PROVIDER/CLINICIAN EMPLOYMENT APPLICATION

ROLLING HILLS CLINIC considers applicants for employment without regard to race, color, age, religion, gender, national origin, disability, marital status, veteran status, sexual orientation or medical condition.

This application form must be typed or clearly printed using black ink only. Provide all requested information. If more space is needed, attach additional sheets. Do not submit curriculum vitae or resume in lieu of completing this application form. "Refer to CV" will not be accepted, and the application form will be returned to you for completion. So that it is understood that you did not intentionally omit an item, type or print N/A (not applicable) beside those items that do not apply to you, unless instructions indicate otherwise. Failure to complete this form in its entirety will delay the credentialing process and your appointment to the Medical Staff. Misrepresentations, inaccuracies, or falsification of information can be grounds for termination of Medical Staff appointment and associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank.

Please Print

Position(s) Applying For:	Date of Application:

Demographic Information

Name (Last, First, Middle)			Other Names Used:		
Email Address:			Social Security Number:		
Home Address:			Office Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:			Office Phone:		

Have you ever filed an application with ROLLING HILLS CLINIC? If yes, please provide the date: _____	☐Yes ☐No
Have you ever been employed with ROLLING HILLS CLINIC? If yes, please provide dates: _____	☐Yes ☐No
Do you have friends or relatives working for ROLLING HILLS CLINIC? If yes, please provide name(s) and relationship(s):_____	☐Yes ☐No
Are you currently employed?	☐Yes ☐No
If you are currently employed, may we contact your current employer?	☐Yes ☐No
If hired, can you present evidence of your U.S. citizenship or proof of your legal right to live and work in this country? *(Proof of citizenship or immigration status will be required upon employment)*	☐Yes ☐No
Have you been convicted of a felony within the last seven years? If yes, state the nature of the crime(s), when and where convicted and disposition of the case(s), (Convictions for marijuana related offenses that are more than two years old, need not be listed) _____ _____ _____	☐Yes ☐No

Professional Education

1. Name of Institution	Dates Attended (mm/yyyy):		
Address:	City:	State:	Zip:
Degree Obtained:	Honors:		
Did you successfully complete this program? ☐ Yes ☐ No (If no, attach explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No (If yes, attach explanation)			
2. Name of Institution	Dates Attended (mm/yyyy):		
Address:	City:	State:	Zip:
Degree Obtained:	Honors:		
Did you successfully complete this program? ☐ Yes ☐ No (If no, attach explanation)			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No (If yes, attach explanation)			

Internship *(If more than one program, use separate sheet)*			
Name of Institution:	Dates Attended (mm/yyyy):		
Address:	City:	State:	Zip
Type of Internship: ☐ Rotating ☐ Straight *(If straight, list discipline)*			
Did you successfully complete this program? ☐ Yes ☐ No *(If no, attach an explanation)*			
Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No *(If no, attach an explanation)*			

Residency *Please include copy of certificate(s). If more programs, use separate sheet*			
1. Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:
Did you successfully complete this program: ☐Yes ☐No *(If no, attach an explanation)*			
Were you the subject of any disciplinary action during your attendance at this institution? ☐Yes ☐No *(If no, attach an explanation)*			
2. Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip:
Did you successfully complete this program? ☐Yes ☐No *(If no, attach an explanation)*			
Were you the subject of any disciplinary action during your attendance at this institution? ☐Yes ☐No *(If yes, attach explanation)*			

Fellowship *Please include a copy of certificate. If more than one program, use separate sheet.*			
Name of Institution:	Program:	Dates Attended (mm/yyyy):	
Address:	City:	State:	Zip
Did you successfully complete this program? ☐Yes ☐No *(If no, attach an explanation)*			
Were you the subject of any disciplinary action during your attendance at this institution? ☐Yes ☐No *(If yes, attach explanation)*			

Teaching Experience/Faculty Appointment *List current and previous appointments. If more than two programs, use separate sheet.*			
1. Name of Institution:	Position/Rank:	Dates of Affiliation (mm/yyyy):	
Address:	City:	State:	Zip
Phone:	Fax:	Program Director:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐Yes ☐No *(If yes, attach explanation)*			

Teaching Experience/Faculty Appointment *(continued)*			
2. Name of Institution:	Position/Rank:	Dates of Affiliation (mm/yyyy):	
Address:	City:	State:	Zip
Phone:	Fax:	Program Director:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐Yes ☐No *(If yes, attach explanation)*			

Professional Organization	**Position** *(if applicable)*

Please indicate any particular interest you have in health care *(e.g. diabetes, children's nutrition, oral surgery, youth therapy, substance abuse, psychotherapy)*

Community Services & Other Interests List any paid/volunteer experience you have had with community service orgs. Including position, dates, comments, and any other pertinent experience.

Board Certification			
1. Name of Board:	Certification Dates (mm/yyyy):	☐Primary	☐Secondary
2. Name of Board:	Certification Dates (mm/yyyy):	☐Primary	☐Secondary
3. Name of Board:	Certification Dates (mm/yyyy):	☐Primary	☐Secondary

If not certified, have you applied for certification examination? ☐Yes ☐No *(If yes, attach explanation)*

If yes, what is the date of the exam? Date: _____

If no, do you intend to apply for certification? ☐Yes ☐No *(If yes, list date:_____)*

If you are not Board Certified, are you Board eligible? ☐Yes ☐No *(If yes, attach explanation)*

Current Hospital Privileges			
Hospital	Location	Type of Admitting Privileges	Length of Assoc.

Professional Licensure

If more space is needed, please list on separate sheet. *If limits or restrictions, please explain on separate sheet.

1. State	License No.	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes ***
2. State	License No.	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes ***
3. State	License No.	☐ Active ☐ Inactive	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes ***

State CDS Number:	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes ***

National Provider Identification (NPI) Number:		**CMS PECOS:** ☐ Enrolled ☐ Not Enrolled ☐ Unknown
DEA Number:	Expiration Date (mm/yyyy):	Limits/Restrictions: ☐ No ☐ **Yes ***
If you do not have a DEA Registration, are you eligible? If no, ☐ Yes ☐ No Why?		

C.P.R. Certification:	**Expiration Date:**
P.A. Supervision Care Number:	**Expiration Date:**

Professional References

Please list names of three (3) individuals who have personal knowledge (within the last 12 months) of your current clinical abilities, ethical character, and interpersonal skills. Receipt of this information is required before action can be taken on your application. For those in training, one reference must be from the Chief of Staff or Departmental Chairperson of your program.

1. Name:	Title:		
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		
2. Name:	Title:		
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		
3. Name:	Title:		
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		
4. Name:	Title:		
Specialty:	Relationship:		Years Known:
Address:	Daytime Phone:	Evening Phone:	
	City:	State:	Zip:
Email Address:	Fax:		

Affiliations/Work History

List in chronological order, beginning with most current, all practice history (past and present) that has occurred since completion of professional school. List hospitals, ambulatory centers, medical, behavioral health and dental offices where you have ever had an affiliation or where you have an application in process. Include all work engagements (including employment, self-employment, and service as an independent contractor). Indicate staff status (Active, Courtesy, Provisional, Temporary, etc.) Do not duplicate fellowship or internship/residency information previously reported. Enter additional affiliations on a separate sheet of paper and attach to application. If there is any gap greater than 30 days in chronology, explain in next section.

1. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes *(If yes, attach explanation)*				
2. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes *(If yes, attach explanation)*				
3. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes *(If yes, attach explanation)*				
4. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐ No ☐ Yes *(If yes, attach explanation)*				

Affiliations/Work History *(Continued)*

5. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐No ☐Yes *(If yes, attach explanation)*				
6. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐No ☐Yes *(If yes, attach explanation)*				
7. Organization Name:		Title/Professional Occupation:		
Full-time or Part time Status:		Dates of Affiliation (mm/yyyy)	Reason for Leaving:	
Street Address:		City:	State:	Zip:
Phone:	Fax:	Staff Status (Active/Not Active):	Supervisor:	
Were you the subject of any disciplinary action during your attendance at this institution? ☐No ☐Yes *(If yes, attach explanation)*				

Explanation of Work History Gaps

Any time period or gaps greater than 30 days since graduation from professional school, which are not explained in the application, must be addressed here. If the application is found to have any unexplained time periods or gaps, the application will not be processed and will be returned to the applicant as incomplete.

Dates (mm/dd/yyyy)	Explanation of work history gap	Person who can verify (phone/email)

Continuing Education

(Continuing Medical Education, Continuing Education Units or Continuing Education): Please use this form to list current continuing education credits earned within the last two years.

Course Title	Description of Course Topic:	Date	# of CME/CUE/CE

Emergency Procedure Certification

Current training and certification in the following is highly desirable for all professionals involved in direct patient care. Please check the appropriate box for any certification you hold.

	Title	Expiration Date
☐	Basic Life Support	_____
☐	Advanced Cardiac Life Support	_____
☐	Advanced Trauma Life Support	_____
☐	Advanced Life Support for Obstetrics	_____
☐	Pediatric Advanced Life Support	_____
☐	Neonatal Resuscitation Program	_____

Malpractice Coverage

List current and past insurance carriers during the past 10 years. If additional space is needed, use separate sheet.

Present Carrier:			Agent Name:	
Address:			Policy Name:	
City:	State:	Zip	Amount of Coverage:	Coverage Dates: (mm/yyyy)
Past Carrier:			Agent Name:	
Address:			Policy Name:	
City:	State:	Zip	Amount of Coverage:	Coverage Dates: (mm/yyyy)
Past Carrier:			Agent Name:	
Address:			Policy Name:	
City:	State:	Zip	Amount of Coverage:	Coverage Dates: (mm/yyyy)

Professional Practice Questions:

For each question, check Yes or No. If you check Yes for any question, provide full details below

1. Has your license to practice in any jurisdiction ever been or ever attempted to have been denied, restricted, limited, suspended, revoked or canceled?	☐Yes	☐No
2. Has your license ever been subjected to probation either voluntarily or involuntarily?	☐Yes	☐No
3. Has your license ever been withdrawn either voluntarily or involuntarily?	☐Yes	☐No
4. Has any disciplinary actions or investigations been initiated against you by any state licensure board?	☐Yes	☐No
5. Have you ever been reprimanded and/or fined, by any local state or federal agency that licenses providers?	☐Yes	☐No
6. Have you ever been the subject of an informal or formal hearing process at any healthcare organization?	☐Yes	☐No
7. Have you ever been the subject of a complaint or have you been notified in writing that you have been investigated as the possible subject of a criminal or civil action by any state or federal agency that licenses providers?	☐Yes	☐No

Professional Practice Questions: *(Continued)*

8. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization (e.g., hospital, HMO, PPO, IPA) professional group or society or regulatoryagency?	☐Yes ☐No
9. Have you been cautioned, reprimanded or disciplined by any institution, any local, state or national professional society or regulatory agency?	☐Yes ☐No
10. Has your employment and or clinical privileges at any hospital, clinic or other health care setting ever been denied, suspended, revoked, reduced, restricted, not renewed, voluntarily or involuntarily relinquished, denied renewal, or has probation ever been invoked?	☐Yes ☐No
11. Have you ever voluntarily or involuntarily withdrawn your application for clinical privileges or terminated clinical privileges before a hospital or health facility's governing board made a decision?	☐Yes ☐No
12. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating in or voluntarily withdrawn, to avoid an investigation by Medicare, Medicaid, Tri-Care and/or any other governmental health related programs?	☐Yes ☐No
13. Have Medicare, Medicaid, Tri-Care, PRO authorities and/or any other third party payers brought charges against you for alleged inappropriate fees and/or quality of care issues?	☐Yes ☐No
14. Has any information pertaining to you, including malpractice judgments and/or disciplinary action ever been reported to the National Practitioner Data Bank or any other practitioner data bank	☐Yes ☐No
15. Has your federal DEA number and/or state controlled substance license been suspended, revoked, restricted, limited or relinquished either voluntarily or involuntarily?	☐Yes ☐No
16. Have you been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	☐Yes ☐No
17. Have you had a claim for professional negligence asserted against you in the past 10 years? (If yes, you are required to note the final judgment and settlements involving yourself as a practitioner. Include date and amount of settlement)	☐Yes ☐No
18. Have liability claims, judgments or settlements been made against a hospital, corporation, or the U.S. Government in professional liability suits based on a case with which you were professionally associated? (If yes, you are required to note the final judgment and settlements involving yourself as a practitioner.)	☐Yes ☐No
19. Have you ever withdrawn from or been suspended, dismissed or expelled from a professional school or postgraduate training program, or has any third party ever attempted to have you withdrawn, suspended, dismissed or expelled from a professional school or postgraduate training program?	☐Yes ☐No
20. Have you ever been placed on probation or taken a leave of absence from a medical, dental, or other graduate school or postgraduate training program?	☐Yes ☐No
21. Have you ever been charged with or convicted of a crime (other than a minor traffic offense) in any state or country?	☐Yes ☐No
22. Have you been the subject of a civil or criminal complaint or administrative action, or are you being investigated as the possible subject of a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	☐Yes ☐No

Professional Practice Questions: *(Continued)*

23. Do you have, or has it been suggested to you that you have a history including the present, of any physical, mental or emotional impairment that either you or an objective third party might think would limit your ability to meet the duties associated with clinical staff membership and which could require an accommodation for you to exercise your clinical privileges and clinical staff duties completely and safely? (If yes, please describe the accommodation needed.)	☐Yes ☐No
24. Do you have, or has it been suggested to you that you have, a diagnosed or undiagnosed chemical dependency (i.e., alcohol, illegal drugs, prescriptive drugs, etc.)?	☐Yes ☐No
25. Are you currently engaged in illegal use of any legal or illegal substances?	☐Yes ☐No
26. Are you currently participating in a supervised rehabilitation program and/or professional assistance program, which monitor you for alcohol and/or substance abuse?	☐Yes ☐No

If you checked Yes for any question, provide full details (do not write on the back, please use a separate sheet).

_____

_____

_____

_____

_____

Certification

By signing this application, I certify that all the information submitted by me in this application is true and complete to the best of my knowledge. I agree to immediately disclose to the governing body any answer to a question above changes to a "Yes" while staff membership and/or privileges are pending or have been granted.

I agree to abide by all lawful standards, policies, rules, regulations, and bylaws of Rolling Hills Clinic, the Indian Health Service, the U.S. Public Health Service, the Department of Health and Human Services, the California Department of Public Health, CA State Licensing Boards, or other governing bodies, as they apply to my responsibilities and practice as a member of the clinical staff.

I further agree to answer any questions concerning the contents of this application either during the application process or subsequent to having been granted privileges. I agree that inquiries may be made to any federal or private sector facility with which I have been affiliated.

I pledge to maintain an ethical practice and to provide for the quality care of all my patients.

_____ _____

Applicant's Signature Date

Health Screens/Immunizations

1. **Rubella and Measles Immunity**
   Applicants requesting hospital/clinic privileges are required to submit evidence of rubella and measles immunity prior to being granted privileges. Individuals born before 1957 do not need to submit proof of immunity to measles. If the titer is negative, the applicant must receive the rubella and measles vaccine. Please submit documentation that your rubella and measles immunity was positive or that you have received the vaccine.

2. **TB Skin Test**
   Applicants are required to submit documentation of a current (within the past 6 months) TB skin test or chest x-ray if the skin test was previously positive or submit proof for treatment of latent TB.

3. **Hepatitis B Immunity**
   Health care professionals are at risk of acquiring Hepatitis B virus (HBV) infection due to occupational exposure to blood and other potentially infectious materials. The Rolling Hills Clinic strongly encourages applicant to obtain the Hepatitis B vaccination series. However, this is not required as a condition of employment.

☐ I have received the Hepatitis B vaccine.

☐ My Hepatitis B antibody test results indicate prior exposure.

☐ I decline the Hepatitis B vaccine at this time.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself; however, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B virus (HBV) infection, a serious disease, due to my occupational exposure to blood or other potentially infectious materials. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at ROLLING HILLS CLINIC at no charge to me.

_____ _____

Applicant's Signature Date

Statement of Understanding and Release

I authorize ROLLING HILLS CLINIC (RHC) and its representatives to inquire of any individual or entity with whom or which I have been associated (including medical malpractice carriers) who or which it deems relevant in its assessment of my professional competence, character and ethical qualifications. This includes any information otherwise protected from disclosure by the Privacy Act, 5 United States Code (U.S.C.) 552a, et seq. and/or the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. This authorization includes copying and inspecting any documentation (including but not limited to any general medical records, behavioral health records and substance abuse treatment records), which ROLLING HILLS CLINIC and its representatives deem relevant.

I consent to the disclosure by ROLLING HILLS CLINIC and its representatives of any information regarding my professional services at any ROLLING HILLS CLINIC facility to any individual or entity to whom or which I subsequently apply for clinical privileges, membership, or licensure. Additionally, I release ROLLING HILLS CLINIC from any liability for providing such information in response to any inquiry made by any ROLLING HILLS CLINIC employee to another ROLLING HILLS CLINIC employee.

I release from any sort of liability ROLLING HILLS CLINIC, any of their representatives, and any third parties from whom or which is obtained either information or documentation for the above purposes.

I understand that I have the right to review information received about me from any outside primary source except references or recommendations that are peer review protected. In the event that the information obtained from outside primary sources varies substantially from the information I have provided, I am aware that I have the right to review and correct, if necessary, the information obtained.

Upon request, I agree to appear for purposes of responding to questions relating to any record, document or information obtained pursuant to the foregoing paragraph. I understand that my refusal to so appear may constitute cause for future denial of clinical privileges and/or appointment to any medical staff or other healthcare position for ROLLING HILLS CLINIC.

All information submitted by me in this application is true and correct to the best of my knowledge. I understand that any intentional misstatement in or omission from this application may constitute cause for denial of appointment or summary dismissal from clinical staff, at the sole discretion of the deciding entity. I agree that in either of these events, I waive all rights of recourse and damages against ROLLING HILLS CLINIC and its representatives.

_____ _____

Applicant's Signature Date

Statement of Health

This statement of health By my signature hereto, I represent that presently, and for five years prior to the date of my signature, I do not have, have not had, and have not been diagnosed and/or treated as having any illness, condition or symptom relating to any physical or behavioral health condition that would impact in any manner upon my ability to either practice medicine in general, or perform any of the functions in particular that are set out in the position description of the position for which I am presently applying.

OR

I have an impairment that

☐ affects my ability to perform the clinical privileges requested and for which I require special accommodation (describe the accommodation needed).

☐ **does not** affect my ability to perform the clinical privileges requested. No special accommodations are needed.

_____ _____
Applicant's Signature Date

This statement must be confirmed by personal primary physician as required by accrediting bodies.

I hereby confirm that the provider identified above ☐ does ☐ does not currently have any health problems (including disability, emotional stability, drug or alcohol dependency) that might impair his/her ability to care for patients.

Reasonable accommodation needed: _____

_____ _____
Name (printed or typed) Signature

_____ _____
Title Date

_____ _____
Address Daytime Phone No.

Upon hire, ROLLING HILLS CLINIC requires all employees to complete a physical examination.

Certification of Professional Licenses and Certificates

I certify that my professional licenses and certifications (nurse, medical, dental, behavioral health or other health profession) have not been terminated, suspended or revoked in any state, the District of Columbia or Puerto Rico.

I currently hold **active** licenses and certifications in the following states and organizations:

State/Organization	Licenses/Certificate Number	Expiration Date

I have inactive licenses and certifications in the following states and organizations:

State/Organization	Licenses/Certificate Number	Expiration Date

I also certify, as required by the false statements provisions of the Program Fraud Civil Remedies Act of 1986, 45 Code of Federal Regulations (CFR) 79, that to the best of my knowledge, each of the above statements are true, accurate, and do not omit any material or facts which would render the statement false, fictitious, or fraudulent as a result of omission.

_____ _____

Applicant's Signature Date

Confidential Malpractice Claims Information Report

Applicant: Complete this form if you answered "Yes" to either professional liability question (Question 17 or 18) on Page 11.
Note: If you have more than one incident to report, complete a separate Supplemental Confidential Malpractice Claims Information Report for each incident. Print and sign each additional report and mail with your completed application.

Please furnish the following information regarding any lawsuits or complaints against you. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response if requested. You may choose to have your attorney complete this form.

1. Date of Claim:_____ Date of Incident:_____

2. Where incident occurred: _____

3. Claimant/patient name: _____

4. Nature of incident (type of case, procedure, major allegation, other pertinent information):
_____

5. Current Status: ☐ Pending/Open or ☐ Closed (date) _____ If closed, indicate:

☐ Dropped ☐ Dismissed ☐ Judgment for defendant (you)

☐ Appeal:_____ ☐ Settled: $_____

☐ Judgment for plaintiff: $_____

Represented by Legal Counsel for this claim/malpractice lawsuit? Yes ☐ No ☐

If yes, give name and contact information of counsel:

Name of Counsel:		Phone Number.	
Address:	City:	State:	Zip:

6. Name of insurance company that provides/provided coverage for this claim:

Name of Insurance Company:		Policy Number:	
Address:	City:	State:	Zip:
Phone:		Fax:	

7. Additional comments: _____

Printed Name_____ Signature_____ Date_____

Privacy Act Notice for Credentials and Privileges Review

Process for Licensed Professional Staff

The Privacy Act of 1974, 5 United States Code (U.S.C.) 552a, requires that a Federal agency provide a notice to each individual from whom it collects information.

1. The authority for collecting the information requested is found in Indian Self Determination and Education Assistance Act (25 U.S.C. 450); Snyder Act (25 U.S.C. 13); Indian Health Care Improvement Act (25 U.S.C. 1601 et. Seq.); and the Transfer Act (42 U.S.C. 2001-2004).

2. The principal purpose for collecting information requested is to systematically review the credentials of all current members of Rolling Hills Clinic (RHC) licensed professional staff and those of persons applying for positions on ROLLING HILLS CLINIC medical, dental, behavioral health staff, either as employees or contractors, regarding membership and the granting of clinical privileges. This information is being requested to ensure that members of ROLLING HILLS CLINIC medical staff are qualified, competent, and capable of delivering quality health services consistent with those of the medical/dental/behavioral health community at large and that they are granted privileges commensurate with their training and competence and with the ability of the facility to provide adequate support equipment, services, and staff. This responsibility includes the initial review and verification of a provider's credentials for the purpose of determining eligibility for medical staff membership. The applicant's training, prior experience, and current competence, the needs of ROLLING HILLS CLINIC medical/dental/behavioral health staff relative to patient load and diagnostic caseload mix, and the ability of the facility to provide adequate support facilities, services and staff must be considered prior to granting medical staff membership and delineating specific medical/dental/behavioral health staff privileges. This responsibility requires a mechanism whereby the credentials and clinical privileges will be evaluated, re-evaluated, and recertified on a recurring and standardized basis.

3. Information contained in the records created for these purposes will be maintained by ROLLING HILLS CLINIC staff in a confidential manner. Releases of this information will only be made on a "need to know" basis to employees of the Department of Health and Human Services (HHS) in the performance for the following routine uses: Records in part or total, may be disclosedto:

a. Authorized organization to conduct program evaluation studies sponsored by ROLLING HILLS CLINIC.

b. State or local government health profession licensing boards, to the National Practitioner Data Bank (NPDB) established under title IV of Public Law (P.L.) 99-660, to the Federation of State Medical Boards and/or similar entities to inform them of current or former ROLLING HILLS CLINIC medical/dental/behavioral health staff members whose professional health care activity so significantly failed to conform to generally accepted standards of professional medical practice as to raise reasonable concern for the health and safety of members of the general public. This will be done within the guidelines for notice, hearing and appellate review as delineated in the medical staff bylaws for ROLLING HILLS CLINIC and/or within other HHS or Indian Health Services regulations or policies.

Privacy Act Notice for Credentials and Privileges Review

Process for Licensed Professional Staff (continued)

c. References listed on ROLLING HILLS CLINIC medical staff application for the purpose of evaluating your professional qualifications, experience, and suitability.

d. State or local health professional licensing boards, health professional organizations, the NPDB established under Title IV of P.L. 99-660, the Federation of State Medical Boards or similar entities for the purpose of verifying that all claimed background and employment data are valid and all claimed credentials are current and in good standing.

e. Other agencies of the Federal Government, State, and local governments and organizations in the private sector you have or will apply to for clinical privileges, membership, or licensure for the purpose of documenting your qualifications and competency to provide health services in your health profession based on your professional performance while employed by ROLLING HILLS CLINIC.

f. Department of Justice in case of litigation.

g. Federal, State or local agency charged with enforcing or implementing a statute, rule, regulation or order when information contained in the record indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature.

h. ROLLING HILLS CLINIC staff will maintain a log of such disclosures. You may review a copy of this log of disclosures. You may review a copy of this log of disclosures or review copies of materials contained in your medical staff credentials and privileges file. To do so, contact the Human Resources.

i. Information collected through the use of ROLLING HILLS CLINIC Credentials and Privileges forms are contained in the Credentials and Privileges Binder located in Human Resources.

j. Applicants are advised that failure to provide the information requested, including Social Security Number, will result in denial to receive, or to continue, funding as a ROLLING HILLS CLINIC medical staff member (direct or contract).

Employment Data Record

Government agencies at times require periodic reports on ethnicity, gender, handicap, veteran and other protected status of employees. Although SUBMISSION OF THIS INFORMATION IS VOLUNTARY, it is greatly appreciated for reporting purposes.

Birth Date (mm/dd/yyyy) ____/____/____ **Gender:** ☐ Male ☐ Female

Part I:

Are you Hispanic or Latino?

☐ Yes ☐ No

If your answer to this question is no or you wish to decline, please Proceed to Part II

Part II:

Please identify yourself by selecting one category below. If you belong to more than one category, please select 'Two or more Races.'

☐ American Indian/Alaska Native

☐ Asian

☐ Hispanic or Latino

☐ Native Hawaiian or other Pacific Islander

☐ Black or African American

☐ Two or More Races – All persons who identify with more than one of the above five races

☐ White

☐ Decline

Veteran Status:

☐ Vietnam Veteran

☐ Recently Separated Veteran

☐ Disabled Veteran

☐ Other Protected Veteran

Disabled Individual:

☐ Disabled Individual

Applicant's Statement

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any documents used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ _____

Signature of Applicant Date

Due to the nature of this organization, Indian Preference will be exercised in the hiring of this position in accordance with the Indian Preference Act (Title 25, US Code, Section 472 and 473). Applicants claiming Indian Preference must submit verification of Indian certified by tribe of affiliation or other acceptable documentation of Indian heritage.

How did you learn about ROLLING HILLS CLINIC:

☐ College Job Fair
☐ Facebook
☐ Job Board
☐ Newspaper Advertisement
☐ Craigslist
☐ Indian Health Services
☐ ROLLING HILLS CLINIC Web Site
☐ Non-Solicited Resume
☐ Employee Referral
☐ Internal Candidate
☐ National Health Service Corp
☐ Recruitment Agency (External)