



# Spokane County Medical Society

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

## PHYSICIAN ASSISTANT MEMBER APPLICATION

### GENERAL INFORMATION AND INSTRUCTIONS TO APPLICANT:

1. 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 Medical Society membership, Hospital Staff membership, if applicable, and the required signatures.
2. If a Physician Assistant applicant is new to the community, or, has not held any previous hospital privileges, then as a courtesy, the Spokane County Medical Society will provide administrative coordination of all hospital medical staff applications in the County. This centralized service to applicants 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.
3. If you want to apply for hospital medical staff privileges at any of the hospitals in Spokane, you must complete and sign page iii. 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.
4. Fees: a filing fee of \$100.00 must accompany the application. Checks should be made payable to the Spokane County Medical Society and mailed to the above address. Any questions should be directed to the membership Department: (509) 325-5010. **ANNUAL DUES FOR PHYSICIAN ASSISTANT MEMBERSHIP ARE DETERMINED YEARLY.**
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 some time to process.)
  - b. Federal DEA Registration listing Spokane address
  - c. Malpractice Insurance Face Sheet
  - d. Board Certification
  - e. Curriculum Vitae
  - f. Utilization plan that you file with the state
  - g. 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. They will be used in the Pictorial Directory of Physicians and for a press release we prepare for the newspaper.
7. 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 a Physician Assistant Program. Complete mailing addresses are required and all dates must include month and year.**

**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 five, section XVI, 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 seven, section XVIII, Peer References, please list medical references from three (3) peers who can attest to your competence and character or have been responsible for professional observation of your work.
- D. Page eight, section XX, Professional Liability, list your Spokane insurance carrier as the Current Insurance Carrier, followed by your previous carriers.

<b>SUPPLEMENTAL INFORMATION</b>		
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:	
<b>MILITARY EXPERIENCE</b>		
Branch of Service:	Dates of Service (To – From Month & Year)	
Rank:		

# 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:
<b>Note: This signature is for hospital staff membership only. Signature is required on the Authorization Statement on the next page also.</b>	

**APPLICATION FOR SCMS/WSMA MEMBERSHIP**

I hereby apply for membership in the Spokane County Medical Society (SCMS) and agree to abide by its Bylaws and the WSMA Principles of Medical Ethics 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 any individual, institution or agency to release information that has a bearing on my professional credentials, competence, character, and ethical qualifications. I further 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, any individual, institution or agency harmless for releasing information as authorized herein.

ATTESTATION: I hereby affirm and attest that all statements, answers, and information are true to the best of my knowledge.

Print Name:	
Signature:	Date:

**SPONSORING PHYSICIAN**

**NOTE: The Sponsoring physician must be a member of Washington State Medical Association/ Spokane County Medical Society.**

Physician Supervisor's Name (please print):	
Physician Signature:	Date:

# 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:
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<b>I. INSTRUCTIONS</b>
<p>This form should be <b>typed or legibly printed in black or blue ink</b>. If more space is needed than provided on original, attach additional sheets and reference the question being answered. <i>Please do not use abbreviations.</i> <b>Current copies of the following documents must be submitted with this application:</b> (all are required for MDs, DOs; as applicable for other health practitioners).</p> <ul style="list-style-type: none"> <li>• State Professional License(s)</li> <li>• DEA Certificate</li> <li>• ECFMG (if applicable)</li> <li>• Face Sheet of Professional Liability Policy or Certificate</li> <li>• Curriculum Vitae (Not an acceptable substitute for completing the application.)</li> </ul> <p style="text-align: center;"><b>** All sections must be completed in their entirety. **</b></p>

<b>II. PRACTITIONER INFORMATION</b>				
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 <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> 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	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: _____ _____ _____
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: _____ _____	
<b>List other office locations with above information on a separate sheet</b>	

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

<b>V. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS</b>					
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 (Attach Additional Sheet if Necessary)			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 (Attach Additional Sheet if Necessary)			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.)			

<b>XI. FELLOWSHIPS</b>		<b>(Attach Additional Sheet if Necessary)</b>		<b>Does Not Apply</b> <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.)					

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

<b>XIII. FACULTY/TEACHING APPOINTMENTS</b>		<b>(Attach Additional Sheet if Necessary)</b>				<b>Does Not Apply</b> <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**

**Are you board or otherwise professionally certified?**

**Yes** If "Yes", please complete below:  **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

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**

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)**

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

<b>C. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)</b>	
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:

<b>D. APPLICATIONS IN PROCESS (Do not abbreviate)</b>			
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:

<b>E. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)</b>		
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):

<b>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:</b>		
	From (mm/yyyy):	To (mm/yyyy):

<b>XVIII. PEER REFERENCES</b>		
List at least <b>three</b> 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) ( )

<b>XIX. PROFESSIONAL AFFILIATIONS (Do not abbreviate)</b>		
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

<b>XX. PROFESSIONAL LIABILITY (Do not abbreviate)</b>			
<b>A. CURRENT INSURANCE CARRIER:</b>		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began:	Expiration Date:

<b>B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)</b>			
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.*

<b>A. PROFESSIONAL SANCTIONS</b>			
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>B. CRIMINAL HISTORY</b>			
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"/>
<b>C. AFFIRMATION OF ABILITIES</b>			
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"/>
<b>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.)</b>			
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 \_\_\_\_\_

Practitioner Name:(print or type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events:

Date:

Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient's clinical outcome:

Date suit or claim was filed:

Name and Address of Insurance Carrier that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Date of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$

**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:**

\_\_\_\_\_  
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