Kaleida Health

Dear Physician:

Thank you for requesting an application to the Medical/Dental Staff of Kaleida Health. Kaleida Health utilizes the Medical Staff Office to complete the primary source verification process.

Please complete all relevant information fields, including dates, names, complete mailing addresses and telephone/fax numbers. This will ensure that your application is processed in a timely manner.

Please note your references should have recent experience in observing and working with you and should be able to provide adequate information pertaining to your present professional competence and character.

Once your application is received and processed by the Medical Staff Office, you will receive an email from *Courion@kaleidahealth.org*. This email will provide you with your system user name and with important instructions. Please add *Courion@kaleidahealth.org* to your email address book now, so that this important email does not go into you Junk folder.

If your application is deemed incomplete (unanswered questions or omissions, including signatures, on the application or if any of the required documentation is not submitted), the Medical Staff Office will notify you of the outstanding information required from you. Your application will also be deemed incomplete if the need arises for new, additional or clarifying information at any time during the application process.

Accreditation standards require verification of certain data with the primary source. This is accomplished by requesting verification directly from the individual or institution and requiring that their response be returned directly to our office. Information requiring primary source verification includes, but is not limited to, professional school graduation, postgraduate training, professional references, hospital affiliations, malpractice history and professional licenses. In addition, we query the National Practitioner Data Bank and the Office of Inspector General's List of Excluded Individuals as part of consideration of any applicant. For your application to be considered complete, all information must be verified. **Please remember it is ultimately the applicant's responsibility to ensure that all information has been received.**

Upon completion of the primary source verification, your application with all related verification and supporting documentation will be reviewed by your department Chief of Service. The Chief of Service will complete the privileging and decision making portion of the application process. The Medical Staff Office will notify you when your application and request for privileges has been approved. Completion of the application **DOES NOT** guarantee acceptance by Kaleida Health.

If you have additional questions, please contact the Medical Staff Office at 716-859-5501.

Kaleida Health

Please enclose the following:

- ❑ Non-refundable application processing fee of $250. You may submit a check payable to the Kaleida Health Medical Staff or remit payment using a charge card (If you are a resident and have not completed your residency, or if you are an unaccredited fellow and are requesting privileges to continue your fellowship, you do not need to submit an application fee)
- ❑ Two recent professional 'quality' color photo, passport size (Driver's license NOT acceptable). We cannot process your application unless these are submitted with your application (photos need to be originals; fax or scanned copies are not accepted)
- ❑ If not U.S. citizen, provide a copy of VISA, H1B/I-94, Perm Resident Card and/or employment authorization, including ECFMG certification
- ❑ Signed copy of your current NYS License Registration Certificate. If you have a limited license, please provide a copy of the license AND a copy of your Affidavit of Agreement with the NYS Dept. of Health
- ❑ Copy of your driver's license
- ❑ Copy of medical school diploma, internship, residency and/or fellowship certificates
- ❑ Copy of your current Federal DEA Certificate, if applicable
- ❑ Copy of the facesheet of your current malpractice or professional liability insurance - minimum $1M/$3M
- ❑ Copy of your current Curriculum Vitae (CV must contain month, day, year and your personal email address)
- ❑ Copy of the mandatory NYS Infection Control training course certificate
- ❑ Copy of all your certifications (CPR, BLS, ACLS, ATLS, NRP, PALS, APLS, etc.)
- ❑ Copy of board certification/recertification certificates or a letter indicating admissibility status
- ❑ Completed New Practitioners Medical Evaluation form – Page 10 - 12 (Note: TB tests are required annually. Applicants aged 70 years or older must undergo and release the results of an IME by an approved neurologist in accordance with MED.19 The Aging Provider Policy as well as any repeat testing recommended by the neurologist.)
- ❑ Completed Chronological List of Activities form – Page 13 (Note: Kaleida Health has a zero day time gap policy)
- ❑ Completed Background Check Authorization form – Page 14
- ❑ Completed Professional Liability Claims Information form, if applicable – Page 15
- ❑ Completed and signed Federal/Champus Acknowledgement form – Page 16
- ❑ Completed Physicians Coverage Policy form – Page 17
- ❑ Completed Memorandum of Intent – Excess Liability Coverage form – Page 18 - 19 (If applying for Excess Liability coverage)
- ❑ Reviewed and signed Certifications, Authorizations and Waivers of Liability Form – Page 20
- ❑ Read the documents found in the Bylaws and Manuals tab at the following website: http://www.kaleidahealth.org/physicians/bylaws_manuals.asp. Print and sign the Documentation Attestation and return with your application
- ❑ Completed and signed Delineation of Privilege form(s). Delineation of privilege forms are found at http://www.kaleidahealth.org/physicians/physician_privileges.asp

Note: If requesting conscious/moderate or deep sedation privileges at Kaleida Health, follow the instructions on the Delineation of Privilege form. This information is also available at http://www.kaleidahealth.org/providers/support/sedation-guidelines-poster.pdf.

Kaleida Health

APPLICATION FOR MEDICAL/DENTAL STAFF MEMBERSHIP

If there is any additional information that is not accommodated on this form, please submit on separate paper.

PLEASE TYPE OR PRINT

I. IDENTIFYING INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DEGREE	GENDER

OTHER LAST NAME UNDER WHICH INFORMATION MAY BE FOUND (Example: Maiden Name)	NPI NUMBER

DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	CITIZENSHIP

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	HOME FAX NUMBER

CELL NUMBER	CELL PHONE TYPE	PAGER NUMBER	EMAIL (For business-related communication)
	__ iPhone __ Blackberry __ Android Brand _____ __ Other _____ Name of Carrier _____		PERSONAL EMAIL

PERSONAL EMERGENCY CONTACT	PHONE NUMBER	RELATIONSHIP

II. REQUESTED HOSPITAL AFFILIATION

Hospital Affiliation			
	Buffalo General Medical Center	☐ **Yes**	☐ **No**
	Women & Children's Hospital of Buffalo	☐ **Yes**	☐ **No**
	DeGraff Memorial Hospital	☐ **Yes**	☐ **No**
	Millard Fillmore Suburban Hospital	☐ **Yes**	☐ **No**

PRIMARY PRIVILEGES REQUESTED IN THE DEPARTMENT OF: SUBSPECIALTY AREA, IF ANY:	**SECONDARY** PRIVILEGES REQUESTED IN THE DEPARTMENT OF: SUBSPECIALTY AREA, IF ANY:

WILL YOU BE WORKING AS A HOSPITALIST? ☐ **Yes** ☐ **No**

DO YOU ANTICIPATE WORKING IN A KALEIDA HEALTH CLINIC? ☐ **Yes** ☐ **No**

If yes, please provide the name of the clinic _____

WILL YOU BE EMPLOYED BY KALEIDA HEALTH? ☐ **Yes** ☐ **No**

III. PRACTICE LOCATIONS

PRIMARY PRACTICE LOCATION		**CREDENTIALING LOCATION**	
GROUP PRACTICE LEGAL NAME (IF APPLICABLE)		GROUP PRACTICE LEGAL NAME (IF APPLICABLE)	
STREET ADDRESS (INCLUDING SUITE NO.)		STREET ADDRESS (INCLUDING SUITE NO.)	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
TELEPHONE ( )	FAX NUMBER ( )	TELEPHONE ( )	FAX NUMBER ( )
OFFICE MANAGER or CONTACT PERSON		OFFICE MANAGER or CONTACT PERSON	
EMAIL ADDRESS OF OFFICE MANAGER OR CONTACT PERSON		EMAIL ADDRESS OF OFFICE MANAGER OR CONTACT PERSON	
PREFERRED METHOD OF COMMUNICATION		□ Mail Address □ Email Address □ Fax Number _____	

PLEASE SUBMIT ANY ADDITIONAL PRACTICE LOCATIONS ON A SEPARATE SHEET OF PAPER.

Kaleida Health

IV. HOSPITAL AFFILIATIONS List all present and previous affiliations in chronological order, most recent first. Please designate the one facility which you consider your primary hospital.

HOSPITAL NAME	ADDRESS	PRIMARY	NATURE OF AFFILIATION/ POSITION	SPECIALTY /SUBSPECIALTY	DATES (From – To)

V. LICENSES AND NUMBERS INFORMATION List all professional licenses currently held. Attach a copy of state registrations.

NEW YORK STATE LICENSE (attach signed copy)	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
DO YOU HAVE ANY LICENSES IN OTHER STATES AND/OR COUNTRIES? (If yes, please list)			
STATE/COUNTRY	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
STATE/COUNTRY	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
DEA NUMBER (attach copy)	**DEA EXPIRATION DATE**	**ECFMG # (attach copy)**	

VI. BOARD STATUS List all present and previous boards. Attach copy of board certification.

BOARD NAME	CERTIFIED?	ELIGIBLE?	DATES (FROM – TO)
PRIMARY SPECIALTY			
SECONDARY SPECIALTY			

Kaleida Health

VII. PROFESSIONAL LIABILITY INSURANCE

List current AND all previous insurance carriers from the beginning of your medical practice. If there is additional previous insurance carrier information that does not fit on this form, please submit on separate paper. Please attach a copy of each malpractice insurance facesheet if available.

CURRENT PRIMARY INSURANCE CARRIER (Insurance carrier, not employer)		POLICY NUMBER	
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS ($1, $3 million minimum)	DATES (FROM – TO)
ALL PREVIOUS LIABILITY INSURANCE CARRIER(S) (From beginning of your medical p ractice)		POLICY NUMBER	
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)
PREVIOUS LIABILITY INSURANCE CARRIER	POLICY NUMBER		
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)
PREVIOUS LIABILITY INSURANCE CARRIER	POLICY NUMBER		
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)

VIII. MEDICAL/DENTAL REFERENCES

List two (2) professionals from your specialty. Please let your references know that they will received a letter from the Medical Staff Office.

NAME	
ADDRESS	
CITY, STATE, ZIP CODE	
TELEPHONE	
EMAIL	
NAME	
ADDRESS	
CITY, STATE, ZIP CODE	
TELEPHONE	
EMAIL	

Kaleida Health

IX. MEDICAL/DENTAL SCHOOL List school of graduation. If others, list separately. Attach copy of diploma.

DO NOT ENTER 'REFER TO CURRICULUM VITAE.' (PLEASE ATTACH COPIES OF ALL EDUCATIONAL CERTIFICATES IF NOT PREVIOUSLY SUBMITTED.)

INSTITUTION			
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON		TELEPHONE	
DEGREE		GRADUATION DATE	DATES (FROM – TO)

ARE YOU A GRADUATE OF A FOREIGN MEDICAL SCHOOL? ☐ YES ☐ NO

If yes, please provide a copy of your certificate with this application.

If yes, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ YES ☐ NO

DATE	CERTIFICATE NUMBER

X. INTERNSHIP/RESIDENCY List all internships and residencies in chronological order, most recent first.

NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR	TYPE	COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)

NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR	TYPE	COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)

NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR	TYPE	COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)

Kaleida Health

XI. FELLOWSHIP List all academic fellowships in chronological order, most recent first.

NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR		COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)
NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR		COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)
NAME OF HOSPITAL/HEALTHCARE FACILITY		SPECIALTY	
STREET	CITY	STATE	ZIP CODE
PROGRAM DIRECTOR		COMPLETED ☐ YES ☐ NO	DATES (FROM – TO)

XII. OTHER TRAINING/CERTIFICATIONS List separately and attach current certification of completion. (ACLS, PALS, BLS, CPR, etc.)

NAME OF INSTITUTION	DATE OF GRADUATION	DEGREE
INFECTION CONTROL TRAINING (Attach certification of completion of an approved course within the past 36 months)		

XIII. TEACHING APPOINTMENTS

NAME OF INSTITUTION	START DATE	END DATE	TYPE OF APPOINTMENT
ADDRESS (Street, City, State, Zip, Country)		DEPARTMENT CHIEF	

Kaleida Health

XIV. CONTINUING MEDICAL EDUCATION (Attach a separate sheet as needed)

All staff are required to complete continuing medical education programs every two (2) years. Educational activities must relate, at least in part, to the privileges granted. This requirement is waived for recent (within one year) graduates.

1. For Medical Doctors (MD) and Doctors of Osteopathy (DO): completion of at least **fifty (50)** hours of CME at each reappointment. Twenty five (25) hours of CME must be in Category 1 and relevant to the practitioner's specialty.
2. For Doctors of Dental Medicine (DDM) and Doctors of Dental Science (DDS): completion at least **sixty (60)** hours of continuing education every three (3) years as defined by New York State.
3. For Podiatrists: completion of **fifty (50)** hours every three (3) years, with at least thirty five (35) of the fifty (50) hours of educational coursework in sciences or in areas dealing with Podiatric practice issues including ethics or risk management.
4. For Allied Health Professionals: completion of New York State CME requirements defined by her/his profession

If audited, you must be able to provide documentation of the seminars or courses attended. Failure to produce such documentation upon request may jeopardize your membership on the Medical/Dental Staff of Kaleida Health.

I am a recent graduate and CME hours are not required until my first reappointment application is due. ☐ YES ☐ NO

If no, indicate the number of CME hours earned since graduation OR list CME activity on an attached sheet. _____
If you have not graduated within the last two (2) years, you must submit number of CME hours or list of CME activity.

Kaleida Health

CONFIDENTIAL PROFESSIONAL INFORMATION

Please completely fill in the answer blocks for each question. Do not draw circles around your answers or use an arrow or line for selections. Applications that do not follow these instructions will be returned.

1. **Have any of the following been denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction? These questions include, but are not limited to any teaching appointment, fellowship, internship, residency and medical school programs.**

a.	Medical, dental or other professional license	☐ Yes	☐ No
b.	Controlled substance registration (DEA)	☐ Yes	☐ No
c.	Academic appointment	☐ Yes	☐ No
d.	Membership in or affiliation with any healthcare facility staff	☐ Yes	☐ No
e.	Clinical privileges at any healthcare facility	☐ Yes	☐ No
f.	Prerogatives or rights at any healthcare facility	☐ Yes	☐ No
g.	Professional society membership or fellowship	☐ Yes	☐ No
h.	Board certification	☐ Yes	☐ No
i.	Professional liability insurance	☐ Yes	☐ No
j.	Participate in any practice, Federal or State insurance program (eg. Medicare, Medicaid)	☐ Yes	☐ No

2. **To the best of your knowledge:**

a.	Have you ever been charged with professional misconduct or received an administrative warning by any state agency or professional association?	☐ Yes	☐ No
b.	Are you the subject of any current investigation by any state agency or professional body?	☐ Yes	☐ No
c.	Have any misdemeanor or felony charges been brought against you?	☐ Yes	☐ No
d.	Have there ever been any findings or have you ever been found to be in violation of Patient Rights?	☐ Yes	☐ No
e.	Have any judgments or settlements been rendered against you in a professional liability case?	☐ Yes	☐ No
f.	Have you received notice of malpractice actions which are pending?	☐ Yes	☐ No
g.	Do you have any physical or mental disorders which may interfere with the practice of your discipline/specialty including alcohol or drug dependence?	☐ Yes	☐ No

3. **Are you presently using illegal drugs or receiving treatment or counseling for the use of illegal drugs? ☐ Yes ☐ No**

4. **If the answer is YES to any of the above questions, please complete the attached Professional Liability Claims Information form or explain on a separate sheet of paper.**

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY ADVISE KALEIDA HEALTH IN WRITING OF ANY NEW, DIFFERENT OR ADDITIONAL INFORMATION RESPONSIVE TO THE ABOVE QUESTIONS.

Kaleida Health

NEW PRACTITIONERS MEDICAL EVALUATION FORM

Please check your primary affiliation:

___Kaleida Health
___Erie County Medical Center
___Roswell Park Cancer Institute
___Mercy Hospital of Buffalo
___Kenmore Mercy
___Sisters of Charity Hospital
___Other _____

In keeping with the requirements of the New York State Department of Health, I certify by my signature below that I have performed a medical evaluation on:

Name _____ **Date of Birth**_____/_____/_____
Please Print

Section A: PAST HISTORY

MEDICAL

_____

_____

SURGICAL

_____

_____

FAMILY HISTORY

_____

_____

REVIEW OF SYSTEMS

_____

_____

ALLERGIES

_____

MEDICATIONS

_____

HABITS

_____

NEW PRACTITIONERS MEDICAL EVALUATION FORM (CONTINUED)

Name _____ **Date of Birth**_____/_____/_____

Please Print

Section B: IMMUNIZATIONS

Immunity to Rubella: Rubella antibody test date_____/_____/_____ Result _____

If negative, date of immunization_____/_____/_____

Immunity to Measles has been documented as follows: (Please check)

____Rubeola Date of Titer_____/_____/_____ Result _____
____Vaccination with Live Measles Vaccine Date immunized_____/_____/_____
____MMR Date Immunized_____/_____/_____
____Born before or on January 1, 1957 (excluded from requirement)

Tuberculin Skin Test (PPD): Date performed_____/_____/_____

Result (please check) ___ Positive/active TB ruled out by chest x-ray
___ Chest x-ray Date_____/_____/_____ Result _____
___ Negative (MUST BE REPEATED ANNUALLY)

IF PPD NOT PERFORMED, PLEASE INDICATE THE REASON BY CHECKING ONE OF THE FOLLOWING AND SUBMIT THE DOCUMENTATION AS INDICATED:

- ☐ Written medical documentation of a past positive skin test, including a chest X-ray report indicating no active disease
- ☐ Documented allergic reaction to the PPD solution – MD documentation is required; refer to the medical director for individual situations
- ☐ Documentation of completed course of preventive therapy, or treatment for the disease
    - There is no contraindication to the tuberculin testing of pregnant or breastfeeding women
    - There is no contraindication to the testing of persons who have received the BCG vaccine
    - PPD should be delayed 4 to 6 weeks after an MMR vaccine has been administered
    - Personnel who are taking steroids in the amount of at least 15 mg. every day for the past month may have a false negative reaction. Assessment for symptoms of active TB should be done at the time of the PPD placement. If it has been two weeks after completing the steroid treatment, the PPD reading should be accurate

VACCINE HISTORY:

Hepatitis B Date_____/_____/_____
DT Date_____/_____/_____
Pneumonia Date_____/_____/_____
Flu Vaccine Date_____/_____/_____
Other Date_____/_____/_____

Kaleida Health

NEW PRACTITIONERS MEDICAL EVALUATION FORM (CONTINUED)

Name _____ **Date of Birth**_____/_____/_____

Please Print

Section C: PHYSICAL EXAMINATION

BP _____ TEMP _____ PULSE _____ RESP_____WEIGHT _____

EYES _____

ENT _____

NECK _____

LUNGS _____

HEART _____

BREASTS _____

ABDOMEN _____

RECTAL _____

PELVIC _____

EXTREMITIES _____

NEUROLOGIC _____

Please Note: Kaleida Health **does not** allow a practitioner to attest to his/her own health status. If you submit the Catholic Health H & P form, another physician **must** attest to your health status.

I have determined that the above-named practitioner is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

_____ _____/_____/_____

Signature of Examining Practitioner Date

_____

Print or Type Name

Kaleida Health

CHRONOLOGICAL LIST OF ACTIVITIES

PROVIDER'S NAME _____

DATE (month/day/year)		TYPE OF ACTIVITY BEGINNING WITH GRADUATION DATE FROM PROFESSIONAL SCHOOL. INCLUDE NAME AND ADDRESS OF EMPLOYERS.
FROM	TO	

Kaleida Health

Consent Form
CF-051914

Disclosure In relation to your application for employment, or your current employment, your prospective employer or present employer may obtain a consumer report and or an investigative consumer report. Such reports may include information as to your character, general reputation, personal characteristics, and or mode of living. Also, subsequent reports may be requested to update, renew or extend employment. This disclosure is given to you in compliance with the Federal Fair Credit Reporting Act and applicable state law. You have the right to request additional disclosures as to the nature and scope of the investigation from your prospective or present employer. Such request must be made in writing.

The following information is for the sole purpose of conducting an employment background investigation

Current Name First Name	Middle Name	Last Name
Maiden First Name	Middle Name	Maiden Last Name
Alias/Other First Name	Middle Name	Alias/Other Last Name

__ __ – __ __ – __ __ __ __
Date of Birth – Month/Day/Year *

* *The Age Discrimination Act in 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.*

__ __ __ – __ __ – __ __ __ __
Social Security Number

Driver's License Number

State of Issue

Current ZIP Code

__ __ __ – __ __ __ – __ __ __ __
Daytime Phone Number

Male ☐ Female ☐

⇨ List Current and all Counties and States you have lived in for the past 7 Years

County	State	ZIP Code	From Month	From Year	To Month	To Year

Have you ever been convicted of crime? Yes ☐ No ☐ Misdemeanor ☐ Felony ☐ Any pending criminal charges? Yes ☐ No ☐

If yes, give location of Court: City_____ County_____ State _____

Type of Offense_____ Date of Offense_____ Case Number _____

Explain _____

****** (IF YOU HAVE MORE THAN ONE CONVICTION OR NEED ADDITIONAL SPACE, LIST ALL INFORMATION ON A SEPARATE SHEET OF PAPER) ******

Authorization Release: I certify receipt of this notice and give permission to my prospective employer and or current employer and its agents to verify the information submitted by me and to conduct a background search on me. I understand this search may include social security number verification and address history, criminal history, driving history, a credit report, education history, license/certification verification, past employment information, and/or reference checks. Such verification shall not constitute a violation of my right to privacy in any manner and I hereby release them from all liability whatsoever for actions related to this information. I understand that the sole purpose for obtaining this information is for employment reasons

_____	_____	_____
Print Name of Applicant/Employee	Signature of Applicant	Date

***** For Employer Use Only *****

Company Name_____ Requested By _____
(PRINT NAME CLEARLY)

DMV Driving History ☐ Drug Screen ☐ Date _____

Kaleida Health

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please PRINT or TYPE answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. Please complete a separate form for each professional liability claim. Only list one case per sheet. (You may photocopy if additional sheets are needed.)

PROVIDER'S NAME				
NAME OF PATIENT INVOLVED	AGE	MONTH/YEAR OF OCCURRENCE	MONTH/YEAR OF LAWSUIT	INSURANCE CARRIER AT TIME

WHAT IS/WAS YOUR STATUS? ☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	LIST OTHER DEFENDANTS

WHAT WAS THE PATIENT'S OUTCOME?

HOW WERE YOU ALLEGED TO HAVE CAUSED HARM OR INJURY TO THE PATIENT?

PLEASE PROVIDE SPECIFICS IN REFERENCE TO THE ADVERSE EVENT

WHAT IS/WAS YOUR ROLE IN THIS EVENT?

CURRENT STATUS		
☐ Still Pending	Who is handling the defense of the case?	
☐ Trial date set (awaiting trial) – Date____/___/____		
☐ Dismissed – Date____/___/____		
☐ Defense Verdict – Date____/___/____		
☐ Settled out of court – Date____/___/____	Total Amount of Settlement $	Amount Paid by You $
☐ Judgment – Date____/___/____	Total Amount of Judgment $	Amount Paid by You $

This Professional Liability Claim Information Form is required on all claims/lawsuits that are reported by your malpractice carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Signature	Date

Kaleida Health

FEDERAL/CHAMPUS ACKNOWLEDGEMENT FORM

NOTICE TO PHYSICIAN

Each year, hospitals that participate in Medicare and Medicaid reimbursements are required to have penalty statements signed by all physicians with admission privileges. Please sign the penalty statements for Champus/Medicare and Medicaid.

MEDICARE NOTICE TO PHYSICIANS

Champus/Medicare payment to hospitals is based on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or 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 laws.

MEDICAID NOTICE TO PHYSICIANS

Payment to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birth weight or admission weight as well. These data must be documented by the patient's medical record. Anyone who misrepresents, falsifies or conceals this information may be subject to fine, imprisonment or civil penalty under applicable Federal and New York State laws.

NOTICE TO PHYSICIAN

Pursuant to the authority vested in the State Hospital Review and Council and the Commissioner of Health by Section 2803 (2) of the Public Health law, paragraph (3) of subdivision (e) of section 405.3 of Part 405 of Article 2 of Subchapter A of Chapter V of Title 10 (health) of the Official Compilation of Codes, rules, and Regulations of the State of New York is hereby amended to be effective upon Publication of Notice of Adoption in the State Register and to read as follows:

(e) (3) At the time that a physician on a hospital's staff is granted admitting privileges or before or at the time the physician admits his or her first patient, (each) hospital shall furnish to (all physicians) such physician (on its Staff) the following notice, which each physician on the hospital staff must sign. The signed notices shall be kept on file by the hospital. The notice to physicians shall state:

"Notice to physicians. Payment to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birth weight or admission weight as well. This data must be documented by the patient's medical record. Anyone who misrepresents, falsifies, or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal and New York State laws."

_____ _____/_____/_____

Signature Date (Handwritten by physician)

_____

Print Name (Do not type or stamp)

PHYSICIANS COVERAGE POLICY

PHYSICIAN'S NAME _____

Physicians who are active or associate staff members are required to:

- Identify coverage physicians(s) within their specialty
- Notify any such physician that they have been designated as coverage physician(s)
- Provide answering service with current coverage information
- Respond within 30 minutes or within time frames established by department chief when assigned on-call responsibilities

If you are part of a group, please identify at least one individual in the group that will provide coverage.

Non-compliance to the above requirements will result in the following action:

- In the event a physician does not have a covering physician, she/he will be given 30 calendar days to provide the Medical Staff Office with covering physician information.
- On the 31st day, the provider will have been deemed to have voluntarily withdrawn from Medical/Dental Staff membership, or alternatively, any medical staff privileges that a physician does not have a covering physician with similar privileges for will be voluntarily relinquished.
- The expectation of the Medical/Dental Staff is during this period that the physician will remain accessible and provide coverage for his/her patients during the period the physician is looking for a new covering physician.
- In the event a physician loses her/his covering physician in between reappointment cycles, the provisions and deadlines described above will immediately become effective.

I attest that I will be responsible to provide physician coverage, by identifying one or more credentialed physicians who have similar staff association appointment and similar privileges at Kaleida Health and who will assume all patient care responsibilities in my absence or when I am unable to provide clinical/operative services.

_____ _____/_____/_____

Signature Date

_____ _____

Name of covering physician Office Address

_____

City/State/Zip

_____

Area Code/Phone Number

Kaleida Health

MEMORANDUM OF INTENT – EXCESS LIABILITY COVERAGE

Should you wish to apply for New York State Excess Liability Coverage at no cost* to you, this may be done in one of the following ways:

1. If your primary coverage is with Combined Coordinating Council, Physicians' Reciprocal Insurers or Academic Health Professional Insurance Association, you must request coverage directly through your primary carrier, listing Kaleida Health as your primary affiliation. It is your responsibility to obtain an application form from your primary carrier, complete the form, and return it to this office as soon as possible to assure timely coverage. Once received, the completed excess liability application will be processed by the Kaleida Health Medical Staff Office and submitted directly to your carrier.

2. If your primary coverage is not provided as noted above, contact HANYS at 866-374-4742 to request an application. It is essential you complete the form and return it to this office as soon as possible to assure timely coverage. Once received, the completed excess liability application will be processed by the Kaleida Health Medical Staff Office and submitted directly to HANYS.

3. If coverage is not available through your primary carrier AND you are denied by HANYS, coverage is available through Medical Malpractice Insurance Plan. Should you choose this option, we will supply the application form at your request. It is essential you complete the form and return it to this office to assure timely coverage. Once received, the completed excess liability application will be processed by the Kaleida Health Medical Staff Office and submitted directly to MMIP. (This coverage is available ONLY if you are unable to obtain coverage as noted in #1 & # 2)

4. Should you choose to obtain Excess Liability Coverage listing another entity as your primary affiliation, you will work directly with the institution you have identified.

*Please Note: If you are applying for Excess Liability Coverage, New York State mandates that your primary malpractice coverage be at a minimum $1,300,000/$3,900,000. In addition, an individual cannot apply to more than one carrier.

The contacts on the next page are provided for your convenience. An application form can be requested directly from any one of these carriers, provided your primary coverage is through that carrier.

Please note your intention regarding Excess Liability by checking one of the following. **This form must be returned with your application.**

- ☐ I am applying for Excess Liability Coverage through_____(identify carrier) and have listed Kaleida Health as my primary affiliation. I am aware it is my responsibility to forward the completed application to the Kaleida Health Medical Staff Office for processing.
- ☐ I am applying for Excess Liability Coverage through another hospital/health system.
- ☐ I **do not** intend to apply for Excess Liability Coverage.

Comments

_____

_____

Print Name _____ Signature _____ Date_____/_____/_____

NYS Section 18 Excess Liability Insurance Carriers

Carriers Contact List

Academic Health Professionals Insurance Association (AHPIA)
1250 Broadway #3401
New York, NY 10001
646-808-0607

Attn: Underwriting and Claims
Steve Capone

www.academicins.com

Combined Coordinating Council (CCC)
225 West 34th Street
7th Floor, #720
New York, NY 10122
212-643-8100
Attn: Underwriting and Claims
John Elias

www.thecccinc.com

Healthcare Professionals Insurance Company (HPIC)
217 Great Oaks Boulevard
Albany, NY 12203
866-374-4742
Attn: Underwriting
Melissa Corigliano
Attn: Claims
Kelly Higgins

www.HealthcareProfessionalsinsurance.com

Hospitals Insurance Company (HIC)
50 Main Street #1220
White Plains, NY 10606
914-220-1800
Attn: Underwriting
Alice Walsh
Attn: Claims
Richard Storey

www.hicgroup.com

Medical Malpractice Insurance Pool (MMIP)
8 British American Boulevard
Albany, NY 12110
518-786-2713
Attn: Underwriting
Nancy Gagnon
ngagnon@mimic.com
Attn: Claims
Tanika Henderson

www.newyorkmedicalmalpracticeinsurance.com

Physicians' Reciprocal
1800 Northern Boulevard
Roslyn, NY 11576
516-365-6690
Attn: Underwriting
William Martin
Attn: Claims
Claire Acosta

www.pri.com

Kaleida Health

CERTIFICATIONS, AUTHORIZATIONS AND WAIVERS OF LIABILITY

I fully understand that any misstatements in or omissions from this application or the supporting documentation submitted herewith constitutes cause for denial of appointment or cause for summary dismissal from the Kaleida Health Medical/Dental Staff to which I am applying. All information submitted by me in connection with this application is true and complete to the best of my knowledge and belief, and no pertinent information has been omitted.

In making this application for appointment to the Medical/Dental Staff of Kaleida Health, I acknowledge that I have received and read the bylaws, rules and regulations of the Medical/Dental Staff, and that I am familiar with the principles and standards of the DNV, the guiding principles for physician-hospital relationships of the New York State Medical Association and the Principles of Ethics of the American Medical Association. I agree to be bound by the terms thereof if I am granted membership or clinical privileges in all matters relating to my appointment to the Kaleida Health Medical/Dental Staff, and I further agree to abide by such hospital and Medical/Dental Staff bylaws, rules, regulations and policies as may be from time to time amended and enacted.

By applying for appointment to the Medical/Dental Staff, I hereby signify my willingness to appear for a personal interview in regard to my application, authorize Kaleida Health, its Medical/Dental Staff and their representatives to consult with administrators and members of the Medical/Dental Staff(s) of other hospitals or institutions with which I may have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Kaleida Health, its Medical/Dental Staff and its representatives of all records and documents, including medical records from other hospitals that may be made material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability Kaleida Health, its Medical/Dental Staff and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability, any and all individuals and organizations, including the hospital(s), its/their Medical/Dental Staff and its/their representatives, who provide information to the hospital(s) or its/theirs Medical/Dental Staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for Medical/Dental 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 questions or doubts about such qualifications**.** I have been advised of, and hereby acknowledge, my obligation to advise the hospital(s) in writing immediately of any new, different or additional information responsive to any of the questions or items requested in or in connection with this application which, at any time it comes to my attention or is made known to me.

_____ _____/_____/_____

Signature Date

_____

Print Name