



### Credentialing Application

Post Street Surgery Center  
2299 Post Street Suite 108  
San Francisco, CA 94115

QI# \_\_\_\_\_

Dear Provider: Please complete this application with the following documentation for processing.

- \*. Copy of CA license
- \*. Copy of DEA license
- \*. Copy of current CV
- \*. Copy of Certificate of Coverage- Malpractice Insurance
- \*. Copy of ACLS card- Anesthesiologist only
- \*. Copy of Fluoroscopy license, if applicable
- \*. Delineation of Privileges
- \*. Independent Provider Agreement
- \*. Medical Staff Participation Agreement

Should you have any questions regarding your application and its process, please call Sarah Sterling at 415.923.3770

Please fax completed information to confidential fax 415.840.0353 or email to [sarah@poststreetsurgery.com](mailto:sarah@poststreetsurgery.com)

#### Identifying Information

Last Name	First Name	Middle Initial	SSN
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Professional Group Name and Address

City	State	Zip
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Tel. #	Fax #	Email
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UPIN #	NPI #
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Home Address	Tel. #
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City	State	Zip
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Tel. #

Date of Birth



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## Medical Licensure/Certification

CA License Number

Expires

DEA Number

Expires

Other State Medical License #

State

Expires

## Premedical Education

College/University

Degrees/Honors

Address

Date of Graduation

## Medical Education

Medical School

Degrees/Honors

Address

Date of Graduation

Foreign Medical Graduate Exam in Medical Sciences, if applicable

Date

## Other Professional Education

College/University

Degrees/Honors

Address

Date of Graduation

## Internship

Hospital

Dates Attended

Address

Full Name of Program Director

Type

Kind (Medical, Surgical, etc.)



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**Residency(ies)**

1. \_\_\_\_\_  
 Hospital \_\_\_\_\_ Dates Attended \_\_\_\_\_

Address \_\_\_\_\_

Description \_\_\_\_\_ Full Name of Program Director \_\_\_\_\_

2. \_\_\_\_\_  
 Hospital \_\_\_\_\_ Dates Attended \_\_\_\_\_

Address \_\_\_\_\_

Description \_\_\_\_\_ Full Name of Program Director \_\_\_\_\_

**Training, Fellowships, Preceptorships, Postgraduate Education**

List in chronological order. Give complete school or hospital name and address, including zip codes; beginning and ending dates; and the name of the immediate superior.

1. \_\_\_\_\_  
 School or Hospital \_\_\_\_\_ Address \_\_\_\_\_

Dates \_\_\_\_\_ Superior \_\_\_\_\_

2. \_\_\_\_\_  
 School or Hospital \_\_\_\_\_ Address \_\_\_\_\_

Dates \_\_\_\_\_ Superior \_\_\_\_\_

3. \_\_\_\_\_  
 School or Hospital \_\_\_\_\_ Address \_\_\_\_\_

Dates \_\_\_\_\_ Superior \_\_\_\_\_

**Hospital and University Affiliations**

List all present and past affiliations in chronological order. Indicate % Staff Status+as: Active/Courtesy, etc. or Academic Title..

1. \_\_\_\_\_  
 Name of Institution \_\_\_\_\_ Address \_\_\_\_\_

Dates Affiliated \_\_\_\_\_ Staff Status \_\_\_\_\_

Department \_\_\_\_\_ Dept. Chief/Chairman (full name) \_\_\_\_\_



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2. \_\_\_\_\_  
Name of Institution Address

\_\_\_\_\_  
Dates Affiliated Staff Status

\_\_\_\_\_  
Department Dept. Chief/Chairman (full name)

3. \_\_\_\_\_  
Name of Institution Address

\_\_\_\_\_  
Dates Affiliated Staff Status

\_\_\_\_\_  
Department Dept. Chief/Chairman (full name)

4. \_\_\_\_\_  
Name of Institution Address

\_\_\_\_\_  
Dates Affiliated Staff Status

\_\_\_\_\_  
Department Dept. Chief/Chairman (full name)

## Certification

\_\_\_\_\_  
Certified by American Board of (Specialty) Certification # Expires

\_\_\_\_\_  
Sub-specialty Board Status (Name of Board) Certification # Expires

\_\_\_\_\_  
If not certified, give present status Date Date of Exam



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## Professional Societies, Awarded Fellowships (ACS, ACP, etc.)

List all memberships past, present or pending in professional societies. Please include date of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach additional sheet if necessary.

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## Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

1. \_\_\_\_\_  
Name Professional Relationship  
\_\_\_\_\_  
Address City State Zip

2. \_\_\_\_\_  
Name Professional Relationship  
\_\_\_\_\_  
Address City State Zip

## Professional Liability

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Insurance Carrier	Amount of Coverage
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Policy #	Agent	Expiration Date
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- Have any professional liability law suits been filed against you during the past ten years (including those closed)?  Yes  No
- Are there any now still pending?  Yes  No
- Has any judgment or settlement ever been made against you in any professional liability cases?  Yes  No
- Have you ever been denied professional insurance, or has your policy ever been cancelled?  Yes  No

If yes to any of the above, please explain on separate sheet



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### Professional Sanctions

- Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?  Yes  No
- Have you ever been refused membership on a hospital medical staff?  Yes  No
- Has your request for any specific clinical privileges ever been denied or granted with stated limitations?  Yes  No
- Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?  Yes  No
- Has your DEA registration ever been suspended or revoked?  Yes  No
- Have you ever been denied membership or renewal thereof or been subject to disciplinary action (other than discipline for failure to complete medical records) in any medical organization or health insurance plan?  Yes  No
- Have you ever received a criminal conviction other than minor traffic violations?  Yes  No
- Have you been sanctioned by either the Medicare or Medicaid program?  Yes  No

### Health Status & Acknowledgment

Have you had an illness or physical disability that impairs, or could impair your ability to practice your medical specialty?

If yes, please explain on a separate sheet.  Yes  No

I declare myself to be in good health with no signs or symptoms of communicable disease.

I understand that due to occupational exposure to blood or other potentially infectious materials that I may be at risk of acquiring Hepatitis B virus (HBV). I have been given to opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I know and understand the risk associated with the contraction of HIV in a surgical setting.



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### Applicant Release and Agreement

By applying for clinical privileges, I hereby signify my willingness to supply information and/or appear for an interview in regard to my application, authorize the facility, its Medical Staff and their representatives to consult with the chief executive officers and members of the medical staffs of other hospitals, and health facilities with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the release of information from my present and past malpractice insurance carrier(s) and to inspection of by the facility and its Medical Staff of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my ethical qualifications for staff membership.

I hereby release from liability all representatives of the facility, and its medical staff, for their acts performed in good faith, and without malice in connection with evaluating my application, credentials and qualifications, and I hereby release from any liability all individuals and organizations who provide information to the facility or its medical staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I further authorize the facility to communicate to other facilities and to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics that the facility may have to acquire, and where such communication is made in good faith and without malice, I consent thereto and agree to hold the facility and its authorized representatives free of liability therefore.

I understand and agree that I, as an applicant for Medical Staff membership or privileges, 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.

By accepting appointment and/or reappointment to the medical staff at Post Street Surgery Center, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules and regulations of the facility, as well as the principles, standards and ethics of the national, state and local associations and state law and regulations that apply to and govern my specialty and/or profession. I agree to conduct my professional activities in the facility and elsewhere in accordance with the highest ethical traditions.

In addition, I agree to notify the facility of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage or Board certification status or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial or appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy of the requests, authorizations, and release to this application to serve as the original.

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Signature

Title

Date

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Please PRINT or TYPE Name



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**LICENSED INDEPENDENT PROVIDER AGREEMENT**

**AGREEMENT** between Post Street Surgery Center, and \_\_\_\_\_, henceforth known as provider.

**WHEREAS**, Post Street Surgery Center, is an ambulatory surgery center in which surgical procedures performed that require the services of a surgeon, anesthesiologist, surgical assistant, etc.

**WHEREAS**, Post Street Surgery Center and Provider desire, upon the terms and conditions set forth, to enter into this Agreement for purposes hereinafter set forth;

**NOW, THEREFORE**, for good value consideration, the receipt and sufficiency of are hereby acknowledged, Post Street Surgery Center and Provider hereby agree as follows:

- 1.1 **Employment:** Neither person or their respective office is of shall be deemed to be an employee or employer of the other and each person and their office is to remain its separate entity.
- 1.2 **Liability:** Neither party is liable for the work of the other.
- 1.3 **Indemnity:** To the extent permitted by law, each person and his respective office indemnify the other against any claim or liability and will old either harmless from any pay or expenses (including without limitation legal fees and court costs) judgments, fines, parties, settlements and other amounts arising out of or in connection with any or omission of either party while working in conjunction with the other. Neither party will be liable to pay the other's legal fees and related charges during any period of this Agreement. The foregoing provisions will survive the termination of this Agreement for any reason whatsoever regardless of fault.
- 1.4 **Insurance:** Each person and his office is to procure his own insurance policies and maintain insurance coverage for all liabilities arising from their respective practices.
- 1.5 **No Joint Venture:** Nothing in this Agreement shall constitute or shall be deemed to constitute a joint venture or partnership between the parties and their offices, and neither party will incur any liability on behalf of the other, or in any way pledge or purpose to pledge the credit of the other, or accept any order or enter into any contract binding the other, except as otherwise provided by this Agreement.
- 1.6 **Provision of Credentialing for Assistant:** Provider agrees to furnish credentialing information for all assistants, scrub technicians, etc. who may be brought to the Post Street Surgery Center for the purposes of assisting in procedures. Provider indemnifies and agrees to hold harmless the Post Street Surgery Center for the acts of these personnel.
- 1.7 **Provision of Special Equipment:** Provider indemnifies and agrees to hold harmless the Post Street Surgery Center for the use and functioning of any equipment which is brought into Post Street Surgery Center for the purpose of use in any procedure. The timely biomedical engineering of all such equipment is the responsibility of Provider.
- 1.8 **Term of Agreement:** This Agreement to remain in effect until termination. Agreement may be terminated by either party at any time by giving 30 days notice of termination to the other. Termination of this agreement will be without prejudice to the rights and obligations accrued to the date of termination.

**In Witness Whereof**, the parties hereto have executed this agreement as of the date and year first written above.

**Post Street Surgery Center**

**Provider**

By: \_\_\_\_\_

By: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_



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### MEDICAL STAFF PARTICIPATION AGREEMENT

**Statement to be affirmed by medical staff applicants:**

My signature affirms that I am aware of the medical staff bylaws and applicable policies and procedures. I agree to abide by all said regulations. Further, as required in the bylaws and in the policies of the organization I agree to participate in and facilitate the peer review process.

I attest that I have accurately documented my training and experience on the application for privileges and that I am competent to perform the privileges for which I have herein applied on the attached privilege list. If I have provided false or misleading information, I acknowledge that any privileges extended may be revoked. Permission is granted to members of this organization to inspect all documents submitted and to verify all information I have submitted.

As a member of the Medical Staff involved in the evaluation and improvement of the quality of care rendered, I recognize that confidentiality is vital to the free and candid discussions necessary to effective medical staff activities; to that end I agree to make myself available for scheduled interview, appointments, and peer review activities.

Further, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of medical staff affairs.

Furthermore, my participation in peer review and quality management activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Medical Staff and/or other individuals involved. I understand that Post Street Surgery Center and the Medical Staff organization are entitled to undertake such actions as deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

By my signature, I agree to hold harmless and will not litigate any person or organization providing information pursuant to this request for privileges, including privileged data referable to any aspect of my professional training; competence; physical, emotional, or mental health; or personal ethics or behavior.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant



## Delienation of Privileges

# Cases Performed within past 2 years

Provider Name	Requested	Must be > 4 to be granted	Granted
<b>These privileges consist of treatment of either surgical or non surgical patients presenting with conditions, illnesses or injuries of the musculoskeletal system. Including admission, history and physical, evaluation, diagnosis, consultation, provision of surgical procedures, nonsurgical treatment, and medical management of pre-operative and post-operative surgical patients.</b> <b>Procedures include but not limited to:</b>			
Amputation, traumatic and elective			
Anterior dorsal spinal surgery			
Anterior lumbar spinal surgery			
Application of skeletal traction			
Arthrodesis			
Arthroscopic surgery (upper extremities)			
Arthroscopic surgery (lower extremities)			
Arthrotomy			
Back and neck pain; chronic and acute			
Biopsy of the muscoskeletal system			
Bone graft			
Cervical discectomy and fusion			
Complex club foot surgery			
Complex rheumatoid surgery			
Complex tendon reconstruction			
Complex tendon transfers			
Contusion, sprains, and strains			
Digit replantation			
Endoscopic Carpal Tunnel Release			

External fixation of fractures			
Fractures and dislocations, open or closed.			
Free microvascular flap			
Infection (surgical and medical treatment)			
Internal fixation of fractures			
Intra-discal chemonucleolysis			
Joint Arthrodesis			
Kyphosis instrumentation			
Ligament reconstruction			
Ostectomy/Osteotomy			
Pelvic osteotomy			
Percutaneous disc revision			
Peripheral nerve surgery			
Reduction and fixation of fractures			
Reduction and fixation of dislocations			
Repair of lacerations			
Skin grafts			
Spinal surgery (other than supplemental procedures)			
Sports medicine and related injuries			
Tendon grafts			
Tenotomy and rhyotomy			
Total joint surgery (other than supplemental)			
Tumor surgery			
Wound debridement			

**Anesthesiology- MUST HAVE CURRENT ACLS**

Airway management-Bronchoscopy			
Airway management-Ventilation using bag and mask			
General Anesthesia			
Local Infiltration regional block			
Monitored anesthesia care ( IV block only)			
Monitored anesthesia care( conscious sedation/IV block)			
Monitored anesthesia care(conscious sedation only)			
Regional anesthesia care-Infiltration			

Regional anesthesia care-Topical			
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**Pain Management - MUST HAVE CURRENT FLUOROSCOPY LICENSE**

Discogram			
Epidurals			
Lead Trials			
Nerve blocks			
Patient controlled analgesia(PCA)			
Permanent Placement of a stimulator			
Pump Placement			
Radiofrequency Ablation			
Sympathetic blocks			
Therapeutic nerve blocks			

**Miscellaneous**

Operate & interpret- Carm, Fluoroscanner <b>(All cases requiring Xray)</b>			
EKG Preliminary Interpretation <b>(All Anesthesiologist Must Request)</b>			

**Other**

Assistant Privileges Only			
Fellow Privileges Only			

\_\_\_\_\_  
Applicant Signature Date

\_\_\_\_\_  
Medical Executive Committee Chairperson or Designee Date

Appointment Term \_\_\_\_\_ - \_\_\_\_\_