EXCEL ANESTHESIA

PERSONAL IDENTIFICATION DATA

Full Name_____

Maiden or Other Name(s) Used _____

Address_____ City_____ State____ Zip Code_____

Home Phone_____ Cell Phone_____ Fax_____

Email Address_____

Gender_____ Marital Status _____ Spouses Name _____

Emergency Contact_____ Relationship_____ Phone#_____

DOB___/___/___ Social Security #_____-_____-_____

Birthplace (City/State)_____ Citizenship _____

Nationality_____ Languages Spoken _____

Drivers License #_____ State_____ Expiration Date _____

Do you accept text messages?_____ NPI#_____

CAQH#_____ Log In_____ Password _____

AANA#_____ Log In _____ Password _____

List All Addresses for the past 7 years including dates:

_____

_____

_____

1. Have you had the Hepatitis B Series/Booster?_____ If yes provide Month/Year _____
2. Have you gotten a Flu shot within the last 12 months?_____ If yes provide Month/Year _____
3. Have you received a TB Test within the last 12 months?_____ If yes provide Month/Year_____

EXCEL ANESTHESIA

LICENSURE INFORMATION

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

License Type_____ State_____ License Number_____

Date Issued_____ Expiration Date_____ Is License Active? _____

BOARD CERTIFICATION

Certifying Board Name	**Mo/Yr Issued**	**Mo/Yr Expired**	**Certificate#**
_____	_____	_____	_____
_____	_____	_____	_____

ACLS Exp Date: _____ BLS Exp Date: _____ PALS Exp Date: _____

EXCEL ANESTHESIA

PROFESSIONAL LIABILITY COVERAGE

Please list your liability coverage for the past 10 years starting with your current coverage.

Name of Carrier: ____________________________________ Agent Name: _________________

Address: ______________________ City __________________ State ____ Zip Code _________

Phone#: ________________ Policy#: _______________ Eff Date: ________ Exp Date: ________

Amount of Coverage: $______________________ Policy Type: Claims Made *or* Occurrence

Name of Carrier: ____________________________________ Agent Name: _________________

Address: ______________________ City __________________ State ____ Zip Code _________

Phone#: ________________ Policy#: _______________ Eff Date: ________ Exp Date: ________

Amount of Coverage: $______________________ Policy Type: Claims Made *or* Occurrence

Name of Carrier: ____________________________________ Agent Name: _________________

Address: ______________________ City __________________ State ____ Zip Code _________

Phone#: ________________ Policy#: _______________ Eff Date: ________ Exp Date: ________

Amount of Coverage: $______________________ Policy Type: Claims Made *or* Occurrence

Name of Carrier: ____________________________________ Agent Name: _________________

Address: ______________________ City __________________ State ____ Zip Code _________

Phone#: ________________ Policy#: _______________ Eff Date: ________ Exp Date: ________

Amount of Coverage: $______________________ Policy Type: Claims Made *or* Occurrence

EDUCATION

College or University

Name_____

Address_____ City_____State___ Zip Code_____

Phone#_____ Fax#_____

Degree_____ Dates: From (Mo/Yr)_____ To (Mo/Yr)_____

Professional School

Name_____

Address_____ City_____State___ Zip Code_____

Phone#_____ Fax#_____

Degree_____ Dates: From (Mo/Yr)_____ To (Mo/Yr)_____

Other Professional Training

Name_____

Address_____ City_____State___ Zip Code_____

Phone#_____ Fax#_____

Degree_____ Dates: From (Mo/Yr)_____ To (Mo/Yr)_____

Post Graduate Training (Internship, Residency, Fellowship)

Name_____

Address_____ City_____State___ Zip Code_____

Phone#_____ Fax#_____

Degree_____ Dates: From (Mo/Yr)_____ To (Mo/Yr)_____

EXCEL ANESTHESIA

EMPLOYMENT HISTORY

List work history in chronological order since completion of post-graduate education, starting with the most recent. Please include specific contact information needed to make direct contact with appropriate person for employment verification.

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

EXCEL ANESTHESIA

EMPLOYMENT HISTORY (Continued)

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

EXCEL ANESTHESIA

EMPLOYMENT HISTORY (Continued)

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

Name_____ Department_____

Address_____

City_____ State_____ Zip Code_____ Dates (Mo/Yr)_____-_____

Phone#_____ Fax#_____ Contact Name_____

EXCEL ANESTHESIA

PRIVILEGES HELD AT HOSPITALS/FACILITIES

Please list all affiliations, past and present, where privileges have been granted starting with the most recent. Please include specific contact information needed to make direct contact with appropriate person for privilege verification.

Hospital Name_____

Address_____

City_____ State_____ Zip Code_____ Department_____

Phone#_____ Fax#_____ Contact Name_____

Dates (Mo/Yr)_____-_____ Status (Active , Resigned, Etc.)_____

Hospital Name_____

Address_____

City_____ State_____ Zip Code_____ Department_____

Phone#_____ Fax#_____ Contact Name_____

Dates (Mo/Yr)_____-_____ Status (Active , Resigned, Etc.)_____

Hospital Name_____

Address_____

City_____ State_____ Zip Code_____ Department_____

Phone#_____ Fax#_____ Contact Name_____

Dates (Mo/Yr)_____-_____ Status (Active , Resigned, Etc.)_____

EXCEL ANESTHESIA

PRIVILEGES HELD AT HOSPITALS/FACILITIES (Continued)

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)____________-____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)____________-____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)____________-____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)____________-____________ Status (Active , Resigned, Etc.)__________________

EXCEL ANESTHESIA

PRIVILEGES HELD AT HOSPITALS/FACILITIES (Continued)

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)_____________-_____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)_____________-_____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)_____________-_____________ Status (Active , Resigned, Etc.)__________________

Hospital Name____

Address____

City__________________________ State_____ Zip Code_______ Department_________________

Phone#_____________________ Fax#___________________ Contact Name__________________

Dates (Mo/Yr)_____________-_____________ Status (Active , Resigned, Etc.)__________________

EXCEL ANESTHESIA

REFERENCES

Provide three medical or health care professionals who have personal knowledge of your current clinical abilities and ethical character, who will provide specific written comments on these matters upon request. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one, must have had organizational responsibility for your performance. At least two need to be in your same specialty. The individuals should not be related to you. Please provide direct contact information.

Name: _____ Title: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone#: _____ Fax#: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone#: _____ Fax#: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ State: ___ Zip Code: _____

Phone#: _____ Fax#: _____ Email: _____

EXCEL ANESTHESIA

DECLARATIONS

Please answer the following questions; provide an explanation on a separate sheet of paper if the answer to any question is yes.

1. Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, not renewed, denied, made subject to probationary conditions, or have proceedings toward any of those ends ever been instituted? Y / N

2. Have your clinical privileges or medical staff status at any health care facility ever been limited, suspended, revoked, not renewed, denied, made subject to probationary conditions or a concurrent monitoring condition, or have proceedings toward any of those ends ever been instituted? Y / N

3. Have you ever resigned or taken a leave of absence from a Hospital or Surgery Center to avoid disciplinary action? Y / N

4. Have you ever voluntarily relinquished a privilege or a procedure to avoid disciplinary action? Y / N

5. Have you ever been denied membership or renewal thereof, or been subjected to disciplinary proceedings or any kind by any medical society or other medical organization, or is such action pending? Y / N

6. Have you ever resigned from a medical society or other medical organization to avoid disciplinary action? Y / N

7. Have any professional liability lawsuits been filed against you as a result of your acts or omissions? Y / N

8. Have any professional liability judgments or settlements been made against you as a result of your acts or omissions? Y / N

9. Have you received any type of sanction or are you currently under investigation by a hospital, surgery center, state licensing agency or other professional health care organization, or are allegations against you pending for: Y / N

    - Improper practices involving Medicare, Medicaid, or other third party reimbursement;

    - Negligence or intentional wrongful acts related to the provision of patient care;

EXCEL ANESTHESIA

10. Have you been subject to administrative actions or received an honorable discharge from any branch of the armed services in lieu of administrative actions? Y / N

11. Do you have an impairment, which even with reasonable accommodation would interfere with your ability to provide care according to accepted standards of professional performance, or would pose a threat to patient health and safety? Y / N

12. Are you now or have you ever been an active or habitual user of any mind or mood altering substances, including, but not limited to alcohol, narcotics, barbiturates, hypnotics, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substances? Y / N

13. Are you receiving or have you received therapy, treatment or counseling for any alcohol or drug abuse or related condition? Y / N

14. Do you regularly take any medication which may affect either your clinical judgment or motor skills? Y / N

15. Are you currently under any limitations in terms of activity or workload? Y / N

16. Are you currently under the care of a physician? Y / N

17. Have you been hospitalized or institutionalized any time during the past 5 years? Y / N

18. Do you have any communicable ailment to which a patient you treat would be exposed? Y / N

19. Have you been arrested for, charged with, convicted of, pled guilty to or pled no contest to, a felony or misdemeanor, other than a traffic violation, in any jurisdiction? Y / N

20. Have you been arrested for, charged with, convicted of, pled guilty to, or pled no contest to a traffic violation involving the use or misuse of alcohol or any illegal substance chemicals? Y / N

21. Has your professional liability insurance coverage ever been terminated by action of the insurance company? Y / N

22. Have you ever been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty? Y / N

23. Has your present professional liability insurance carrier excluded any specific procedures for your coverage? Y / N

24. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank of Healthcare Integrity and Protection Data Bank? Y / N

25. Do you have any conflicts of interest with any hospital or facility in the Greater Kansas City Area?

Please answer the following questions as they appear on a few of our Facility Applications:

Please provide a short summary as to why you desire to be a member of our staff and how you plan to contribute to helping us meet our mission.

Please provide the type of position you are seeking and a description of duties you desire to perform in the Surgery Center.

EXCEL ANESTHESIA

CHART AUDIT CARD

Printed Name: _____

Credentials: (MD, CRNA, DO, etc.)_____

Signature: _____

Chart Signature: _____

Chart Initials: _____