APPLICATION CHECKLIST

for Appointment to the Medical Staff

You must submit the following documents with your application:

- ☐ Texas Department of Insurance - Texas Standardized Credentialing Application
  Download the application at http://www.tdi.state.tx.us/forms/lhlhmo/lhl234.doc
  This document cannot be saved to this website. You may complete the application and save a copy on your hard drive. Please print, sign, date and return a signed version to the Medical Staff Office
- ☐ UTMB Hospital Addendum *pages 2-5*
- ☐ Four (4) recent passport style photos
- ☐ A copy of your current and valid Photo ID issued by State or Federal agency
- ☐ A current copy of your Texas State Medical License certificate, *if applicable*
  You can apply for licensure through the Texas Medical Board website at
  http://www.tmb.state.tx.us/professionals/physicians/physicians.php
  or call (512) 305-7130 for information.
  Please be aware that the licensure process in Texas takes at least 3 to 6 months
  OR
  A current copy of your Texas Nursing License certificate, *if applicable*
- ☐ A current copy of your DEA certificate, *if applicable*.
  The registration process takes 4-6 weeks: Apply online at:
  https://www.deadiversion.usdoj.gov/webforms/jsp/regapps/common/newAppLogin.jsp
- ☐ A current copy of your DPS certificate, *if applicable*.
  The registration process takes 3-4 weeks: Request application via email to: **tppcsr@txdps.state.tx.us**
  or call (512) 424-2188 to request an application
- ☐ A completed Department/Division Clinical Privilege(s) form for the privileges you are requesting, including any required documentation to support your request
- ☐ Medicare Acknowledgement Statement form *page 6*
- ☐ If Allied Health Professional, complete and sign the Delegation of Prescriptive Authority form *page 7*
- ☐ Current CV in UTMB format. See sample format, *attached* *page 8*
- ☐ Supporting documentation for CME or CEU credits
- ☐ Copy of Board Certification certificate(s), *if applicable*
- ☐ Copy of ECFMG Certificate, *if applicable*
- ☐ Medical Staff Dues ($45.00) – check made payable to “Medical Staff Dues Fund”
- ☐ If you are providing your own Malpractice Liability Coverage, please submit proof of coverage with amounts and expiration. Must include carrier, dates and amounts of coverage.

utmb Health

MEDICAL STAFF SERVICES

UTMB HOSPITAL ADDENDUM

TO THE TEXAS DEPARTMENT OF INSURANCE STANDARDIZED CREDENTIALING APPLICATION

301 University Blvd, Room 7.144 JSA
Galveston, TX 77555-0519, Office (409)772-5281 Fax (409) 747-2004

Attach four (4)
Recent
Passport size (2x2) photos

PERSONAL INFORMATION

Last Name:	First Name:	Title (i.e MD, DO, APN, PA)
UTMB Route Number:	Full or Part Time:	UTMB Faculty Rank:
Department:	Division:	Anticipated Start Date:
Email:	Cell Phone Number:	Pager:

ADDITIONAL INFORMATION

1. The Texas Standardized Credentialing Application request an explanation for any time gaps greater than six (6) months. UTMB requires that if you have had gaps of thirty (30) days or more in your work history an explanation is required for each. Please explain gaps below.

_____

_____

_____

2. Have you **EVER** had any malpractice actions (pending, settled, arbitrated, mediated or litigated)? ☐ Yes ☐ No
If YES, please complete and **submit attachment G** of the Texas Standardized Credentialing Application.

ALLIED HEALTH PROFESSIONALS

Only complete this section if you are an ANP, PA, etc.

1. Will you be providing prescriptive services at UTMB? _____Yes _____No
2. Will you be prescribing controlled substances at UTMB? _____ Yes* _____ No

If YES, please submit a copy of your required DEA and DPS certificates.

3. If YES to question #1, who is your UTMB supervising physician? _____

APPLICANT'S NAME: _____
(please print)

FOR PHYSICIANS ONLY: **Texas Medical Licensure Information**	**Check one**
Do you have an unrestricted Texas Medical License?	NO:_____ YES:_____
If NO, have you submitted an application to the Texas Medical Board (TMB)? ➢ Date application submitted to TMB_____	NO:_____ YES:_____

CONTINUING EDUCATION

I have obtained the following CME/CEU credits for credentialing requirements at UTMB. Additionally, these continuing education courses satisfy state requirements needed to maintain and renew my license to practice in my field and in the State of Texas through my respective licensing board and related, at least in part to the clinical privileges granted to me. I further understand it is my responsibility to maintain documentation for my respective licensing agency should I be audited or required to produce such information.

PHYSICIANS **Number hours earned during the past two years**	
Category I Continuing Medical Education Credits	Number:
Category II (informal) Continuing Medical Education Credits:	Number:

ALLIED HEALTH PROFESSIONALS **Number hours earned during the past two years**	
Category I Continuing Education Credits	Number:
Category II (informal) Continuing Education Credits:	Number:

Please include a list and/or evidence of the CME/CEU credits obtained during the previous 2 years

APPLICANT'S NAME: _____
(PLEASE PRINT)

PLEASE COMPLETE PEER INFORMATION ON THIS FORM AND RETURN WITH YOUR APPLICATION. OUR OFFICE WILL CONTACT YOUR PEERS. PLEASE USE THE SAME PEERS AS LISTED ON YOUR TEXAS STANDARDIZED CREDENTIALING APPLICATION. References must have firsthand knowledge of your abilities within the past five (5) years and cannot be a relative. Three (3) peer references are required.
A peer is defined as a practitioner in the same professional discipline.

Peer 1 (Please print clearly)

Name: _____

Business Address: _____

City: _____ State/Zip: _____

Fax number: _____ Phone: _____

e-mail address: _____

Peer 2 (Please print clearly)

Name: _____

Business Address: _____

City _____ State/Zip _____

Fax number: _____ Phone: _____

e-mail address: _____

Peer 3 (Please print clearly)

Name: _____

Business Address: _____

City _____ State/Zip _____

Fax number: _____Phone: _____

e-mail address:_____

CONSENT AND RELEASE

I fully understand that any significant misstatements in or omissions from this application constitute a cause for denial of appointment or reappointment or cause for summary dismissal from the medical staff at The University of Texas Medical Branch at Galveston. All information submitted by me on the Texas Department of Insurance Standardized Credentialing Application and on this Addendum is true, correct and complete, to my best knowledge and belief. I understand I have the right to review information in support of my credentialing application. I understand I have the right, upon request to be informed of the status of my credentialing application. Additionally, I will be informed if information received during the credentialing process differs from information I have reported on my application and I will have the right to correct erroneous information.

By applying for appointment/reappointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualification. I hereby further consent to a criminal background check, the inspection by the hospital, its staff and its representatives of all records and document, 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 moral and ethical qualifications for staff membership. I hereby consent to the release from liability all representative of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its medical staff, in good faith and without malice concerning my professional competence, ethics, and other qualifications for staff appointment/reappointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, 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 also agree that should an adverse decision be made with respect to my staff membership, state status, and/or clinical privileges, I will exhaust the administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action.

I will not participate in any form of fee-splitting. Moreover, I pledge myself to shun unwarranted publicity, dishonest money-seeking, and commercialism. I have not requested privileges for any procedures for which I am not trained. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

I agree to report health problems that would affect my ability to practice medicine, and will agree to submit to a health examination acceptable to the Credentials or Medical Staff Executive Committee, should this be considered necessary. I further agree to report any changes in my staff membership status at any other hospitals or changes to my health that may occur during the next two years.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS CONSENT AND RELEASE, WHICH SHALL REMAIN VALID THROUGHOUT THE TERM OF MY APPOINTMENT/REAPPOINTMENT TO THE MEDICAL STAFF AT THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON.

Applicant's Signature _____ **Date** _____

Print Name: _____

MEDICARE ACKNOWLEDGEMENT STATEMENT

"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, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. "

I have read and understand the aforementioned statement.

_____

Applicant's Signature

_____

Applicant's Printed/Typed Name

_____

Date

DELEGATION OF PRESCRIPTIVE AUTHORITY

FOR ALLIED HEALTH PROFESSIONALS ONLY

If you are a Physician, you DO NOT need to submit this form

COMPLETE ONE (1) FORM PER DELEGATED PHYSICIAN *(make copies as needed)*

If you are writing prescriptions for Dangerous Drugs and Schedules III – V you must provide a DEA and DPS certificate.

Practitioner's Name Department Division

_____ _____ _____
Name Department Division

UTMB Practice Location

_____ _____ _____ _____
Address City State Zip

Telephone Number _____ Texas License Number _____

If you are an Advanced Practice Nurse please provide your Prescriptive Authority Number _____

Describe practice location: _____Primary Site (must have same practice address as the physician)
_____Medically Underserved Area or Population
_____Alternate Practice Site

Allied Health Professionals Signature: _____

TO BE COMPLETED BY THE UTMB SUPERVISING PHYSICIAN

UTMB Supervising Physician's Name (Please Print) _____ _____ _____
Last First Middle

Telephone Number _____Texas License Number _____

Delegation Begin Date _____ End Date (if applicable) _____

Submitting and signing this form is considered acknowledgement that, I hereby accept professional and legal responsibility for the oversight of the AHP's prescriptive practices.

UTMB Supervising Physicians Signature: _____

UTMB CURRICULUM VITAE
FORMAT SAMPLE

NAME:

PRESENT POSITION AND ADDRESS: (month/year date format)

BIOGRAPHICAL: (i.e. Birthdate (optional); Birthplace (optional); Citizenship; Business Address and Telephone; Home Address and Telephone)

EDUCATION: Start date (month/year date format) and End date (month/year date format)

BOARD CERTIFICATION: (mm/dd/yy)

LICENSURE INFORMATION: (mm/dd/yy)

PROFESSIONAL WORK HISTORY AND TEACHING EXPERIENCE: (academic; non-academic)
(The last five years of your work history must reflect start date month/year date format and end date month/year date format

RESEARCH ACTIVITIES: If applicable
- Area of Research
- Grant support
  - Current
  - Pending
  - Past

COMMITTEE RESPONSIBILITIES: If applicable

TEACHING RESPONSIBILITIES
- A. TEACHING RESPONSIBILITIES AT UTMB:
- B. TEACHING RESPONSIBILITIES AT OTHER UNIVERSITIES (AT THE UNIVERSITY OF ….)

MEMBERSHIP IN SCIENTIFIC SOCIETIES/PROFESSIONAL ORGANIZATIONS:

HONORS:

ADDITIONAL INFORMATION:
- Editorial Board
- Journal Reviewer for
- Grant Reviewer for
- Professional Skills (i.e. Faculty mentor, professional development endeavors)
- Other

PUBLISHED:
- A. ARTICLES IN PEER-REVIEWED JOURNALS:
- B. OTHER:
  - Thesis/Dissertation
  - Proceedings and Symposia
  - Reviews
  - Book Chapters
  - Varia (online modules, CDs)
- C. ABSTRACTS:

PUBLICATIONS - IN PRESS:
PUBLICATIONS - SUBMITTED:
PAPERS AND CONTINUING EDUCATION PROGRAMS PRESENTED:
INVITED LECTURES AT SYMPOSIA AND CONFERENCES:
INVITED LECTURES - OFF CAMPUS:

Legislation Requiring Electronic Death Registration

ALL UTMB MEDICAL STAFF MUST BE REGISTERED BY EMPLOYMENT START DATE

House Bill 1739, which mandates electronic death registration for funeral homes and medical certifiers, was signed by the Governor on June 15, 2007, and took effect on September 1, 2007. Section 193.002 of the Texas Health & Safety Code now requires the person in charge of interment or in charge of removal of a body from a registration district for disposition to file death certificates electronically as specified by the State Registrar.

Likewise, Section 193.005 requires that medical certifiers on a death certificate submit the medical certification and attest to its validity using an electronic process (currently Texas Electronic Registrar) approved by the State Registrar.

Please register immediately by clicking on http://www.dshs.state.tx.us/vs/edeath/

Failure to register and be in the system by employment start date could result in formal complaint to Texas Medical Board by family member, funeral home, medical examiner etc. All complaints to Texas Medical Board will be investigated and may result in loss or restriction on training permit or medical license.

Below is a sample of the online registration form that includes data required to successfully complete registration and process as UTMB Medical Staff. An Institutional email account GME.TERNotice@utmb.edu has been created for data entry under field name 2nd TER Facility Contact Email Address. The State's database will release a secondary notice to GME.TERNotice@utmb.edu and the Institutional GME Office will retrieve, then contacting Medical Staff Services to ensure action is taken by medical staff members.

CONTACTS:

Roger Faske, Manager – Central Texas – 512-458-7111 ext 2530
Albert Rivera, Team Lead – South and West Texas – 512-458-7111 ext 2949
Deborah Austin – UTMB Administrative Secretary, Autopsy Division – 409-772-2859 or daustin@utmb.edu