zip Code:
Home Telephone Number: ()	Pager Number/Cell Phone Number: ()		E-Mail Address:	
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):			Citizenship:
Social Security Number	Languages spoken by Practitioner		Have you ever voluntarily opted-out of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Urgent Care <input type="checkbox"/> Hospital Based				<input type="checkbox"/> Male <input type="checkbox"/> Female
NPI:	Medicare UPIN:	Medicare Number: (WA)	Medicaid Number(s):	L & I Number(s):
Specialty:			Sub specialties:	
Other Professional Interests in Practice, Research, etc.:				

III. PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting

Clinic/Group Solo Practice Home Based Hospital Based Other

Name of Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code: Org. NPI#:
Patient Appointment Telephone Number: ()		Fax Number: ()	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:		Administration Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Credentialing Contact (if different from above):		Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Hours Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____ _____	
If you are a PCP, do you provide OB services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____			
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the name and specialty below: _____ _____			
Please list languages spoken by office staff: _____ _____			

Effective Date at Secondary Practice location (MM/YY) _____

Name of Secondary Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code: Org. NPI#
Patient Appointment Telephone Number: ()		Fax Number: ()	
Mailing Address: (if different from above)			

Billing Address: (if different from above)	
Office Manager / Administrator Name:	Administration Telephone Number: ()
E-mail Address:	Fax Number: ()
Credentialing Contact (if different from above):	Telephone Number: ()
E-mail Address:	Fax Number: ()
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No If you are a PCP, do you provide OB services? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you limited your practice in any way (e.g. 18 years or older?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name and specialty below: _____ _____ Please list languages spoken by office staff: _____ _____	Office Hours Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____ Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain how your patients obtain advice and care after hours: _____ _____ _____
List other office locations with above information on a separate sheet	

IV. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS (Attach Additional Sheet if Necessary)		
Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Date Issued:	

V. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS					
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

VI. UNDERGRADUATE EDUCATION (<i>Do not abbreviate</i>)			Does Not Apply <input type="checkbox"/>
College or University Name:	Degree Received (be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received (be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

VII. MEDICAL/PROFESSIONAL EDUCATION (<i>Do not abbreviate</i>)			
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

VIII. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION					Does Not Apply <input type="checkbox"/>
Institution:	Address		City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:		Faculty Director:		

IX. INTERNSHIP/PGYI (<i>Attach Additional Sheet if Necessary</i>)				Does Not Apply <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	

X. RESIDENCIES (<i>Attach Additional Sheet if Necessary</i>)				Does Not Apply <input type="checkbox"/>
Institution:	Phone Number:	Fax Number:	Program Director:	
Mailing Address:	City:	State:	Zip Code:	
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)				

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

XI. FELLOWSHIPS		(Attach Additional Sheet if Necessary)		Does Not Apply <input type="checkbox"/>	
Institution:	Phone Number:	Fax Number:	Program Director:		
Mailing Address:	City:	State:	Zip Code:		
Course of Study:		From (mm/yyyy):	To (mm/yyyy):		
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
Institution:	Phone Number:	Fax Number:	Program Director:		
Mailing Address:	City:	State:	Zip Code:		
Course of Study:		From (mm/yyyy):	To (mm/yyyy):		
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					

XII. PRECEPTORSHIP		(Attach Additional Sheet if Necessary)			Does Not Apply <input type="checkbox"/>	
Institution:	Address:	City:		State:	Zip Code:	
Telephone Number ()	Fax Number ()		Email Address			
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)		Training:		Department Chairman:		

XIII. FACULTY/TEACHING APPOINTMENTS		(Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:	Address:	City:		State:	Zip Code:		
Telephone Number ()	Fax Number ()		Email Address				
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)		Position:		Faculty Director:			

XIV. BOARD CERTIFICATION	Does Not Apply <input type="checkbox"/>
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Are you board or otherwise professionally certified?

<input type="checkbox"/> Yes If "Yes", please complete below:	<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.
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Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? Yes No
 If so, list certification and date:

If you participate in a specialty which does not have board certification, please indicate specialty:

XV. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XVI. MILITARY, HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply <input type="checkbox"/>
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Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT MILITARY AFFILIATIONS (Do not abbreviate)

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

B. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)
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Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

C. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:

D. APPLICATIONS IN PROCESS (Do not abbreviate)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

E. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

E. PREVIOUS HOSPITAL AFFILIATIONS (<i>Do not abbreviate</i>) cont'd		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		
Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

F. Inpatient Coverage Plan (for those without admitting privileges)	Does Not Apply <input type="checkbox"/>
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

G. Covering Providers/Call Group			Does Not Apply <input type="checkbox"/>
Provider Name	Title	Address	Phone Number

XVII. WORK HISTORY (<i>Do not abbreviate. Do not list if already listed under Hospital Affiliations</i>)					
Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is <u>not</u> sufficient.					
Name of Current Practice / Employer:		Contact Name:		Telephone Number: ()	
				Fax Number: ()	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)

Name of Practice / Employer:	Contact Name:			Telephone Number: ()	
Reason for Leaving:				Fax Number: ()	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ()	
Reason for Leaving:				Fax Number: ()	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:		
	From (mm/yyyy):	To (mm/yyyy):

XVIII. PEER REFERENCES		
List at least three professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.		
Name of Reference:	Title and Specialty:	E-mail Address:
Mailing Address:	City:	State: Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()
Name of Reference:	Title and Specialty:	E-mail Address:
Mailing Address:	City:	State: Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()
Name of Reference:	Title and Specialty:	E-mail Address:
Mailing Address:	City:	State: Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()

XIX. PROFESSIONAL AFFILIATIONS (Do not abbreviate)		
Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO

XX. PROFESSIONAL LIABILITY (Do not abbreviate)			
A. CURRENT INSURANCE CARRIER:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began:	Expiration Date:
B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)			
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A. PROFESSIONAL SANCTIONS			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Other professional registration or certification in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	c.	Specialty or subspecialty board certification	YES <input type="checkbox"/> NO <input type="checkbox"/>
	d.	Membership on any hospital medical staff	YES <input type="checkbox"/> NO <input type="checkbox"/>
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES <input type="checkbox"/> NO <input type="checkbox"/>
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES <input type="checkbox"/> NO <input type="checkbox"/>
	g.	Professional society membership or fellowship	YES <input type="checkbox"/> NO <input type="checkbox"/>
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES <input type="checkbox"/> NO <input type="checkbox"/>
	i.	Academic Appointment	YES <input type="checkbox"/> NO <input type="checkbox"/>
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. CRIMINAL HISTORY			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES <input type="checkbox"/> NO <input type="checkbox"/>
	a.	Do you have notice of any such anticipated charges?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Are you currently under governmental investigation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C. AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES <input type="checkbox"/> NO <input type="checkbox"/>
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are there any such claims being asserted against you now?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		YES <input type="checkbox"/> NO <input type="checkbox"/>

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date _____
 Type or Print name here _____

XXII. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name
Here: _____

Signature: _____
(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

