

APPLICANT'S NAME:

Addendum To Texas Standardized Credentialing Application

- **Children's Medical Center of Dallas**
 - **Parkland Health & Hospital System**
 - **Parkland Community Health Plan**
 - **UT Southwestern University Hospitals & Clinics**
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Please list the name below of your current primary admitting/attending facility:

Please provide the contact information below of your specialty/department chairperson at your current primary admitting attending facility:

Name of Chairperson:	Street Address, City, State, & Zip	Specialty
Phone Number:	Fax Number:	

Your Ethnicity: Caucasian, Non-Hispanic African-American Hispanic
 American Indian/Alaskan Asian/Pacific Islander

Do you wish to be listed as:

Primary Care Provider Specialist
 Both Primary Care Provider & Specialist Allied Health Provider

CME: Please complete the Continuing Education Attestation document included in your application packet.

You will be notified prior to committee review of any information obtained during the credentialing process that varies substantially from the information provided on the application. You will be given an opportunity to correct any conflicting information.

Applicant's Initials

Date

If you answer "YES" to any question, please provide details on a separate sheet of paper. Include a copy of any order or settlement where applicable.

1. Have you ever withdrawn an application for medical staff membership or clinical privileges, failed to seek reappointment or renewal of medical staff membership or privileges, been refused medical staff privileges or has there been any voluntary or involuntary termination of membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another healthcare facility? Yes No
2. Have you not reapplied for staff appointment or clinical privileges or have you withdrawn your application or surrendered your privileges to avoid an investigation by any healthcare entity? Yes No
3. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your medical practice changed at any hospital or other healthcare institution within the last two years? Yes No
4. Has your authorization to practice in any jurisdiction expired or been reduced, suspended, limited, revoked, cancelled or otherwise diminished in any manner and/or have you ever voluntarily or involuntarily relinquished or agreed to have your license or certification limited, suspended, revoked, cancelled, restricted or diminished in any manner? Yes No
5. Have you voluntarily or involuntarily surrendered your State or Federal controlled substance registration or have you been the subject of any disciplinary action or proceeding brought by any State or Federal licensing or regulatory agency (including State or Federal controlled substance registration), or board including, but not limited to, reprimands, probation, monitoring (other than routine), limitation of practice or procedures or mandatory second opinions? Yes No
6. Have you ever been arrested, convicted of a felony or misdemeanor; or have you received probation or deferred adjudication; or are any charges pending against you at this time? Yes No
7. Has your professional liability insurance (malpractice) coverage been suspended, denied or voluntarily relinquished? Yes No
8. Have you ever had any malpractice claims brought against you? Yes No
9. Have you ever been affected by or sought counseling or treatment for drug use, chemical or alcohol dependency or behavioral problems? Yes No
10. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgical center, or other business dealing with the provision of ancillary health services, equipment or supplies? If "Yes," please provide the following information. Attach an additional page if needed. Yes No

Name of Business		Tax Identification Number	Telephone Number
Street Address	City	State	Zip Code
Type of Organization		Size or Organization	Percent of Business Owned/Invested by Applicant

Nature of Business Interest (e.g. owner, partner, investor)

I ATTEST THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE** _____

PRINTED NAME:

PHOTO

NOTE: A CURRENT PHOTO IS REQUIRED FOR ALL NEW APPLICANTS.

THEREFORE, WE MUST RECEIVE YOUR CURRENT, DISTINGUISHABLE PHOTO BEFORE WE CAN PROCEED WITH THE PROCESSING OF YOUR APPLICATION.



ATTESTATION, AUTHORIZATION, AND RELEASE FORM

1. I have not requested privileges for which I am not qualified by training and experience to perform;
2. I certify that I agree to abide by and be bound by, the bylaws, rules, regulations, policies and procedures of Children's Medical Center of Dallas, Parkland Health & Hospital System, UT Southwestern University Hospital St. Paul, and UT Southwestern University Hospital Zale Lipshy, hereby referred to as UTSW Affiliated Hospitals for which I am applying for appointment as now written and as may be amended from time to time.
3. I agree that I shall not cause denial or access to treatment or accommodations at the facility(ies) at which I am granted appointment/privileges, and for which are medically indicated and available, on the basis of such considerations as a person's sex, race, color, creed, national origin, sexual preference, or handicap.
4. I fully understand that any significant misstatements in or omissions from Sections I or II of my application may constitute cause for denial of appointment;
5. I hereby acknowledge and agree that I have the sole burden of producing adequate information for a proper evaluation of my professional, ethical, health and other qualifications for appointment/medical staff membership and/or clinical privileges, and burden of resolving any doubts about such qualifications, and that my application will not be processed if I fail to provide or fail to obtain any information required or requested. I further agree to appear for pre-appointment interviews regarding my application;
6. I agree to notify the Chief/President of the Medical Staff(s)/Medical Director in writing of any of the following circumstances within 15 (fifteen) days of my receipt of written or verbal notice of the same:
 - The reduction, suspension, limitation, revocation, voluntary or involuntary relinquishment, or any diminishment of my staff privileges at any hospital, healthcare facility or entity (excluding suspension of clinical privileges for less than thirty (30) days based on failure to complete medical charts);
 - The reduction, suspension, limitation, revocation, cancellation or any diminishment of my professional license, my controlled substance registration certificates or any other certificate or permit to prescribe or administer controlled substances;
 - The commencement of a formal investigation, any arrest or the filing of charges by any law enforcement authority or agency, or health regulatory authority or agency (excluding traffic offenses that do not involve allegations of driving while intoxicated or under the influence, and letter received from the Texas Medical Foundation or other peer review organizations); and
 - Any change in my physical or mental health that could potentially affect my ability to safely and appropriately exercise any of the clinical privileges I have requested. I agree to submit to a physical or mental examination acceptable to the Board of Managers/Directors or any committee responsible for evaluating my credentials should examination be considered necessary in their sole discretion regarding my physical or mental health status.
7. I agree to notify the Chief/President of the Medical Staff(s)/Medical Director in writing of the filing of a civil suit against me alleging negligence and liability within sixty (60) days of my receipt of written or verbal notice of the same. I acknowledge and agree that failure to notify as described in Sections 5 or 6 within the prescribed time period may be grounds for disciplinary actions, up to and including termination of my appointment/privileges.
8. I request and authorize UTSW Affiliated Hospitals, or other hospitals and institutions with which I have been or may have been associated, their medical staffs, professional licensing board of any state in which I hold a license or practice my profession, professional societies, other third parties and organizations, and their representatives, to release information, records, and documents, including medical records and quality assurance data concerning my professional qualifications and competence, ethics, character, physical and mental health, and other qualifications for medical staff appointment and/or clinical privileges requested at this or any other healthcare entity. I further authorize UTSW Affiliated Hospitals to notify any other hospital or healthcare entity at which I have appointment and/or clinical privileges of any action taken by one of its delegating entities that may be reportable to the Texas State Board of Medical/Dental/Podiatry Examiners under the Texas Medical Practice Act or the Healthcare Quality Improvement Act of 1986, as they may be amended from time to time. I further request and authorize UTSW Affiliated Hospitals to consult with representatives of other hospitals and healthcare entities and members of medical staffs of other hospitals and healthcare institutions with which I am or may have been associated, and with all others who may have information related to my professional qualifications and competence, my character, ethical qualifications, physical or mental health status and ability to work cooperatively with others. I also authorize UTSW Affiliated Hospitals to conduct further investigation(s) regarding my qualifications for medical staff membership and clinical privileges they deem necessary.
9. By applying for appointment and/or clinical privileges at UTSW Affiliated Hospitals, regardless of whether or not I am granted appointment and/or privileges, I extend absolute immunity to, and release and hold harmless from any and all liability UTSW Affiliated Hospitals, their representatives, medical staff, Board of Managers/Directors, other hospitals, healthcare entities and institutions providing information, their representatives, medical staffs, Board of Managers/Directors; and any third parties for any acts, communications, reports, records, statements, documents, or recommendations or disclosures involving me, performed, made in good faith and without malice, requested or received by UTSW Affiliated Hospitals, to, from, or by any third party, including otherwise privileged or confidential information. I additionally agree that, when an adverse ruling is made with respect to medical staff membership, medical staff status, and/or clinical privileges, I will exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action.
10. I agree that submission of this application does not constitute approval or acceptance by UTSW Affiliated Hospitals and grants me no rights or privileges in any UTSW Affiliated Hospital until such time as I receive notice of acceptance.
11. By my signature below, I certify that all information submitted in my application and in all supporting documents is true, complete and correct. I agree to supplement the information in my application and supporting documents should any statement, although true when made, become untrue due to change in circumstances or discovery of new information.

Signature

Date

