

UNIVERSITY OF VIRGINIA HEALTH SYSTEM
SUPPLEMENTAL APPLICATION FOR INITIAL HOUSESTAFF APPOINTMENT

Please print or type all information.

Name _____ Social Security No. _____

Training Program _____

Please respond to the following questions. If you answer YES to any of these questions, except for question #1a, you must provide a full explanation of the details on a separate sheet, including date, place, reason, and disposition of the matter, as well as other, relevant information.

	<u>YES</u>	<u>NO</u>
1. Health Status:		
a. If you perform invasive procedures, have you complied with the U.S. Public Health Service recommendation to know your health status regarding blood borne pathogens such as hepatitis B and human immunodeficiency virus?	_____	_____
b. Do you currently suffer from any physical, mental, or emotional problems, which affect, or are likely to affect, your ability to perform your duties as a housestaff member or which may place a patient at risk?	_____	_____
c. Do you take any medication or drugs (including alcohol or any form of drug, legal or illegal) which affect, or is likely to affect your ability to perform your duties as a housestaff member or which may place a patient at risk?	_____	_____
d. Do you have an impairment for which you will request accommodations in order to perform your responsibilities?	_____	_____
2. Have you ever been denied clinical privileges by or appointment to any health care facility or managed care entity?	_____	_____
3. Has your membership status or clinical privileges by another health care facility or managed care entity ever been revoked, suspended, limited, reduced, and/or not renewed?	_____	_____
4. Has your membership in a local, state, or national medical society or other professional society ever had been suspended, terminated, or denied?	_____	_____
5. Has any state or federal licensing entity revoked, suspended, limited, or denied a certificate or license to you or taken any other disciplinary action?	_____	_____
Please attach a copy of your current medical license.		
6. Have you ever voluntarily or involuntarily relinquished your professional license (including DEA), any or all clinical privileges, or membership in a medical society or association:		
a) While under investigation by the health care entity, or	_____	_____
b) In return for not conducting such investigation or proceeding.	_____	_____
7. Has your narcotic license ever been revoked, suspended, or limited in any way?	_____	_____
8. Have you ever been denied a DEA registration number or been issued a restricted registration?	_____	_____
If currently registered, give number and state of issue.		
DEA Number _____ State of Issue _____ Expiration date _____		
State Pharmacy Number _____ Expiration date _____		
9. Malpractice information:		
a. Have you ever had a malpractice claim filed against you or is a claim currently pending against you?	_____	_____
b. Has a lawsuit ever been settled on your behalf?	_____	_____
c. Has a verdict ever been rendered against you in a malpractice lawsuit?	_____	_____
d. Have you ever been denied professional liability coverage?	_____	_____

If yes to 9a)-9c), please provide a letter from the attorneys who are/were assigned to represent you in the malpractice actions. The letter must address: current status of malpractice case, physician's role in alleged negligent actions, whether expert reviews of the physician's care have been obtained and the general substance of those reviews, and anticipated trial date or expectation of settlement. If yes to 9d), please provide a letter from the carrier explaining reasons for denial of coverage.

	<u>YES</u>	<u>NO</u>
10. Have you ever been suspended, excluded, or debarred from participation or otherwise sanctioned or had civil monetary penalties levied against you by a Medicare, Medicaid, or other Federal program?	_____	_____
Do you have outstanding payments with Medicare?	_____	_____
11. Have you ever been convicted, entered into a plea bargain, or pled Nolo Contendere to a felony, crime of moral turpitude, healthcare fraud or other crime related to governmentally financed healthcare programs, or criminal abuse or neglect of patients?	_____	_____
12. Do you currently have clinical privileges at any other institution(s)? Please provide name and address of institutions.	_____	_____

Should the answer to any of these questions change, I understand that I am under a continuing obligation to notify the Credentials Committee of such change or changes in writing so long as I remain a member of the Housestaff.

I hereby make application for appointment to the Housestaff of the University of Virginia Health System. I understand and agree that as an applicant for Housestaff membership, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. I fully understand that any significant misstatements in or omissions from this application constitute cause for denial, modification, suspension, or revocation of my appointment and/or clinical privileges. I certify that to the best of my knowledge and belief all information provided in this application is true, correct, and complete.

Further, should reasonable question exist regarding my physical or mental ability to perform the privileges granted, I agree to undergo a mental or physical examination, if requested. Should the examination provide evidence of mental or physical impairment, I understand it is my burden to show reasonable evidence that the impairment does not interfere with my professional competence.

In making this application, I understand, and agree, that in applying for clinical privileges in the University of Virginia Health System, I may also be applying to be credentialed and privileged for any University of Virginia entity or affiliate entity or third party contractor of any part of the University of Virginia, including the Medical Center and affiliated foundations, such as the Health Services Foundation. I agree to the release of my credentialing and privileging information by the Credentials Committee and its staff office for such purposes where required by contract with one of these entities and/or where requested or endorsed by the Health System in accordance with established policy. My credentialing and privileging information may be released only for the purpose of my being credentialed by such third party contractors under an institutional contract or for credentialing by an arm of the University, unless otherwise explicitly authorized by me in writing. All reasonable effort will be made to maintain this information as confidential and to preserve any legal privilege afforded the information.

If granted clinical privileges, I agree, as a member of the Housestaff of the University of Virginia Health System, to abide by the established practices, procedures, and policies of the Medical Center and those of its programs, clinical departments, and other institutions to which I may be assigned. Further, I pledge to maintain an ethical practice, abiding by the ethical principles set forth by the American Medical Association, with my patient's interest at the center of the care I render.

Signature of Applicant _____ Date of Application _____