

St. Elizabeth Healthcare

Covington – Edgewood – Falmouth – Florence – Ft. Thomas – Grant County

Medical Affairs
One Medical Village Drive
Edgewood, KY 41017

Telephone: (859) 301-2115
Fax: (859) 301-2469

Dear Applicant:

Thank you for your interest in applying for privileges at St. Elizabeth Healthcare. In addition to this application, please select and print the appropriate delineation of privileges for your specialty from our web site as well as the Bylaws, Rules and Regulations.

In order for us to begin processing your application request, please complete and return the following:

1. *Application. (Form KAPER-1)*
2. *Timeline.*
3. *Medicare Acknowledgment Statement.*
4. *Patient Safety Attestation*
5. *Delineation of Privileges. (Your supervising physician must sign this form.)*

In addition, please submit the following:

1. *Check for \$350 payable to the St. Elizabeth Medical Staff. (Statement enclosed)*
2. *One recent, wallet-sized photograph of yourself for ID badge and hospital web site.*
3. *Current CV, which details clinical training, experience and affiliations from the completion of professional school until the present time. Explain any gap in time.*
4. *Copy of professional liability insurance face sheet for your current coverage.*
5. *Copy of proof of certification.*
6. *Collaborative Practice Agreement (ARNP) or Supervising Physician Approval Letter from the KBML (PA).*
7. *Copies of certificates from professional school(s).*

Once we receive your application, we will contact your institutions of post-graduate training, hospital affiliations, work experiences and peer references for verifications. Please note that responsibility for obtaining timely responses rests with the applicant; however, we are committed to timely and efficient completion of your application process. **Prior to granting of privileges, you will be required to come to the Medical Affairs Office with your government-issued photo ID.**

Crystal Geiman (859-301-7381) or Karen Smith (859-301-2188) will be your primary contact; however, all of the Medical Affairs staff are available to assist you. If you have any questions regarding this application, please call the Medical Affairs Office at 859-301-2115.

INSTRUCTIONS FOR COMPLETING KAPER-1

This form is a universal application required by the State of Kentucky for all health care systems to utilize in credentialing and privileging practitioners. Please note that the Page number for this document begins with Page 47.

Section XIII Professional Employment and Affiliations (Pages 54 & 55)

Please complete the Timeline, which follows the KAPER-1 application. By doing this, you may skip Section XIII.

Section XIV Peer References

- If you completed your professional education within the last two years, one peer reference must be from your program director, **OR**.
- If you have completed your professional education prior to two years, one peer reference must be from your supervising physician from your last employment.
- The remaining two references should be from peers (professionals with like credentials, e.g., ARNP for ARNP applicant).

Please indicate your requested starting date: _____

Your e-mail address: _____

Your cell phone: _____



**Kentucky Application
for
Provider Evaluation and
Reevaluation**

April 2009

KAPER-1 (04/2009)

I. PERSONAL IDENTIFICATION DATA

Name: Last Suffix First Middle Maiden Name Degree

Medical Staff Allied Health (please specify)

Residence: Phone: Fax:

Primary Office Address: Phone: Fax:

Secondary Office Address: Phone: Fax:

Billing Office Address: Phone: Fax:

Credentialing Address: Phone: Fax:

Credentialing Contact: Credentialing Email:

Preferred Mailing Address: Primary Office Residence Other (please specify)

Phys. Email Address: Prac. Admin's Email: Office Web Address:

Date of Birth: Gender: Place of Birth:

Social Security #: Marital Status:

Citizenship: Spouse:

(If not a US citizen, please complete the next three fields)

Visa Status: Alien Reg. #: Exp. Date:

Language Spoken:

ECFMG #: Pager #: Alpha Digital Voice

Medicare #: Cellular #:

Medicaid #: Answering service #:

UPIN: Are you taking new patients? :

EIN: Taxonomy Code:

NPI #:

Clinical Specialty/Subspecialty:

Other interests in practice, research, etc.:

Name others with whom you are or will be associated in practice:

Nature of association: Solo Group Partnership Corporation Effective Date:

Other: (please specify):

Name of Practice (if applicable):

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: Specialty: Telephone:

Name: Specialty: Telephone:

Name: Specialty: Telephone:

II. EDUCATIONAL DATA

(All periods of time must be accounted for from entrance into medical school to the present)

Please indicate if your name at any educational institution is different than the name listed on your application. Yes No
If YES, please identify other name(s): _____

A. Schools

Undergraduate College/University: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____
From (mm/yy) / To (mm/yy)

Medical/Dental/Other College: _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____
From (mm/yy) / To (mm/yy)

B. Internships

Name: _____
Type of Internship From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____
Type of Internship From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

During this internship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Check if more than two internships were begun or completed. Please supply the same information on a separate sheet and attach.

C. Residencies

Name: _____
Type of Residency From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Residency From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Chairman/Chief of Service: _____

Did you complete the residency? Yes No

During this residency, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Check if more than three residencies were begun or completed. Please supply the same information on a separate sheet and attach.

D. Fellowship and/or Other Postgraduate Training

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____ / _____
Type of Fellowship From (mm/yy) To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Name: _____
Type of Fellowship _____ From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Did you complete the fellowship? Yes No

During this fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign or did you voluntarily resign?
If YES, please explain on a separate sheet and attach.

Yes No

Check if more than three fellowships were begun or completed. Please supply the same information on a separate sheet and attach.

E. Other Professional Training

School: _____
Chairman/Chief of Service _____ From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

School: _____
Chairman/Chief of Service _____ From (mm/yy) / To (mm/yy)

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Degree: _____

Check if more than two training programs were begun or completed. Please supply the same information on a separate sheet and attach.

III. TEACHING APPOINTMENTS

Name: _____
Department Chief _____ Type of Appointment _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ From (mm/yy) / To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

Name: _____
Department Chief _____ Type of Appointment _____

Address: _____

City/State/ZIP: _____
City St ZIP ZIP+ From (mm/yy) / To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

IV. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last three years? If YES, please supply an attached list and/or certificate of attendance.

YES NO List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

<input type="checkbox"/> CPR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ACLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> ATLS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> PALS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____
<input type="checkbox"/> NRP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date of Expiration _____

Please attach copies of all certificates.

V. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

State:	License #:	Date Issued:	Expiration Date:	Status:	License Obtained by:
KY State: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #2: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #3: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #4: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #5: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #6: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #7: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity
State #8: _____	_____	_____	_____	<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Exam <input type="checkbox"/> Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

VI. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____
 Federal DEA Certificate #: _____ Expiration: _____

VII. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____
 Certificate #: _____ Expiration: _____
 State: _____
 Certificate #: _____ Expiration: _____

VIII. PROFESSIONAL LIABILITY DATA

(This application cannot be processed without proof of amount of professional liability)

Name of Carrier: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Policy #: _____ Amount of Coverage: _____

Date of Inception: _____ Date of Expiration: _____

Name of Agency: _____

CLAIMS MADE OCCURRENCE (Check One)

Please list any other professional liability carriers you have used within the last five (5) years: _____

Answer the following questions:

- 1. Has your professional liability insurance coverage been terminated by action of the insurance company? N/A Yes No
- 2. Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? N/A Yes No
- 3. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? N/A Yes No
- 4. Have any professional liability suits or claims been filed against you? N/A Yes No
- 5. Have any professional liability suits or claims been filed against you which are presently pending? N/A Yes No
- 6. Have any judgments or settlements been made against you in professional liability cases? N/A Yes No
- 7. If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund? N/A Yes No
- 8. If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act? N/A Yes No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

Pending Settled Date: _____

List the allegations: _____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

Amount of jury award or amount awarded by the court: _____

IX. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? Yes No (If not Board admissible, please explain on separate sheet and attach)
2. If yes, list full name of certifying board and date which you obtained certification/recertification:

_____ Date: _____
Date: _____
Date: _____
Date: _____
3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
_____ Date: _____
4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____
5. List date of next required recertification (if applicable): _____
6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. Yes No

X. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1. Are there any actions that have been initiated or are any pending against you by any state licensing board? Yes No
 Pending Resolved
2. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? Yes No
3. Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s). Yes No
4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? N/A Yes No
5. Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed? N/A Yes No
6. If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged? N/A Yes No
7. Have you been named as a defendant or convicted of a felony or misdemeanor? Yes No
8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility? Yes No
9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board? Yes No
10. Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility? Yes No
11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? Yes No

XI. PERSONAL HEALTH STATUS

Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1. Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No
2. Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No
3. Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership? Yes No

XII. PROFESSIONAL SOCIETIES

Membership in local, state, or national medical societies

Dates

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

Name: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____
City: _____ State: _____ ZIP: _____

1. I would like to use this application for membership in the _____ County Medical Society and the KMA.
A separate dues statement will be sent.
2. I am already a member of my local medical society. Please specify society: _____

XIII. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)

Address: _____ Type of Privileges/Position: _____

City/St/ZIP: _____
City St ZIP ZIP+ Country

Phone: _____ Fax: _____ Email (if available): _____

Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

B. Affiliations

List in chronological order all professional affiliations since completion of post-graduate education, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

Name: _____ Department: _____ / _____
From (mm/yy) To (mm/yy)
Address: _____ Type of Privileges/Position: _____
City/ST/ZIP: _____
City St ZIP ZIP+ Country
Phone: _____ Fax: _____ Email (if available): _____
Reason for leaving: _____

XIV. PEER REFERENCES

Name three physicians who have personal knowledge of your current clinical abilities, and ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your performance. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: _____

Address: _____

City/State/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/State/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

Reference: _____

Address: _____

City/State/ZIP: _____ Country: _____

Phone: _____ Fax: _____ Email (if available): _____

XV. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____

Date: _____

ACKNOWLEDGEMENT STATEMENT

The following statement is required (by Medicare/Champus regulation) to be signed by each physician when he/she joins the Medical Staff. This must be signed and dated in the physician's own handwriting using his/her legal signature (initials are not accepted).

According to federal guidelines, stamped signatures and typed dates are not acceptable.

MEDICARE/CHAMPUS

"Notice to physicians: Medicare/Champus payment to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal law."

I certify that I have received the above statement.

Signature: _____ Date: _____

Type or Printed Name: _____

TIMELINE

In chronological order from professional school to the present, please list professional school, residencies, fellowships, employment and hospital affiliations. Include the month, date and year.

This form will replace Section XIII Professional Employment and Affiliations on the KAPER-1 application. Please explain all gaps in time (over 30 days) in the order they occurred. PLEASE WRITE LEGIBLY.

FROM	TO	TYPE	Facility Name (complete addresses, Phone & fax #'s)
		<input type="checkbox"/> Medical or Nursing School <input type="checkbox"/> Internship _____ <input type="checkbox"/> Resident in _____ <input type="checkbox"/> Fellow in _____ <input type="checkbox"/> Grad School _____ <input type="checkbox"/> Other School _____ <input type="checkbox"/> Employment _____ <input type="checkbox"/> Move, vacation, medical leave, etc. (explain in nest column)	 Phone: _____ Fax: _____

FROM	TO	TYPE	Facility Name (complete addresses, Phone & fax #'s)
Month Day & year		<input type="checkbox"/> Medical or Nursing School <input type="checkbox"/> Internship _____ <input type="checkbox"/> Resident in _____ <input type="checkbox"/> Fellow in _____ <input type="checkbox"/> Grad School _____ <input type="checkbox"/> Other School _____ <input type="checkbox"/> Employment _____ <input type="checkbox"/> Move, vacation, medical leave, etc. (explain in nest column)	 Phone: _____ Fax: _____

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		Phone:	Fax:

St. Elizabeth Healthcare

Covington – Edgewood – Falmouth – Florence – Ft. Thomas – Grant County

Medical Affairs
One Medical Village Drive
Edgewood, KY 41017

Telephone: (859) 301-2115
Fax: (859) 301-2469

PATIENT SAFETY ATTESTATION Medical Staff and Allied Health Professional Staff

As part of St Elizabeth Healthcare’s commitment to patient safety, your support and endorsement of this document is critical. This document highlights the current patient safety focus impacting all physicians and other health care workers. Numerous accrediting agencies, including The Joint Commission, require compliance with these standards. Our own Medical Staff Executive Committee, the Board of Trustees and Administration echo these endorsements. The ultimate goal is not only to meet, but also to exceed, these standards. This is in the best interest of our Medical Staff, St. Elizabeth associates, and above all, our patients.

Thank you in advance for your attention and for the completed return of this document. If you have any questions, please call the Medical Affairs office at (859) 301-2115.

Joseph W. Gross, FACHE
President and Chief Executive Officer

George Hall, MD
Allen J. Zobay, MD
Vice President
Medical Affairs

Stephen Hensley, MD
Karl Schmitt, MD
Co-President
Medical Staff



I, _____, will comply with the following patient safety standards and goals, and I agree to the following philosophies:

1. Everyone has a vested interest in doing the right thing and can stop any process at any time.
2. Noncompliance or lack of interest by physicians has a negative impact on the patient, as well as all staff.
3. I will cooperate with the staff implementing the “time out,” repeat and verify and other patient safety procedures.
4. I will be an “Active” participant in the “time out” and the repeat and verify process.
5. I will be attentive and respectful in completing any process conducive to patient safety.
6. I will be part of the “Team” during any process impacting patient safety.
7. I am accountable for my actions.
8. I have a working knowledge of the System’s policies/practices on restraint and/or seclusion, and I am aware that I may contact the Medical Affairs Office if I have any questions on these policies/practices.
9. I will comply with the National Patient Safety Goals:
 - Correct patient identification
 - Effective communication
 - Hand washing
 - Legibility.

Signature

Date

To complete your application, this letter must be signed and returned to the Medical Affairs Office.

St. Elizabeth Healthcare

Covington – Edgewood – Falmouth – Florence – Ft. Thomas – Grant County

Medical Affairs
One Medical Village Drive
Edgewood, KY 41017

Telephone: (859) 301-2115
Fax: (859) 301-2469

BILLING STATEMENT

PLEASE REMIT DUES AND PROCESSING FEE WITH APPLICATION

PLEASE MAKE CHECK PAYABLE TO:

ST. ELIZABETH MEDICAL STAFF

DESCRIPTION	CHARGE
FEE FOR TWO-YEAR APPOINTMENT	\$200.00
INITIAL APPLICATION PROCESSING FEE	\$150.00
TOTAL	\$350.00

FEES MUST BE PAID BEFORE APPLICATION IS PROCESSED

Medical Affairs Office

Phone 859-301-2115

Robert Prichard, MD

Sr. V.P. and Chief Medical Officer

Phone: 859-301-7380

Fax: 859-301-7386

George Hall, MD

VP Medical Affairs

Phone: 859-572-3679

Fax: 859-572-2349

Allen Zobay, MD

VP Medical Affairs

Phone: 859-301-2356

Fax: 859-301-7386

Mary Ann Arnold

Director

Phone: 859-301-3853

Fax: 859-301-2469

Joanne Rigsbee

Manager

Phone: 859-301-7383

Fax: 859-301-2469

Karen Alexander

Physician Services Coordinator

Phone: 859-212-4873

Fax: 859-212-5221

Karen Burns

Medical Staff Coordinator (Credentialing)

Phone: 859-301-2316

Fax: 859-301-2469

Linda Day

Sr. Medical Staff Coordinator

Phone: 859-301-3855

Fax: 859-301-7386

Crystal Geiman

Medical Staff Coordinator (Credentialing)

Phone: 859-301-7381

Fax: 859-301-2469

Jane Graves

Practice Manager

Phone: 859-301-2423

Fax: 859-301-2066

Miranda Kleman

Medical Staff Coordinator

Phone: 859-212-5229

Fax: 859-212-5221

Karen Smith

Medical Staff Coordinator (Credentialing)

Phone: 859-301-2188

Fax: 859-301-2469