MCLAREN HEALTH CARE CORPORATION

UNIFORM CREDENTIALING APPLICATION

FOR MEDICAL STAFF & ALLIED HEALTH PROFESSIONALS

It is the policy of McLaren Health Care Corporation that no person, on the basis of race, gender, sexual orientation, national origin or ancestry, age, marital status, handicap or veteran status shall be discriminated against in the awarding of medical staff/allied health professional affiliation and/or clinical privileges.

Membership and privileges are not guaranteed simply by submitting this application to a McLaren Subsidiary to which you are applying. Each Subsidiary utilizes its own credentialing and approval process. *Please see the Designation Page for mailing address and contact names.*

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

Check the box for each Subsidiary(s) you would like to apply for Membership / Clinical Privileges to:
Printed Name:_____

McLaren BAY REGION	☐	McLaren Bay Region Medical Staff Services 1900 Columbus Avenue Bay City, MI 48708	medstaffservbay@mclaren.org T 989-894-3806 F 989-891-8172
McLaren BAY SPECIAL CARE	☐	McLaren Bay Special Care Jackie Heintskill, Executive Assistant 3250 E Midland Road Bay City, MI 48706	jackie.heintskill@mclaren.org T 989-667-6851 F 989-667-6809
McLaren CARO REGION	☐	McLaren Caro Region Marsha Kaplaniak, Executive Assistant 401 N. Hooper St., PO Box 435 Caro, MI 48723	marsha@cch-mi.org p 989.672.5801 f 989.672.5801
McLaren CENTRAL MICHIGAN	☐	McLaren Central Michigan Missy Dorwin 1221 South Drive Mt. Pleasant, MI 48858	missy.dorwin@mclaren.org T 989-772-6821 F 989-953-5110
McLaren FLINT	☐	McLaren Flint Medical Staff Services 401 S Ballenger Hwy. Flint, MI 48532	billie.cnudde@mclaren.org T 810-342-4295 F 810-342-4970 Samantha.quinlan@mclaren.org T 810-342-2348 F 810-342-4970
McLaren GREATER LANSING	☐	McLaren Greater Lansing 401 W Greenlawn Ave. Lansing, MI 48910-2819	MGLMedicalStaff@McLaren.org T 517-975-7575 F 517-975-7580
BARBARA ANN Karmanos CANCER INSTITUTE	☐	Peggy Gulewicz, Manager Medical Affairs Mail Code GE00RO 4100 John R Detroit, Michigan 48201	gulewicp@karmanos.org T 313-576-8881 F 313-576-9832
McLaren LAPEER REGION	☐	McLaren Lapeer Region Medical Affairs Office 1375 North Main Street Lapeer, MI 48446	mclarenlapeermedicalstaffoffice@mclaren.org T 810-667-5895 F 810-667-5790
McLaren MACOMB	☐	McLaren Macomb Medical Staff Services 1000 Harrington Blvd Mt. Clemens, MI 48043	Laurie.crossman@McLaren.org T 586.493.8393 F 586.493.8799
McLaren MEDICAL GROUP	☐	McLaren Medical Group Contract Management G-3235 Beecher Road, Suite C Flint, MI 48532	angela.richards@mclaren.org T 810.342.1029 stacey.wing@mclaren.org T 810.342.1022 rebecca.miller5@mclaren.org T 810.342.1586 F 810.342.1070
McLaren NORTHERN MICHIGAN	☐	McLaren Northern Michigan Jessica Parks, Medical Staff Coordinator 416 Connable Avenue Petoskey, MI 49770	jparks@northernhealth.org T 231.487.3468 F 231.487.7998
McLaren OAKLAND	☐	McLaren Oakland Medical Affairs Office 50 N Perry Street Pontiac, MI 48342	peggy.hagen@mclaren.org T 248-338-5210 F 248-338-5584
McLaren PORT HURON	☐	McLaren Port Huron Amanda Schiller 1221 Pine Grove Avenue Port Huron, MI 48060	aschiller@porthuronhospital.org T 810-989-3757 F 810-985-2675
McLaren PHYSICIAN PARTNERS	☐	McLaren Physician Partners 2701 Cambridge Court, Ste. 200 Auburn Hills, MI 48326	MPPENROLLMENT@McLarne.org T 248-484-4933 F 248-484-4999
McLaren THUMB REGION	☐	McLaren Thumb Region 1100 S Van Dyke Bad Axe, MI 48413	mstanke@huronmedicalcenter.org T 989-269-2881 F 989-269-5260

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

Note: You must provide the entire application and supporting documentation to one McLaren Facility. The McLaren Facility you've submitted the application to, will then forward your application on to the additional facilities as you have indicated above. Upon receipt of your application, each healthcare entity will individually respond to your request with information specific to your application.

If you are applying at multiple McLaren facilities, please be sure to notify your professional references they will receive a request from each entity separately.

Should you have any questions or require additional information, contact the appropriate representative listed on the Designation Page.

SECTION A – INSTRUCTIONS

1. Please type or legibly print all information and sign the designation page and the applicant's consent and release in Section P. Curriculum Vitae (CV) will not be accepted as replacement for any part of this application.

2. If the appropriate response is "none," write "none"; if the item does not apply to you, write "n/a".

3. If more space is needed, attach additional sheets and make reference to the question being answered.

4. **Incomplete applications will be returned and will delay processing time.**

5. Please **INCLUDE CURRENT LEGIBLE COPIES** of the following documents with this application

___ CV or Resume (mm/dd/yy)
___ Licensure/Registration (Michigan physician/dental/podiatric and controlled substance; professional; all other states)
___ Federal Controlled Substance License (DEA), registered to the state you are applying for clinical privileges in
___ Professional Liability Insurance Certificate of Coverage from Insurance Carrier (going back at least 10 years)
___ ECFMG Certificate (if foreign medical graduate)
___ Medical/Professional School Diploma
___ Certificate of Internship/Residency/Fellowship
___ Residency and/or fellowship training logs (If completion is within the most recent 2 years)
___ Certifications (specialty/subspecialty boards, BLS, ACLS, ATLS, etc.)
___ PPD status validation within previous 12 months
___ Proof of Current Influenza Immunization (Seasonal)
___ Current Driver's License **OR** Government issued State Identification
___ Color Photo (current; used for website)
___ Medicare/Champus Acknowledgement Statement (p. 14)
___ Sterling Infosystems Authorization (p. 15)
___ Access & Confidentiality Agreement Signature Page (p. 16)

McLaren Health Care Corporation Required Policy(s)

Corporate Standards of Conduct (CC0120)
___ Signature Page (pg 14 of the link above)
HIPAA Administrative Policy (CC 1105)
Acceptable Use of Technology Resources (IS 2010)
Email, Communications & Collaboration (IS 2020)

6. Credentialing Application Fees and Dues**
Application fees are specific to each organization, information will be provided by individual locations.
***Note:** If you are making this application per your employment agreement with McLaren Medical Group (MMG) please note MMG will pay the application fee.*

7. Bylaws, Delineation of Privileges, Corresponding PA/APRN Required Agreements
The above listed items are specific to each organization, information will be provided by individual locations.

8. Requested Start Date _____

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

SECTION B - PERSONAL INFORMATION

1. _____ ❑ MD ❑ DO ❑DPM ❑ CRNA ❑ NP ❑ PA
   Last Name First Name Middle Initial
2. Date of Birth _____ 3. Birthplace (City/State) _____ 4. Ethnicity (optional) _____
5. Social Security Number _____ 6. _____ Male _____ Female
7. Other Legal Name(s) Used _____
8. Home Address _____
   Number and Street City State Zip Code
9. Home Phone _____ 10. Cell Phone _____ 11. Home Fax _____
12. Email Address _____ 13. Secondary Email Address _____
14. All current and prior city and states of residence _____
15. Citizenship _____ 16. Languages spoken _____
17. If not a citizen of the United States, please indicate the status of your VISA and include a copy. _____
18. Emergency Contact _____ 19. Relationship _____
20. Emergency Contact Home Phone _____ 21. Emergency Contact Cell Phone _____

SECTION C – PROFESSIONAL DATA

1. Practice Specialty _____ Practice Subspecialty _____
2. Allied Health Professionals – Please list supervising/sponsoring physician(s)
   Physician Name _____ Physician Name _____
   Physician Name _____ Physician Name _____
3. Since Medical/Professional School, list all licenses, including Controlled Substance, ***(current and expired)*** If more than the space provided, please supply the same information on a separate sheet and attach.
   State _____ License Number _____ Expiration Date _____ Type _____
   State _____ License Number _____ Expiration Date _____ Type _____
   State _____ License Number _____ Expiration Date _____ Type _____
   State _____ License Number _____ Expiration Date _____ Type _____
4. DEA Registration # _____ Expiration Date _____ State(s) of Record _____
   DEA Registration # _____ Expiration Date _____ State(s) of Record _____
5. NPI # Individual _____ 6. NPI# Organization _____
7. CAQH # _____ 8. ECFMG # _____

OFFICE PRACTICE INFORMATION

Corporation Name _____

Clinic name if different from Corporation name _____

Nature of Practice ❑ Solo ❑ Single Specialty Group ❑ Multi-specialty Group

Corporate Federal Tax Identification Number _____

Remittance Address _____
Number and Street City State Zip Code

Name of Group Members (or attach list) _____

_____

_____

SECTION C – PROFESSIONAL DATA (Continued)

Primary Office Name _____

Office Address _____
Number and Street City State Zip Code

General Phone _____ Ext._____ Fax _____

Private Phone _____ Ext. _____ Answering Service _____

Cell Phone _____ Pager Number _____

Office Manager/Contact _____ Email _____

Direct Phone _____ Website address _____

Secondary Office Name _____

Office Address _____
Number and Street City State Zip Code

General Phone _____ Ext._____ Fax _____

Private Phone _____ Ext. _____ Answering Service _____

Cell Phone _____ Pager Number _____

Office Manager/Contact _____ Email _____

Direct Phone _____ Website address _____

(for additional practices please provide same information on separate sheet)

Billing Office

Billing Company Name _____

Billing Co. Address _____
Number and Street City State Zip Code

Office Manager/Contact _____ Email _____

Direct Phone _____ Website address _____

Academic Office (if affiliated with a university)

Name & Address _____
Number and Street City State Zip Code

Office Manager/Contact _____ Email _____

Direct Phone _____ Website address _____

SECTION D – PRACTICE DEMOGRAPHICS

1. Primary Practicing Hospital _____ 2. Emergency on-call number _____

3. I understand that a requirement for privileges at most McLaren Subsidiaries includes the name(s) of physician(s) who are "on staff" ***and*** have agreed to take call or provide daily inpatient coverage of my patients in the event I am unavailable or unobtainable:

Physician _____ Facility: _____ Phone: _____

Physician _____ Facility: _____ Phone: _____

Physician _____ Facility: _____ Phone: _____

4. Will you utilize/employ nurse practitioners, physician assistants, nurse midwives, physical therapists, occupational therapists, or other licensed professionals for the institutions at which you are applying?

If **YES**, please attach a list with names and specialties. ❑ YES ❑ NO

5. Are you enrolled in the following:
   a. Medicare program? ❑ YES ❑ NO
   b. Michigan Medicaid program? ❑ YES ❑ NO
   c. CHAMPS** ❑ YES ❑ NO

** You are not required to accept Medicaid, but you must provide proof you are enrolled with CHAMPS

SECTION E – EDUCATIONAL DATA

UNDERGRADUATE COLLEGE/UNIVERSITY (**If attended more than one, attach a separate sheet.**)

College/University _____ Phone _____ Fax _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Degree _____ Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Year Graduated _____

MEDICAL/PROFESSIONAL SCHOOL (**If attended more than one, attach a separate sheet.**)

College/University GME Office _____ Degree _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Year Graduated _____

INTERNSHIP/PRECEPTORSHIP/CLINICAL TRAINING PROGRAMS (**If attended more than one, attach a separate sheet**)

Describe below all training programs that you have participated in. Please provide **complete** addresses, email, phone and fax numbers.

Type of Program _____ Program Director _____ Email _____

Institution Name _____ Phone _____ Fax _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Program Completed? ❑ Yes ❑ No
If No, Please provide explanation on a separate sheet and attach.

RESIDENCIES/FELLOWSHIPS

List in chronological order below all residencies/fellowships which you have begun or completed. If more than four residencies/fellowships, please supply the same information on a separate sheet and attach.

Please provide complete addresses, email addresses, phone and fax numbers.

*__Please Note__ Your specialty program must be accredited by a body recognized by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association, The Commission on Dental Accreditation of the American Dental Association, or the American Podiatric Medical Association.

1. ❑ Residency ❑ Fellowship Program Director _____ Email _____

   Institution Name _____ *Specialty _____

   Address _____
   Number and Street City State Zip Code

   Phone _____ Fax _____ Email _____

   Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Program Completed? ❑ Yes ❑ No
   If No, Please provide explanation on a separate sheet and attach.

2. ❑ Residency ❑ Fellowship Program Director _____ Email _____

   Institution Name _____ *Specialty _____

   Address _____
   Number and Street City State Zip Code

   Phone _____ Fax _____ Email _____

   Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Program Completed? ❑ Yes ❑ No
   If No, Please provide explanation on a separate sheet and attach.

SECTION E – EDUCATIONAL DATA - continued

3. ❑ Residency ❑ Fellowship Program Director _____ Email _____

Institution Name _____ *Specialty _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Date(s) From _____ to _____ Program Completed? ❑ Yes ❑ No
(mm/dd/yyyy) (mm/dd/yyyy) If No, Please provide explanation on a separate sheet and attach.

4. ❑ Residency ❑ Fellowship Program Director _____ Email _____

Institution Name _____ *Specialty _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Date(s) From _____ to _____ Program Completed? ❑ Yes ❑ No
(mm/dd/yyyy) (mm/dd/yyyy) If No, Please provide explanation on a separate sheet and attach.

SECTION F – BOARD or PROFESSIONAL CERTIFICATION DATA

Name of Board OR Certifying Entity	Specialty	Initial Certification Date	Expiration Date	Recertification Date	Expiration Date
1.					
2.					
3.					
4.					
5.					

Are you Board Eligible? ❑ Yes ■ No

Have you applied for board(s) OR professional certification other than those indicated above ❑ Yes ❑ No

Have you been accepted to take the certification exam? ❑ Yes ❑ No

If yes, list board(s) and date(s) _____

If not certified, do you intend to apply? ❑ Yes Specify timeframe _____

❑ No Specify reason _____

Have you ever taken and not passed a medical board examination? ❑ Yes ❑ No

If yes, will you re-take? ❑ Yes ❑ No

If so, when does the eligibility expire? _____
(mm/dd/yyyy)

SECTION G – ACADEMIC APPOINTMENT

ACADEMIC APPOINTMENT

Please identify all academic appointments. **If more than two, please provide information on a separate sheet and attach.**

1. Name of Institution _____

   Appointment Type _____ Department _____

   Address _____
   Number and Street City State Zip Code

   Phone _____ Fax _____ Email _____

   Date(s) From _____ to _____
   (mm/dd/yyyy) (mm/dd/yyyy)

2. Name of Institution _____

   Appointment Type _____ Department _____

   Address _____
   Number and Street City State Zip Code

   Phone _____ Fax _____ Email _____

   Date(s) From _____ to _____
   (mm/dd/yyyy) (mm/dd/yyyy)

SECTION H – HOSPITAL/INSTITUTION AFFILIATIONS

HOSPITAL/INSTITUTION STAFF MEMBERSHIPS

List the hospital(s) (**in chronological order**) at which you currently hold or have held staff membership and/or clinical privileges including your department assignments and staff category.

If there are more than three, please supply the same information on a separate sheet and attach.

1. Hospital/Institution _____ Admitting privileges ❑ Yes ❑ No

   Address _____
   Number and Street City State Zip Code

   Department _____ Appointment Type _____ Category _____

   Chairperson _____ Email _____

   Date(s) From _____ to _____ Reason for leaving _____
   (mm/dd/yyyy) (mm/dd/yyyy)

   Medical Staff Office Information

   Contact Name _____ Email _____

   Phone _____ Fax _____

2. Hospital/Institution _____ Admitting privileges ❑ Yes ❑ No

   Address _____
   Number and Street City State Zip Code

   Department _____ Appointment Type _____ Category _____

   Chairperson _____ Email _____

   Date(s) From _____ to _____ Reason for leaving _____
   (mm/dd/yyyy) (mm/dd/yyyy)

   Medical Staff Office Information

   Contact Name _____ Email _____

   Phone _____ Fax _____

SECTION H – HOSPITAL/INSTITUTION AFFILIATIONS - continued

3. Hospital/Institution _____ Admitting privileges ❑ Yes ❑ No

Address _____
Number and Street City State Zip Code

Department _____ Appointment Type _____ Category _____

Chairperson _____ Email _____

Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Reason for leaving _____

Medical Staff Office Information

Contact Name _____ Email _____

Phone _____ Fax _____

SECTION I – PROFESSIONAL WORK HISTORY

CHRONOLOGICAL PROFESSIONAL HISTORY

Please identify all professional employers, locum tenens, clinics, private or group practice, ambulatory surgery center, and/or military service, listing most recent first. Account for ALL intervals of time (including nonprofessional employers, etc.) not included in Section G.

If there are more than two, please supply the same information on a separate sheet and attach.

1. Organization/Practice Name _____ **Status** (Mark as applicable) Owner ❑ Employee ❑ Subcontractor ❑ Other ❑

Address _____
Number and Street City State Zip Code

Office Manager Name _____ Email _____

Phone _____ Fax _____

Date(s) from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Reason for leaving _____

2. Organization/Practice Name _____ **Status** (Mark as applicable) Owner ❑ Employee ❑ Subcontractor ❑ Other ❑

Address _____
Number and Street City State Zip Code

Office Manager Name _____ Email _____

Phone _____ Fax _____

Date(s) from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Reason for leaving _____

SECTION J – UNACCOUNTED INTERVALS

UNACCOUNTED INTERVALS ❑ Yes ❑ No

Since medical/professional school graduation or within the past 10 years, are there any unaccounted intervals (greater than 30 days)?

If yes, please list below and provide an explanation. If more space is required, please attach as needed.

Date From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Explanation _____

Date From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Explanation _____

Date From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Explanation _____

SECTION K – PROFESSIONAL SANCTIONS

Please answer each of the questions. **If the answer to any of these questions is YES, please provide full details on a separate sheet, and attach.**

Have any of the following ever been, or are any currently in the process of being denied, terminated, revoked, suspended, reduced, limited, censored, reprimanded, placed on probation, not renewed, voluntarily or involuntarily relinquished while under investigation or in exchange for an investigation or action not being taken, or investigated?

	Yes	No
Medical or other professional		
Registration/License in any state		
DEA Registration		
Academic Appointment		
Membership of any hospital staff		
Clinical Privileges		
Prerogatives/rights on any medical staff		
Other institutional affiliation or status		
Professional organization/society membership, fellowship or Board Certification		
Employment by any hospital/institution or military		
Professional Liability Insurance		
Private, State, or Federal health insurance programs (For example, Medicare or Medicaid)		
Have you ever been convicted of a felony or misdemeanor (excluding civil infraction traffic offenses) or is a felony charge currently pending against you?		
Have there been any disciplinary actions taken against you at any institution where you are currently or have been a member?		

SECTION L – HEALTH STATUS

If you answer **YES** to any of these questions, please provide a full explanation of the details on a separate sheet and attach.

	Yes	No
Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform all elements of the clinical privileges for which you have applied without a direct threat to the health and safety of others?		
Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients?		
Regarding chemical substances, have you or do you participate in any of the following to the extent that your ability to competently and safely perform the essential functions of a practitioner in your area of practice is or has been compromised?		
Use illegal drugs		
Consume alcohol		
Prescribe drugs for yourself		
Use chemical substances		
Have you ever been treated for substance abuse?		

SECTION M – PROFESSIONAL LIABILITY DATA

1. Name of **current** carrier _____ Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Policy # _____ Limits _____

Has your **current** professional liability insurance carrier excluded any specific procedures from your coverage? ❑ YES ❑ NO

If YES, list the procedures which have been excluded and provide a full explanation on a separate sheet including the name of the carrier, the date and specific information concerning any limitation and attach.

2. Name of all **previous** carriers and dates (if more than **three** please supply the same information on a separate sheet and attach)

Name of carrier _____ Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Policy # _____ Limits _____

Name of carrier _____ Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Policy # _____ Limits _____

Name of carrier _____ Date(s) From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Email _____

Policy # _____ Limits _____

3. **LEGAL ACTIONS**

	Yes	No
a. Have you ever been denied professional liability coverage or has your policy been cancelled or denied renewal?	☐	☐

If you answered YES to question 1, please provide a full explanation of the details on a separate sheet and attach.

	Yes	No
b. Within the past 10 years, have there been, or are there currently pending, any claims arising out of your care or supervision of care for a patient? ***For this purpose, "claim" includes a lawsuit, arbitration, settlement or request for payment of damages.***	☐	☐

If you answered YES to question 2, please complete the information on the following page. If additional space is needed, please attach a separate sheet as needed.

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

Provider Disclosure of Claims History

***All dates must be in mm/dd/yyyy format**

Claim Status ❑ Claim ❑ Suit ❑ Open ❑ Closed ❑ Notice of Intent

Name of Patient (Plaintiff) _____ Date of Occurrence _____

Date Claim Filed _____ Claim Settlement Date _____ Settlement Amount $_____

Insurance Carrier Name _____ Policy Number _____

Insurance Carrier Email _____ Insurance Carrier Phone _____

Address _____
Number and Street City State Zip Code

Insurance Carrier Fax _____

Resolution Method ❑ None ❑ Arbitration ❑ Dismissed ❑ Judgment for Defendant
❑ Judgment for Plaintiff ❑ Mediation ❑ Settled

Description of Allegations _____

_____

Were you the primary defendant? ❑ YES ❑ NO Number of Co-defendants _____

Your involvement in the case _____

_____

Description of alleged injury to patient _____

_____

Did the alleged injury result in death? ❑ YES ❑ NO

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ❑ YES ❑ NO

Claim Status ❑ Claim ❑ Suit ❑ Open ❑ Closed ❑ Notice of Intent

Name of Patient (Plaintiff) _____ Date of Occurrence _____

Date Claim Filed _____ Claim Settlement Date _____ Settlement Amount $_____

Insurance Carrier Name _____ Policy Number _____

Insurance Carrier Email _____ Insurance Carrier Phone _____

Address _____
Number and Street City State Zip Code

Insurance Carrier Fax _____

Resolution Method ❑ None ❑ Arbitration ❑ Dismissed ❑ Judgment for Defendant
❑ Judgment for Plaintiff ❑ Mediation ❑ Settled

Description of Allegations _____

_____

Were you the primary defendant? ❑ YES ❑ NO Number of Co-defendants _____

Your involvement in the case _____

_____

Description of alleged injury to patient _____

_____

Did the alleged injury result in death? ❑ YES ❑ NO

To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ❑ YES ❑ NO

SECTION N – PEER REFERENCES (ALL AREAS MUST BE COMPLETE)

Professional References must be of equal or greater education level to applicant

Physician Applicants must provide other physicians (i.e., MD/DO/DPM/DDS)

Allied Health Professional Applicants must provide two references with the same credential and two Physicians

****None of the individuals may be related to you by family. Do NOT give names of your program directors as they may automatically be contacted.** These individuals must have personal knowledge of your current clinical abilities in your specialty area, ethical character, health status, and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from the Hospital and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through ***recent observation*** of your professional practice over a reasonable period of time.

1. Name _____ ❑ MD ❑ DO ❑DPM ❑ CRNA ❑ NP ❑ PA Relationship _____

Facility/Organization _____

Specialty _____ Email Address _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Length of time known _____

2. Name _____ ❑ MD ❑ DO ❑DPM ❑ CRNA ❑ NP ❑ PA Relationship _____

Facility/Organization _____

Specialty _____ Email Address _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Length of time known _____

3. Name _____ ❑ MD ❑ DO ❑DPM ❑ CRNA ❑ NP ❑ PA Relationship _____

Facility/Organization _____

Specialty _____ Email Address _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Length of time known _____

4. Name _____ ❑ MD ❑ DO ❑DPM ❑ CRNA ❑ NP ❑ PA Relationship _____

Facility/Organization _____

Specialty _____ Email Address _____

Address _____
Number and Street City State Zip Code

Phone _____ Fax _____ Length of time known _____

SECTION O – CONTINUING MEDICAL EDUCATION DATA
(NOT APPLICABLE FOR CURRENT RESIDENTS/FELLOWS)

Sign the statement below

I hereby certify that I have completed CME (Category I) credit related to my scope of practice and as required by the state in which I am applying for clinical privileges. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request may jeopardize my membership or affiliation with the organization.

_____ _____

Signature *Date*

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

SECTION P – APPLICANT'S CONSENT AND RELEASE

I, the undersigned, hereby apply for medical staff or allied health professional affiliation and clinical privileges with the McLaren Hospital ("Hospital") listed on the Designation Page. Copies of this application, including my signature below, are as valid as the original.

I understand and agree that as an applicant, I have the burden of producing adequate information for proper evaluation of my qualifications and for resolving any doubts about my qualifications. I understand that my application will not be processed until it is deemed complete by the Hospital. I have the responsibility to keep the application current by informing the Hospital of any change in my professional liability insurance coverage, the filing of a lawsuit or other submission of a claim against me relating to my competency to practice my profession, any change in my affiliation status at another hospital, or any other material change or addition to the information provided in this application. I will provide the Hospital with updated current information regarding all questions on this application form as it becomes available. I will provide additional information that may be requested by the Hospital or its authorized representatives. My failure to provide information requested, will prevent my application from being evaluated and acted upon.

I attest that the information included in this application is current, complete, accurate and true, and fairly represents the current level of my qualifications for the clinical privileges requested. I understand that as a condition to making this application, any misrepresentation, misstatement or omission from this application, whether intentional or not, may result in an automatic and immediate rejection of this application, or termination of any medical staff or allied health professional affiliation or clinical privileges granted before discovery of the misrepresentation, misstatement or omission.

By applying for medical staff or allied health professional affiliation or clinical privileges, I hereby

- Agree to appear for an interview in regard to my application if requested;
- Authorize the Hospital and their representatives to consult with administrators and members of other healthcare facilities or organizations with which I am or have been associated, malpractice carriers, or anyone else who may have information bearing on my qualifications;
- Consent to the inspection by the Hospital and their representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications to carry out the clinical privileges requested.
- Authorize the Hospital and their representatives to provide other healthcare facilities and organizations, licensing boards, associations and others concerned with provider performance and the quality and efficiency of patient care with any information about me relevant to such matters.
- Agree that I have disclosed in my application all criminal convictions and any felony charges brought or pending against me. I further authorize the Hospital and its representatives to request, and any individual, company, firm, corporation or public agency, including law enforcement agencies to divulge, any criminal records or information, verbal or written, pertaining to me, including information or data received from other sources.

I hereby release from liability to the fullest extent permitted by law all representatives of the Hospital and its Medical or Professional Staff for their acts performed and statements made in good faith and without malice within its scope as a review entity. I hereby release from liability any and all third parties who in good faith, and without malice, provide information to the facility or organization concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior or any other matter that might have an effect on my competence, on patient care or on the orderly operation of any hospital or healthcare facility or organization.

I agree to

- Abide by the bylaws, rules and policies of the Hospital, as such documents may be changed from time to time;
- Abide by the medical staff bylaws, rules and policies and the rules and policies of the department and clinical service to which I am assigned;
- Adhere to recognized principles governing the practice of medicine, participate in continuing education program which relate, at least in part, to the privileges granted to me by the Hospital, and document such participation when requested to do so;
- Provide for care for my patients consistent with the standard of practice of my profession, accept committee assignments, accept administrative consulting assignments and participate in staffing emergency room service areas in my specialty on a reasonably agreed-upon basis if requested to do so;
- Comply with applicable local, state and federal laws, including abstaining from the division of fees or remuneration for referrals under any guise whatsoever;
- Maintain a constructive interest and cooperate in advancing the Hospital as a quality healthcare facility or organization; and
- Seek consultation by physicians of appropriate clinical experience as needed or requested.
- A hearing and appeal procedures as set forth in the Hospital's Medical Staff Fair Hearing Plan shall be my sole and exclusive remedy with respect to any professional review action taken at the Hospital. If, notwithstanding the provisions in this "Authorization to Release Information & Immunity," I institute legal action against the Hospital, its Medical Staff, or its authorized representatives and do not prevail, I agree to reimburse the Hospital and any Medical Staff members who are named in the action for all costs incurred in defending such legal action, including reasonable attorneys' fees.

I acknowledge that medical staff or allied health professional affiliation and clinical privileges at the Hospital are not a right of every licensed professional who makes application for the same.

I understand that

- The Hospital may determine I do not meet the eligibility criteria for appointment or privileging, in which case my application will not be accepted or processed.
- My application will be evaluated in accordance with prescribed procedures defined in the medical staff bylaws and rules;
- All medical staff recommendations relative to my application are subject to the ultimate action of the Hospital's Board;
- If approved, my medical staff or allied health professional affiliation and clinical privileges may be provisional for the time period determined by the Hospital's Board;
- Reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the Hospital, acceptable performance of all responsibilities, as well as the other factors deemed relevant by the Hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to medical staff bylaws and rules, and upon final approval of the Hospital's Board.
- Any individual who provides care, treatment, and services is free to raise concerns to The Joint Commission without retaliatory action when the hospital has not adequately prevented or corrected problems that can have or have had a serious adverse impact on patients.
- I have received and had an opportunity to read a copy of the medical staff bylaws and rules of the Hospital and such policies and directives as are applicable to appointees to the medical staff or allied health professional, and acknowledge I shall be bound by the terms thereof, any subsequent modifications or amendments thereof and any other established written policies of the Hospital, which are consistent with the bylaws and rules, whether or not I am granted medical staff or allied health professional affiliation or clinical privileges; and
- The provisions of the medical staff bylaws relating to confidentiality and release from liability are express conditions of my application for, and acceptance of medical staff or allied health professional affiliation and the continuation of such affiliation and to my exercise of privileges.

_____
Print or Type Name

_____
Original Signature Original Initials

_____
Date

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

SELECT ALL FACILITIES YOU ARE APPLYING FOR PRIVILEGES AT:

❑ Karmanos Cancer Ctr & Inst.	❑ McLaren Flint	❑ McLaren Northern Michigan
❑ McLaren Bay Region	❑ McLaren Greater Lansing	❑ McLaren Oakland
❑ McLaren Central Region	❑ McLaren Lapeer	❑ McLaren Physician Partners
❑ McLaren Caro Region	❑ McLaren Medical Group	❑ McLaren Port Huron
❑ McLaren Health Plan	❑ McLaren Macomb	❑ McLaren Thumb Region

The Final Rules of the Medicare/CHAMPUS Program regulations require that we have an acknowledgement of the following statement on file from each physician who treats Medicare and CHAMPUS patients. This statement is in lieu of a "Penalty Statement" on each Medicare/CHAMPUS medical record.

In submitting each Medicare/CHAMPUS claim, the hospital will certify that we have your acknowledgement on file.

Please sign, date and return this required attestation with your application.

MEDICARE ATTESTATION

MEDICARE payment to hospitals is based in part 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. (42 CFR 412.46)

CHAMPUS ACKNOWLEDGEMENT STATEMENT

CHAMPUS payment to hospitals is based in part 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.

I acknowledge receipt of this notice.

_____ _____

Physician Signature Date

_____

Print or type full name

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

❑ Karmanos Cancer Ctr & Inst.	❑ McLaren Flint	❑ McLaren Northern Michigan
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❑ McLaren Central Region	❑ McLaren Lapeer	❑ McLaren Physician Partners
❑ McLaren Caro Region	❑ McLaren Medical Group	❑ McLaren Port Huron
❑ McLaren Health Plan	❑ McLaren Macomb	❑ McLaren Thumb Region

Standard Disclosure Regarding Employment
Background Report

McLaren Health Care Corporation, and its affiliates ("COMPANY") may obtain from Sterling Infosystems, Inc. ("STERLING"), 1 State Street, New York, NY 10004, (877) 424-2457, www.sterlinginfosystems.com, a consumer report and/or an investigative consumer report ("REPORT") that contains background information about you in connection with your employment or employment application. If you are hired, to the extent permitted by law, COMPANY may obtain from STERLING further reports throughout your employment for an employment purpose without providing further disclosure or obtaining additional consent.

The REPORT may contain information about your character, general reputation, personal characteristics and mode of living. The REPORT may include, but is not limited to, credit reports and credit history information; criminal and other public records and history; public court records (e.g., bankruptcies, tax liens and judgments); motor vehicle and driving records; educational and employment history, including professional disciplinary actions; drug/alcohol test results; and Social Security verification and address history, subject to any limitations imposed by applicable federal and state law. This information may be obtained from public record and private sources, including credit bureaus, government agencies and judicial records, former employers and educational institutions, and other sources.

If an investigative consumer REPORT is obtained, in addition to the description above, the nature and scope of any such REPORT will be employment verifications and references, or personal references.

Authorization to Obtain Employment
Background Report

I have read the Disclosure Regarding Employment Background Report provided by McLaren Health Care Corporation, and its affiliates ("COMPANY") and this Authorization to Obtain Employment Background Report. By my signature below, I hereby consent to the preparation by Sterling Infosystems, Inc. ("STERLING"), a consumer reporting agency located at 1 State Street, New York NY 10004, (877) 424-2457, www.sterlinginfosystems.com, of background reports regarding me and the release of such reports to the COMPANY and its designated representatives, to assist the COMPANY in making an employment decision involving me at any time after receipt of this authorization and throughout my employment, to the extent permitted by law. To this end, I hereby authorize, without reservation, any state or federal law enforcement agency or court, educational institution, motor vehicle record agency, credit bureau or other information service bureau or data repository, or employer to furnish any and all information regarding me to STERLING and/or the COMPANY itself, and authorize STERLING to provide such information to the COMPANY. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

A Summary of Your Rights Under the Fair Credit Reporting Act is available here.

Signature **Today's Date**

Applicant First Name: _____ Middle: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____

Present Address: _____

City/State/Zip: _____

DL Number: _____

MCLAREN HEALTH CARE CREDENTIALING APPLICATION
ALL MEDICAL PROFESSIONALS

ACCESS AND CONFIDENTIALITY AGREEMENT

Applicant Name: _____
(Type or Print your name legibly)

"Confidential/Proprietary Information and/or PHI" includes information relating to:

A. Any individuals' Protected Health Information (PHI), which is defined in the HIPAA Regulations as information that identifies an individual (name, Social Security Number, account number, etc.) and is created or received by a healthcare provider, health plan, or healthcare clearinghouse, is transmitted or maintained in any medium (including electronic, Medical Records, paper, oral, etc.), and relates to the past, present or future physical or mental health condition, or payment for the provision of care (including medical records, conversations, admitting information, patient financial information, etc.);
B. Volunteers, Clergy, Medical Staff, Employees (including medical records, compensation, benefits, employment records, and disciplinary actions);
C. McLaren Health Care Corporation, to include its Subsidiary(s) (MHC), specific information (including financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, technology, source code, etc.); and
D. Proprietary third-party information (including computer programs and technology, client or vendor information and source code).

I understand and acknowledge:

1. As a member of the workforce (employees, physicians, contracted personnel, residents, interns, students, volunteers, agents, and other individuals authorized to act on behalf of MHC) I may learn of, or have access to, Confidential/Proprietary Information and/or PHI through computer systems (including but not limited to, patient care, clinical, financial, patient records, actuarial, claims, etc. systems) or through my employment/affiliation.
2. It is my responsibility to use Confidential/Proprietary Information and/or PHI only as minimally necessary to perform my legitimate job duties, as well as safeguard and limit access to any Confidential/Proprietary Information and/or PHI in any medium (including written, oral or electronic formats).
3. It is my responsibility to safeguard and not share my sign-on, password and/or authorization parameter (hereinafter jointly referred to as "access code") for accessing Confidential/Proprietary Information and/or PHI.
4. It is my responsibility to protect any and all Confidential/Proprietary Information and/or PHI obtained while performing my legitimate job duties, even after my employment/affiliation with MHC has ended.
5. MHC may routinely monitor and audit my access to information regarding, but not limited to employees, physicians, patients, public figures, VIPs, relatives, etc. to verify the appropriateness of my access to such information as it relates to my legitimate job duties.
6. It is my responsibility to sign-off any computer or system when I have completed my task, will be leaving the area or no longer require access.
7. I am not to allow another individual to access system(s) using my access code and that I am responsible for all activity logged under my access code.
8. It is my responsibility to use the MHC devices and systems, to include email and internet usage, in ways consistent with the MHC Policies Acceptable use of Technology Resources (IS 2010) and Email, Communications and Collaboration (IS 2020), as applicable.
9. It is my responsibility to notify my supervisor or the Privacy/Compliance Officer immediately if I suspect or learn of any security breach, that my access code(s), or any Confidential/Proprietary Information and/or PHI has been inappropriately used or disclosed.
10. MHC may, at any time, revoke my access code(s) to any system(s) to which I have access.
11. I am required, at all times, to comply with all MHC's policies and procedures, Standards of Conduct, etc.
12. I must protect the confidentiality of all Confidential/Proprietary Information and/or PHI, I encounter during my employment/affiliation even after my relationship with MHC has ended.
13. A violation of my responsibilities as discussed above may independently constitute a violation of applicable criminal/civil laws.

I have reviewed the information provided and understand my responsibility to protect the Confidential/Proprietary Information and/or PHI created and/or maintained by MHC that I have access to or encounter while performing my job duties.

_____ _____
Signature Date