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 ____________________

PECOS User ID____________________________________ 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______

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: ___________

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

EXCEL ANESTHESIA

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_________________

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_________________

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_________________

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.)_________________

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;

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: ____