Memorial Hospital of Gardena
Where each life is our priority

1145 W. Redondo Beach Blvd
Gardena, CA 90247
(310) 538-6650 Telephone
(310) 512-6154 Facsimile
www.mhglax.com

Dear Allied Health Practitioner (AHP):

Thank you for your interest in applying to the AHP Staff of Memorial Hospital of Gardena. Enclosed you will find a Allied Health Practitioner application. Please complete the applicable forms in their entirety and return them to the Medical Staff Services Department as soon as possible. Upon receipt of a completed application, the verification process will begin ***(this process normally takes a minimum of three {3} months).*** Any omissions may cause a significant delay in processing.

As the credentialing process requires documentation from many sources, it has been our experience that there can be considerable delays in receiving responses from Universities, Nursing Schools, Peer References, etc. ***Providing complete addresses and telephone/fax numbers will assist the Medical Staff Office in expediting the processing of your application. Incomplete applications will not be processed, nor will a CV be accepted in lieu of a completed application.***

The following items "MUST" be submitted with your application before processing can be initiated: Please make sure to enclose the following: IMPORTANT **Non-refundable application fee of $500 payable to MHG Medical Staff**

- **Copy of your current California State License**
- **Copy of your current DEA Certificate**
- **Copy of your current Malpractice Insurance Certificate (proof of coverage for the privileges requested is required in the coverage amount of $1M/3M)**
- **Curriculum Vitae**
- **Copy of your Tuberculosis Skin Test or X-ray report**
- **Copies of Certificates of Completion for Allied Health Professional Education (RN; NP; PA)**
- **Current copy of ACLS/BLS/PALS/NRP (if applicable)**
- **Category I CEU's Credits for the past two (2) years (Total of 30 hours required. Certificates or written summary of courses is accepted)**
- **The Allied Health Professional is required to present to the Medical Staff Office a valid picture ID issued by a state or federal, agency (e.g., CA Driver's License or Passport) to verify identification.**
- **Current small Passport Photo for Identification Purposes**

If you have any questions regarding the application, processing, or the contents of this application packet, please do not hesitate to contact the Medical Staff Office at 310-538-6650. Again, we wish to thank you for your interest in Memorial Hospital of Gardena.

Sincerely,

Ashok Kumar, MD

Ashok Kumar, MD
Chief of Staff

PLEASE RETURN THIS LETTER WITH APPLICATION

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Confidential / Proprietary

Non Employed Physician Extender Application

I. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application or the application may be considered incomplete:**

- State Professional License(s)
- CV/ Resume
- Certificates of Education/Training
- Professional Liability Insurance Declaration
- CPR/PALS/ACLS/BCLS Certificate, if applicable
- DEA if applicable
- Photo within the past two years

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:	Degree:
Is there any other name under which you have been known? Name(s):			
Home Mailing Address:	City:		
	State:	ZIP:	
Home Telephone Number: ( ) Home Fax Number: ( )	E-Mail Address: Pager Number: ( )		
Birth Date: Birth Place (City/State/Country):	Citizenship:		
Social Security #:	Gender[2]: ❑ Male ❑ Female	Marital Status[2]:	
Specialty:	Other Languages spoken[2]:		
Subspecialties:	Title:		

III. PRACTICE / SPONSORING PHYSICIAN INFORMATION

Practice Name (if applicable):		
Primary Office Street Address:	City:	
	State:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

[1]As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2]This information will be used for consumer information purposes only.

Practitioner Name: _____

PRACTICE INFORMATION (Continued)		
Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	

How many days per month do you anticipate caring for patients at Memorial Hospital of Gardena? _____

IV. PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

V. PROFESSIONAL TRAINING AND EXPERIENCE

Include preceptorships, postgraduate education, military, and other training in chronological order, giving name, address, city and ZIP code, and dates.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ❑ Yes ❑ No (If "no," please explain on separate sheet.)

Institution:	Program Director:	
Mailing Address:	City:	
	State:	ZIP:

PROFESSIONAL TRAINING AND EXPERIENCE (Continued)

Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ❑ Yes ❑ No (If "no," please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ❑ Yes ❑ No (If "no," please explain on separate sheet.)

VI. BOARD OR OTHER CERTIFICATION

Name of Issuing Board or Organization:	Certification Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for certification other than those indicated above? ❑ Yes ❑ No

If so, list board(s) or organization(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

VII. CONTINUING PROFESSIONAL EDUCATION

Continuing professional education must relate to your practice and will be reviewed when granting patient care responsibilities.
Provide a list of all courses taken in the past two years.

VIII. PROFESSIONAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State License Number:	Issue Date:	Expiration Date:

IX. ALL OTHER STATE PROFESSIONAL LICENSES. List All Professional Licenses Now or Previously Held. (Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

X. PROFESSIONAL LIABILITY (Remember to include a copy of professional liability insurance declaration sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:

Practitioner Name: _____

PROFESSIONAL LIABILITY (Continued)			
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:	
Does your insurance extend to all privileges you have requested? Yes ☐ No ☐ Exclusions:			

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XII. PEER REFERENCES

List three professional references from your specialty area, *not including relatives or associates in practice.* If possible, include at least one member from the Medical Staff of each facility at which you have or have had patient care responsibilities.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observations or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Relationship:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:

Practitioner Name: _____

XIII. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. **Please explain any gaps (over 3 months)** in professional work history on a separate page. Include offices, clinics, and military.

Current Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Previous Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Previous Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	

XIV. PROFESSIONAL LIABILITY MATTERS

If you answer "YES" to any of the following questions, please give full details on the form attached (make additional copies if needed)..

A. Have any professional liability claims been filed against you, have you reported any malpractice claim to your insurance carrier, or have you received any letters of intent to sue?	YES	NO
B. Are any professional liability claims pending against you?	YES	NO
C. In the past seven years, have any settlements been made in any professional liability care in which you or your insurer had to or agreed to make a monetary payment?	YES	NO
D. Have you been denied professional liability insurance, has your policy been cancelled, has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any professional liability carrier expressed any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?	YES	NO

XV. LEGAL HISTORY

Are there any pending or completed agency, government, or court cases, decisions or judgments involving allegations that you:
If you answer "YES" to any of the following questions, please give full details on an additional page.:

A. Have you ever been convicted of any crime other than a minor traffic violation?	YES	NO
B. Do you have any criminal charges currently pending?	YES	NO
C. Are there any prior or pending government agency or third party payor proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to, Medicare and Medicaid fraud and abuse proceedings and convictions?	YES	NO

XVI. ACTIONS OR PENDING ACTIONS: LICENSURE, CERTIFICATIONS, and OTHER

If you answer "YES" to any of the following questions, please give full details on an additional page. Has any action, including any investigation, ever been undertaken, whether still pending or completed, which involves denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment by resignation or expiration (including relinquishment that was requested or bargained for) of your:

Status as a student in good standing in any clinical education program?	YES	NO
Membership in any local, county, state, regional, national or international professional organization?	YES	NO
Professional school faculty position or membership?	YES	NO
Specialty board certification?	YES	NO
License or certificate to practice any profession in any state or country?	YES	NO
Drug Enforcement Administration or other controlled substances registration?	YES	NO

Practitioner Signature: _____ Date: _____

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[2] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the suspension, revocation or non-renewal of my license to practice in California; (ii) any suspension, revocation or non-renewal of my DEA of other controlled substances registration; or (iii) any cancellation or non-renewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by California Board of Nursing or other regulatory agency taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a report with the California Board of Nursing or other regulatory agency, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of my allied health membership or patient care responsibilities at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of any proposed or actual exclusion or adverse action against me under the Medicare or Medicaid programs or any other federally funded or state health care program, including, but not limited to, fraud and abuse proceedings or convictions; and in such case I further agree to immediately notify the hospital.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my patient care responsibilities, employment or practitioner participation agreement. A photocopy of this document shall be as effective as the original; however, current dates are required on pages 7 and 8.

Print Name Here_____

Practitioner Signature_____ Date _____

(Stamped Signature Is Not Acceptable)

[2]The intent of this release is to apply, at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

Professional Liability Action Explanation

Please complete this form for each pending or settled professional liability action filed and served, or any payment made on behalf of you, the allied health or Health Professional Affiliate applicant. All questions must be answered completely. Please provide a separate sheet for each malpractice action. If additional sheets are required, please photocopy this page prior to completing.

Date of Alleged Incident:			Date Suit Filed:
Patient Name:	Sex:	Age:	Location of Incident:

Your relationship to Patient:

Allegation:

Your role: ☐ Primary defendant ☐ Co-defendant ☐ Other:

Liability Carrier When Incident Occurred:

Additional Named Defendant(s):

Plaintiff Name (if different from patient):

LAWSUIT/ARBITRATION STATUS

☐ Lawsuit/arbitration still ongoing, unresolved.
☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
☐ Judgment rendered and I was found not liable.
☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
☐ Lawsuit/arbitration dismissed or settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at the time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please type or print.**

_____

_____

_____

I certify that the information in this document and any attached documents is true and correct. I agree that this Hospital, its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the Participating Practitioner Application. I further agree to notify this Hospital in a timely manner of any change to the information included in this form.

_____
Name (please print or type)

_____/
Practitioner Signature (Original Signature Required) Date