LOURDES
Paducah, KY

ALLIED HEALTH PROFESSIONAL
COVER PAGE

REAPPOINTMENT APPLICATION

(Must be completed, signed, dated and returned with packet)

Including the REAPPOINTMENT APPLICATION, additional forms to be returned:

[ ] Job Description

[ ] If any additions, deletions or modifications to current privileges are requested, documentation of training and/or experience to support request is attached. **[ ] N/A**

[ ] Clinical Privileges (Current Clinical Privileges are enclosed for your review. Please return those as well) – **for Podiatrist and Clinical Psychologist only.**

[ ] Supervisory Physician Agreement

[ ] Current Kentucky License

[ ] BLS Certification

[ ] ACLS Certification **(Required for CRNA's and any Allied Health Professionals working in ER.)**

[ ] CME's / CEU's – (for past two years) OR [ ] CME Attestation Form.

[ ] Current TB Skin Test Results

[ ] Competency Checklist (per your specialty) – please complete and have reviewed by your sponsoring physician (their signature and date needed as well). You or your sponsoring physician can return to the Medical Staff Office (must be received by deadline date). If you have an additional sponsoring physician, a Competency Checklist must be completed by him/her as well.

[ ] Current government-issued photo ID (copy of your driver's license will be sufficient).

I understand that Lourdes is a non-smoking facility.

[ ] I do hereby make formal application for reappointment to the Allied Health Professional Group at Lourdes.

_____
Printed Name

_____ _____
Signature of Applicant Date

KAPER-1 (01/2009)
Part B, Section 2

For Health Care Providers Desiring Reevaluation for Hospital or Health Care Facility Privileges

Commonwealth of Kentucky
Instructions - KAPER-1 (01/2009), Part B, Section 2

A. Uniform Application for Reevaluation (Recredentialing) Form. Following is the KAPER-1 (01/2009), Part B, Section 2 developed pursuant to KRS 304.17A-545(5) for reevaluation (recredentialing) of health care providers. The form is available on the Web site of the Kentucky Department of Insurance at http://insurance.ky.gov. Prior to completing this form, a health care provider who desires reevaluation (recredentialing) by a hospital or health care facility is advised to contact that specific hospital or health care facility for information regarding submission of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction.

B. Cover Letter. A cover letter, which is signed and dated by the provider, who desires reevaluation (recredentialing) by a hospital or health care facility, requesting consideration of the complete KAPER-1 (01/2009), Part B, Section 2 and required attachments, as applicable and specified in item C of this instruction, may be required.

C. Required Attachments. Unless otherwise specified in this instruction, one (1) photocopy of each of the following supporting documents should be labeled and attached to the complete form KAPER-1 (01/2009), Part B, Section 2 in the following order:

1. Current medical, dental or professional license or evidence of licensure, as applicable;
2. Current federal drug enforcement agency (DEA) certificate for each state of practice;
3. Current state substance registration certificate, as applicable;
4. Proof of current professional liability insurance, including name, limits of liability and expiration dates. Additionally, if an affirmative response is entered for any question in Section VII of this section, provide a written explanation on an additional page of this attachment;
5. Proof of continuing medical education (CME) or continuing education unit (CEU) credits obtained in the past two (2) years; and
6. Separate pages, as applicable, in page number order.

I. PERSONAL IDENTIFICATION DATA

Name: _____ _____ _____ _____ _____ _____
Last Suffix First Middle Maiden Name Degree

☐ Medical Staff ☐ Allied Health (please specify) _____

Residence: _____ Phone: _____
_____ Fax: _____
_____

Primary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Secondary Office Address: _____ Phone: _____
_____ Fax: _____
_____

Billing Office Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Address: _____ Phone: _____
_____ Fax: _____
_____

Credentialing Contact: _____ Credentialing Email: _____

Preferred Mailing Address: ☐ Primary Office ☐ Residence ☐ Other (please specify) _____

Phys. Email Address: _____ Prac. Admin's Email: _____ Office Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse: _____

(If not a US citizen, please complete the next three fields)

Visa Status: _____ Alien Reg. #: _____ Exp. Date: _____

Language Spoken: _____

ECFMG #: (if applicable): ☐ - ☐☐☐ - ☐☐☐ - ☐ Pager #: _____ ☐ Alpha ☐ Digital ☐ Voice

Medicare #: _____ Cellular #: _____

Medicaid #: _____ Answering service #: _____

UPIN: _____ Are you taking new patients? _____

EIN: _____ Taxonomy Code: _____

NPI #: _____

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc.: _____

Name others with whom you are or will be associated in practice: _____

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice (if applicable): _____

Covering physician(s) to be called in my absence (Allied Health Professionals list sponsoring physician):

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

Name: _____ Specialty: _____ Telephone: _____

II. TEACHING APPOINTMENTS

Name: _____ _____ _____
Department Chief Type of Appointment

Address: _____

City/State/ZIP: _____ _____ / _____
City St ZIP ZIP+ From (mm/yy) To (mm/yy)

Phone: _____ Fax: _____ Email (if available): _____

III. POST-GRADUATE AND CONTINUING EDUCATION COURSES

Have you participated in post-graduate/continuing education courses in the last two (2) years? If YES, please supply an attached list and/or certificate of attendance.

☐ YES ☐ NO ☐ List and/or certificates attached

Do you have a cardio-pulmonary resuscitation certificate?

☐ CPR	☐ Yes	☐ No	Date of Expiration	_____
☐ ACLS	☐ Yes	☐ No	Date of Expiration	_____
☐ ATLS	☐ Yes	☐ No	Date of Expiration	_____
☐ PALS	☐ Yes	☐ No	Date of Expiration	_____
☐ NRP	☐ Yes	☐ No	Date of Expiration	_____

Please attach copies of all certificates.

IV. LICENSURE INFORMATION

List all current and past professional health care licenses held and attach copies of all active licenses. Allied Health Professionals: list all certifications.

	State:	License #:	Date Issued:	Expiration Date:	Status:		License Obtained by:	
KY State:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #2:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #3:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #4:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #5:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #6:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #7:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity
State #8:	_____	_____	_____	_____	☐ Active	☐ Inactive	☐ Exam	☐ Reciprocity

If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.

V. DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

(This application cannot be processed without current Federal DEA Certificate for each state in which you practice)

Federal DEA Certificate #: _____ Expiration: _____

Federal DEA Certificate #: _____ Expiration: _____

VI. STATE NARCOTICS REGISTRATION: CONTROLLED SUBSTANCE REGISTRATION (CSR)

Some states require additional CSR certificates. Attach copies of any additional CSR certificates you have.

State: _____

Certificate #: _____ Expiration: _____

State: _____

Certificate #: _____ Expiration: _____

VII. PROFESSIONAL LIABILITY DATA

Answer the following questions as they apply to the last two (2) years:

1.	Has your professional liability insurance coverage been terminated by action of the insurance company?		☐ Yes	☐ No
2.	Have you been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?		☐ Yes	☐ No
3.	Has your present professional liability insurance carrier excluded any specific procedures from our coverage?		☐ Yes	☐ No
4.	Have any professional liability suits or claims been filed against you?		☐ Yes	☐ No
5.	Have any professional liability suits or claims been filed against you which are presently pending?		☐ Yes	☐ No
6.	Have any judgments or settlements been made against you in professional liability cases?		☐ Yes	☐ No
7.	If applying to an Indiana facility, do you participate in the Indiana Patient Compensation Fund?	☐ N/A	☐ Yes	☐ No
8.	If applying to a Virginia facility, do you participate in the Birth-related Neurological Injury Compensation Act?	☐ N/A	☐ Yes	☐ No

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date and specific information concerning any limitation, settlement or judgment.

PROFESSIONAL LIABILITY DETAIL SHEET

(Please copy this page if additional sheets are needed)

☐ CHECK HERE IF NOT APPLICABLE

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced:

☐ Pending ☐ Settled Date: _____

List the allegations: _____

_____

Date of occurrence: _____

Name of institution involved (i.e., hospital): _____

Name and address of insurance carriers involved: _____

Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgments against you.

Title of the court case: _____

The court case number: _____

The venue of the case (place where court case took place, such as County District Court or Circuit Court): _____

_____

Allegations listed in complaint: _____

Date of incident leading to complaint: _____

Place of incident: _____

Name and address of malpractice insurance carrier: _____

_____

Amount of jury award or amount awarded by the court: _____

VIII. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES OR AMERICAN OSTEOPATHIC ASSOCIATION

(Allied Health Professional: list national certifications)

1. Are you board certified? ☐ Yes ☐ No (If not Board admissible, please explain on separate sheet and attach)

2. If yes, list full name of certifying board and date which you obtained certification/recertification:
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____

3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:
   _____ Date: _____

4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____

5. List date of next required recertification (if applicable): _____

6. Have you ever been examined by a specialty board but failed to pass the exam? If yes, please explain. ☐ Yes ☐ No

IX. INDIVIDUAL PRACTICE INFORMATION

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.

1.	Are there any actions that have been initiated or are any pending against you by any state licensing board? ☐ Pending ☐ Resolved		☐ Yes	☐ No
2.	Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed?		☐ Yes	☐ No
3.	Have you ever received notice of a proposed or actual exclusion (suspension, sanction, otherwise restricted) from any private health care program(s) or any health care program(s) funded in whole or in part by the state or federal government, including Medicare or Medicaid? If so, provide a detailed description of this matter, including the current status of your participation in such program(s).		☐ Yes	☐ No
4.	Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?	☐ N/A	☐ Yes	☐ No
5.	Have your narcotics registration certificates ever been limited, suspended, revoked, voluntarily or involuntarily surrendered or not renewed?	☐ N/A	☐ Yes	☐ No
6.	If applicable, is your federal (to include District of Columbia and territories of U.S.A.) and/or state narcotics registration certificate being challenged?	☐ N/A	☐ Yes	☐ No
7.	Have you been named as a defendant or convicted of a felony or misdemeanor?		☐ Yes	☐ No
8.	Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily denied, suspended, diminished, revoked, limited or not renewed at any health care facility?		☐ Yes	☐ No
9.	Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?		☐ Yes	☐ No
10.	Have you ever been the subject of disciplinary proceedings or a focus review based on inappropriate quality of care at any hospital or health care facility?		☐ Yes	☐ No
11.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?		☐ Yes	☐ No

X. PERSONAL HEALTH STATUS

Please answer each of the following questions in full AS THEY PERTAIN TO THE LAST TWO YEARS. If the answer to any question is "yes," please provide full explanation of the details on the appropriate Explanation Sheet.

1.	Do you currently have, or have you ever had any physical, mental, or emotional condition which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
2.	Have you ever been admitted to any hospital or been involved in a treatment program for any physical, mental or emotional condition which impaired or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No
3.	Do you currently have, or have you ever had a dependency on or abuse of the use of alcohol or drugs, or are you currently or have ever been involved in a treatment program for a dependency on or abuse of alcohol or drugs which impaired, or might reasonably be considered to impair, your ability to perform the procedures or provide the treatment for which you have requested clinical privileges or to meet the requirements of medical staff membership?	☐ Yes	☐ No

XI. PROFESSIONAL EMPLOYMENT AND AFFILIATIONS

A. Employment

List in chronological order all professional employment within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________________ __________ / __________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: __________ Fax: __________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ __________ / __________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: __________ Fax: __________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ __________ / __________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: __________ Fax: __________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________________ __________ / __________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: __________ Fax: __________ Email (if available): ______________________

Reason for leaving: ______________________

B. Affiliations

List in chronological order all professional affiliations within the past two (2) years, starting with your current position. This includes all hospitals, corporations, military assignments, government agencies, group practices, other healthcare facilities or other types of activity. Complete addresses must be included. Date must be in MM/YY format. If you have a gap in employment of more than thirty (30) days, please explain on a separate page. "See CV" is not acceptable. Please attach additional sheets if more space is needed.

Name: ______________________ Department: ______________________ __________ / __________
From (mm/yy) To (mm/yy)

Address: ______________________ Type of Privileges/Position: ______________________

City/St/ZIP: ______________________
City St ZIP ZIP+ Country

Phone: __________ Fax: __________ Email (if available): ______________________

Reason for leaving: ______________________

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ____

Name: ______________________ Department: ______________ ________ / ________
From (mm/yy) To (mm/yy)
Address: ______________________ Type of Privileges/Position: ______________
City/St/ZIP: ____
City St ZIP ZIP+ Country
Phone: __________ Fax: __________ Email (if available): ______________
Reason for leaving: ____

XII. PEER REFERENCES

Name two peers who have personal knowledge of your current clinical abilities, ethical character, who will provide specific written comments on these matters upon request from Hospitals, Medical Societies, or Authorized Credentialing Services. 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. The individuals should not be related to you by blood or marriage, training directors, partners/associates in your current group practice, or anyone with whom you have or anticipate having a financial relationship. Requested sources: practitioner in same specialty or practitioners with whom you have a referral pattern. If you recently completed training, you may use chief resident or other training colleague. Allied Health Professional should list their sponsoring physician, another physician and one peer from the same specialty as the applicant. Please note that you may be required to follow further directions of an individual hospital or facility in order to accommodate variations in medical staff bylaws.

Reference: ____
Address: ____
City/St/ZIP: ______________________ Country: ______________
Phone: __________ Fax: __________ Email (if available): ______________

Reference: ____
Address: ____
City/St/ZIP: ______________________ Country: ______________
Phone: __________ Fax: __________ Email (if available): ______________

XIII. AUTHORIZATION AND RELEASE OF APPLICANT (HEALTHCARE FACILITY RELEASE)

(Please read carefully before signing)

As a condition of applying for/accepting medical staff appointment or clinical privileges at the healthcare facilities listed in this application ("Hospital"), and whether or not my application is accepted, I acknowledge, consent, and agree as follows:

A) I extend absolute immunity to, and release from all liability, the Hospital, its authorized representatives, and third parties (as defined in subsection C below), for any good faith communications, recommendations, disclosures or administrative action involving and pertaining to: (1) applications for appointment, reappointment or clinical privileges; (2) periodic reappraisals; (3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, reappointment, or any other disciplinary action; (4) summary suspensions; (5) hearings and appellate reviews; (6) care evaluations; (7) utilization reviews; (8) any other healthcare facility, medical staff, department, service or committee activities; (9) my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and (10) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of the Hospital.

B) I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. The Hospital and its authorized representatives may consult with and obtain information, including otherwise privileged or confidential information, from the Hospital's medical staff appointees and employees and from any third party bearing on my professional qualifications, all matters listed in subsection A, and any other matters bearing on my satisfaction of the criteria for reappointment to the medical staff. I authorize all persons and organizations having any knowledge of such matters to release said information to the Hospital or its authorized representatives upon request and I consent to the reporting of disciplinary information described below in section C.

C) The term "Hospital and its authorized representatives" means the Hospital, its governing entity, persons who have any responsibility for or knowledge pertaining to the matters outlined in subsection A above, and authorized Centralized Verification Organization (CVO). The term "third party" means any individual, including a reappointee to the medical staff or other healthcare facilities, other physicians and health practitioners, government agencies, professional liability insurers, and other entities from whom or by whom the Hospital, authorized CVO, or other authorized representatives have requested or supplied information pertaining to matters in subsection A above.

I acknowledge and agree that: (1) medical staff reappointment and clinical privileges are not a right; (2) applications and requests will be evaluated in accordance with prescribed procedures defined in the Hospital and medical staff bylaws, rules and regulations; (3) I shall be bound by the medical staff bylaws, rules and regulations, and corporate compliance programs, as amended from time to time, of hospitals to which I now and may subsequently apply; (4) I pledge to provide for continuous care for my patients in the hospital; (5) Hospital or its authorized representatives and third parties acting in their official capacities will notify authorized CVO and appropriate governmental agencies, boards or professional associations of disciplinary or professional action taken with respect to me if required to be reported to the Kentucky Medical Licensure Board by KRS 311.606 or if required to be reported by the authorized CVO, by medical staff bylaws, or by any other state or federal law; and (6) that this authorization, attestation and release is irrevocable for any period during which I am an applicant for or have medical staff privileges at Hospital, or, if later in time, for as long as Hospital may be under a duty to report information pursuant to the Health Care Quality Improvement Act of 1986. Pub. L. 99-660.

I represent and warrant that at the time of this application and at all times while I maintain medical staff membership that (1) I am not nor have I ever been, excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid; (2) I have not been convicted under any state or federal law of any offense for which I could face mandatory exclusion from participation in any state or federal health care program, including Medicare and Medicaid; (3) I have not committed any act for which I may be permissibly excluded from participation in any state or federal health care program, including Medicare and Medicaid; (4) I do not hold, and have never held, a direct or indirect ownership or controlling interest of five percent (5%) or more in any entity that has been excluded or suspended for any period of time whatsoever from participation in any state or federal health care program, including Medicare and Medicaid, nor have I ever been an officer, director, agent, or managing employee of any such entity; and (5) I have never been convicted of a federal health care offense as defined in 18 U.S.C. § 24, including any theft, embezzlement, fraud, or other acts as prohibited therein with regard to any public or private health plan. I agree to notify Hospital immediately in the event I am unable to maintain one or more of these representations.

D) Information and documents derived from or compiled in connection with matters listed in subsection A above, shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination of any status or privilege granted in reliance upon it.

Applicant's Signature: _____ **Date:** _____