John C. Lincoln
HEALTH NETWORK

Honored by Experts. Honored to Serve.

Dear Allied Health Professional:

Thank you for your interest in applying to John C. Lincoln Health Network Allied Health Professional Staff. The Medical Staffs bylaws, rules and regulation, as well as department rules and regulations are available online for your review at www.jcl.com/credentialing. Also enclosed are the following for you to complete and return:

- Application
- Invoice for non-refundable application fee **(can now be paid online, see invoice)**
- Applicant Agreement/Release of Information and Liability
- Practitioner Code of Conduct
- Privilege delineation form **(print from website for each facility you are applying)**
- Applicable job scope/description
- Physician sponsor agreement form **(1 for each Board Approved physician on staff you will be working with)**
- Statement of Allied Health Professional
- CME log **(complete the log only, NO certificates. Must meet criteria on form)**
- Notice of Identity verification and Badge requirement **(required before privileges granted)**
- TB Test **Results** within 24 months or TB Questionnaire **(Chest X-ray result only if test positive)**
- NPI form
- Background Check authorization and request forms

Please attach copies of the following documents

- Curriculum Vitae
- Current Malpractice Insurance Certificate ($1million minimum with approved carrier)
- Board Certification certificate
- Case logs for past 2 years for those privileges requesting (**MUST be list of procedures and how many practitioner has complete-NO other log format will be accepted)**

PLEASE BE ADVISED THAT DATES & SIGNATURES ARE ONLY VALID FOR SIX MONTHS.

If you have any questions, please feel free to contact the Credentialing office at 623-434-6104. Again, thank you for your interest in John C. Lincoln Network hospitals and we look forward to working with you.

John C. Lincoln
HEALTH NETWORK

** IMPORTANT INFORMATION **

IDENTITY VERIFICATION/ID BADGE

John C Lincoln Health Network is requiring all new applicants requesting privileges to provide positive identity verification.

***Prior to an applicant's first day of practice in the Hospital, each applicant shall present to the* Medical Staff Services office (at either campus) to verify his/her identity and present a legible government issued ID card (current driver's license; military card or passport) or a federal/state government ID with a current photo.**

In addition, JCL has instituted a policy requiring all practitioners with approved privileges to be issued photo ID badges which are to be worn when on either campus for security and patient safety purposes. You can have your photo taken for your ID badge at the same time you come in to do your identity verification.

****Please be advised that in accordance with Medical Staff Bylaws Article (6) six, failure to verify identity within 90 days of notification or prior to practicing in the Hospital (which ever comes first) will result in the automatic termination of your privileges.**

If you have any questions, please call either Medical Staff Services Department:

John C. Lincoln North Mountain
250 East Dunlap Avenue
Phoenix, AZ 85020
(602) 870-6317

John C. Lincoln Deer Valley
19829 North 27th Avenue
Phoenix, AZ 85027
(623) 879-5409

THIS FORM IS FOR YOUR RECORDS- DO NOT RETURN

John C. Lincoln
HEALTH NETWORK

Network Credentials Verification Office
Date Reviewed:_____Initials: _____
Basic Req. met: ☐ Yes ☐ No
Application complete? ☐ Yes ☐ No
Date app complete: _____

APPLICATION FOR ALLIED HEALTH MEMBERSHIP

(__) North Mountain (__) Deer Valley

Name: _____ Degree:_____ DOB:_____ Place of Birth_____

List other names used: _____Citizenship_____

Specialty: _____ Social Sec #:_____

Home Address_____
City State Zip

Home Phone: _____ Name of Spouse:_____

Cell Phone Number: _____ Pager Number: _____

e-mail address:_____

I. Current/Future Practice Information

Name of **Current** practice group or Professional Corporation:_____

Dates of Affiliation *(or anticipated start date*): From: _____To:_____ Contact Person: _____

Address:_____City:_____State:_____Zip_____

Phone Number: _____ Fax Number: _____

Secure e-mail address for correspondence & Reappointments: _____
(REQUIRED)

Name(s) of Sponsoring Physician/Employer:_____

Reason for leaving: _____

☐ Not leaving current practice

Name of **Future** practice group or Professional Corporation:_____

Dates of Affiliation *(or anticipated start date*): From:_____ To:_____ Contact Person:_____

Address:_____City:_____State:_____Zip_____

Phone Number:_____ Fax Number: _____

Secure e-mail address for correspondence & Reappointments: _____

Name(s) of Sponsoring Physician/Employer:_____

II. Practice History (Please list all positions held for the past 10 years, LEAVE NO TIME GAP UNACCOUNTED FOR.

1. Name of practice group or professional corporation:_____

   Dates of Affiliation: From:_____ To:_____ Contact Person: _____

   Address:_____City:_____State:_____Zip_____

   ***Phone Number: _____ *Fax Number: _____ *Email:_____**

   *Reason for leaving: _____

2. Name of practice group or professional corporation:_____

   Dates of Affiliation: From:_____ To:_____ Contact Person: _____

   Address:_____City:_____State:_____Zip_____

   ***Phone Number: _____ *Fax Number: _____ *Email:_____**

   *Reason for leaving: _____

3. Name of practice group or professional corporation:_____

   Dates of Affiliation: From:_____ To:_____ Contact Person: _____

   Address:_____City:_____State:_____Zip_____

   ***Phone Number: _____ *Fax Number: _____ *Email:_____**

   *Reason for leaving: _____

4. Name of practice group or professional corporation:_____

   Dates of Affiliation: From:_____ To:_____ Contact Person: _____

   Address:_____City:_____State:_____Zip_____

   ***Phone Number: _____ *Fax Number: _____ *Email:_____**

   *Reason for leaving: _____

5. Name of practice group or professional corporation:_____

   Dates of Affiliation: From:_____ To:_____ Contact Person: _____

   Address:_____City:_____State:_____Zip_____

   ***Phone Number: _____ *Fax Number: _____ *Email:_____**

   *Reason for leaving: _____

(If additional space is needed, attach separate sheet)**

III. Education/Training (applicable to position - attach copies of degrees/certificates.

School Name_____

Degree:_____ Dates attended from:_____ to:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____Fax Number: _____

School Name_____

Degree:_____ Dates attended from:_____ to:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____Fax Number: _____

School Name_____

Degree:_____ Dates attended from:_____ to:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____Fax Number: _____

(If additional space is needed, attach separate sheet)**

IV. Hospital Affiliations

1. Please list all Hospitals and Surgery Centers at which you are or were a member of the allied health staff during the previous 10 years, or to which you are in the process of applying for allied health staff membership.
   If Hospital/Facilities are out of Arizona, provide contact information for the Medical Staff office.

   ***Primary Hospital Affiliation**:_____

   Address:_____City:_____State:_____Zip_____

   Phone Number: _____Fax Number: _____

   Dates of Affiliation: From:_____ To:_____

IV. Hospital Affiliations Cont.

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

***Healthcare Facility**:____

Address:_______________________________City:______________State:_____Zip_________

Phone Number: _________________________Fax Number: _________________________

Dates of Affiliation: From:____________ To:_____________

2. Have you ever voluntarily/involuntarily withdrawn/terminated your allied health staff application/ membership or voluntarily/involuntarily experienced a limitation, reduction, or loss/denial of clinical privileges at another hospital/healthcare facility? No___ Yes___*
IF YES, PLEASE EXPLAIN:_____

3. Are you currently, or have you ever been subject to disciplinary or corrective action, such as admonition, censure, reprimand, probation, nonprovisional supervision, suspension, termination, revocation, or reduction of privileges by any allied health staff and/or healthcare organization? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

V. Licensure (attach copies of current licenses)

1. List **ALL** state licenses applied for or issued *(if license not issued, please state reason)*:

State	License #	Date Issued	Expiration Date

2. Has any license entitling you to practice your profession in any jurisdiction ever been investigated, denied, suspended, placed under stipulation, limited, revoked or been voluntarily/ involuntarily relinquished or has a letter of censure or concern been issued to you? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

3. Has your narcotics license ever been refused, suspended, limited, revoked, or voluntarily/involuntarily relinquished, or is it currently being challenged or investigated? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

4. Are you presently being investigated by any licensing agency? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

VI. DEA REGISTRATION

DEA Number: _____ Expiration Date:_____ ☐ DEA Pending ☐ I do not have a DEA

VII. Board Certification Status

Please provide information regarding your Board Certification status.

Board Name	(Year Certified)	(Year Recertified)	(Expiration)

Board Name	(Year Certified)	(Year Recertified)	(Expiration)

VIII. Health Status

1. Do you have any medical or psychological condition that is reasonably likely to affect your ability to perform professional or medical staff duties? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

2. Are you presently, or have you ever been dependent on or treated for alcohol or drugs? No___ Yes___*
*IF YES, PLEASE EXPLAIN:*_____

3. Are you able to perform all the services and essential functions of a practitioner with the privileges you are requesting, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes___ No___*
   *IF NO, PLEASE EXPLAIN:*_____

4. Are you currently taking medication or under any other therapy that is reasonably likely to affect your ability to perform professional or medical staff duties? No___ Yes___*
   *IF YES, PLEASE EXPLAIN:*_____

IX. Other Pertinent Information

1. Have you ever been charged with a crime involving alcohol or controlled substances? No___ Yes___*
   *IF YES, PLEASE EXPLAIN:*_____

2. Have any felony and/or misdemeanor criminal charges ever been brought against you? No___ Yes___*
   *IF YES, PLEASE EXPLAIN:*_____

3. Have you ever been suspended, sanctioned, investigated or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare, Blue Cross)? No___ Yes___*
   *IF YES, PLEASE EXPLAIN:*_____

X. Professional Liability Insurance (attach copy of current certificate)

Please list current professional liability insurance information and list ALL policies under which you've been covered for the previous 10 years.

Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____ City _____ State _____Zip _____

Phone Number:_____ Fax Number:_____

Dates of coverage: From:_____ To: _____ Retro Date: _____

PRIOR CARRIERS:

1) Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____
City State Zip

Phone Number:_____ Fax Number:_____

Dates of coverage: From:_____ To: _____

PRIOR CARRIERS CONT: (If additional space is needed, attach separate sheet)

2) Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____
City State Zip

Phone Number:_____ Fax Number:_____

Dates of coverage: From:_____ To: _____

3) Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____
City State Zip

Phone Number:_____ Fax Number:_____

Dates of coverage: From:_____ To: _____

4) Name of Policyholder:_____ Policy #:_____

Name of Insurance Carrier:_____

Mailing Address:_____
City State Zip

Phone Number:_____ Fax Number:_____

Dates of coverage: From:_____ To: _____

---

1. Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, judgments, arbitration proceedings or complaints involving your professional practice? No___ Yes___*

* **If YES, you must complete the attached "Confidential Information Report" below for EACH claim, suit, settlement, or judgment. (*If more than one, please copy the Information Report for each*.)**

2. Does your malpractice coverage exclude you from providing any specific procedures or practicing any portions of your specialty? No___ Yes___*

*IF YES, PLEASE EXPLAIN:*_____

3 . Has your malpractice insurance been canceled or denied by any carrier? No___ Yes___*

*IF YES, PLEASE EXPLAIN:*_____

XI. Peer Review & Competency References

In support of my application for clinical activities at John C. Lincoln North Mountain Hospital and/or John C. Lincoln Deer Valley Hospital, I submit the following names of four peer references (no relatives, or current/pending employers or associates) who can attest to my current competency.

A peer is considered someone in the same specialty, example: a Physician Assistant would provide names of other Physician Assistants, Nurse Practitioners would provide names of other Nurse Practitioners, etc. The peer reference must address your training or experience, clinical competence, and ability to perform the privileges requested.

PLEASE INCLUDE FAX NUMBERS/E-MAIL ADDRESS TO EXPEDITE THE PROCESS

Name: _____ Specialty: _____

Address: _____ City: _____ State: ____ Zip Code:_____

***Phone:** _____ ***Fax:** _____ ***E-mail:** _____

Name: _____ Specialty: _____

Address: _____ City: _____ State: ____ Zip Code:_____

***Phone:** _____ ***Fax:** _____ ***E-mail:** _____

Name: _____ Specialty: _____

Address: _____ City: _____ State: ____ Zip Code:_____

***Phone:** _____ ***Fax:** _____ ***E-mail:** _____

Name: _____ Specialty: _____

Address: _____ City: _____ State: ____ Zip Code:_____

***Phone:** _____ ***Fax:** _____ ***E-mail:** _____

***Indicates required information**

XII. TIME GAPS *(must account for time gaps less than 90 days. Gaps greater than 90 days must be accounted for by you and verified in writing by someone other than yourself. You must account for all time gaps that occurred during the previous 10 years.*

☐ **I have no time gaps**

1) From: _____ To: _____

Explanation:

_____

_____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: _____ *P#: _____ *F#: _____

Address: _____ City: _____ State: _____ Zip: _____

==========

2) From: _____ To: _____

Explanation:

_____

_____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: _____ *P#: _____ *F#: _____

Address: _____ City: _____ State: _____ Zip: _____

==========

3) From: _____ To: _____

Explanation:

_____

_____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: _____ *P#: _____ *F#: _____

Address: _____ City: _____ State: _____ Zip: _____

(*If additional space is needed, attach separate sheet)*

John C. Lincoln
HEALTH NETWORK

CONFIDENTIAL INFORMATION REPORT
(Pursuant to A.R.S. 36-445.01)

If you answered "yes" to question 1 under Section XIII of the Application for Membership, you must furnish the following information regarding each lawsuit or complaint. Attach copies of all documentation relating to each case. You may choose to have your attorney complete this form, but it is your responsibility to provide additional documentation.

_____ _____ _____
Mo/Yr of Incident Where Incident Occurred Name of Plaintiff(s)

Nature of Incident:_____

_____

_____

_____

Outcome of Incident:

Dropped_____ Dismissed_____ Pending_____ Settled_____ Amount $_____

Verdict: for You_____ For Plaintiff_____ Amount $_____

Recommendation by Legal Panel:

For You_____ For Plaintiff_____ Not Presented to Panel_____

Represented by legal counsel for this claim/malpractice lawsuit? Yes _____ No _____

Name of Insurance Company that provided coverage for this claim:

Insurance Cmpany:_____

Address & Telephone Number_____

_____ _____
Physician Signature Date

_____
Name (please print)

Additional information may be provided on a separate sheet.

JOHN C. LINCOLN HEALTH NETWORK
INVOICE APPLICATION FEE

****You can now pay your application fees online ****
www.jcl.com/credentialing
click on **"make payment now"**

OR YOU CAN MAIL YOUR PAYMENT TO:

John C. Lincoln Health Network
Credentialing Office
2500 W Utopia Rd #100
Phoenix, AZ 85027

Please make check payable to:
"John C Lincoln Health Network"

NORTH MOUNTAIN ONLY ALLIED HEALTH PROFESSIONAL	DEER VALLEY ONLY ALLIED HEALTH PROFESSIONAL
$335.00	$300.00

NETWORK PEDIATRIC ALLIED HEALTH PROFESSIONAL
$300.00

BOTH NORTH MOUNTAIN & DEER VALLEY HOSPITALS ALLIED HEALTH PROFESSIONAL
$435.00

NOTE: The application fee or proof of online payment must accompany the application. If payment is not received, your application will not be processed. This application fee is non-refundable unless qualifications for privileges are not met. If you are applying for both North Mountain and Deer Valley at the time of initial application, you will only pay one application fee. If you have any questions, please call (623) 434-6104.

THIS FORM IS FOR YOUR RECORDS- DO NOT RETURN

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS AND CLINICS

APPLICANT'S AGREEMENT RE: RELEASE OF INFORMATION AND REALASE OF LIABILITY

In making application to be appointed/reappointed to the Allied Health Staff(s) of one or more of the John C. Lincoln Health Network ("Lincoln") Hospitals and/or to be employed by a medical practice owned by John C. Lincoln or one of its affiliates ("Clinic"), I state that the foregoing information is complete and accurate to the best of my knowledge and belief. I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment, reappointment or employment and/or cause for summary dismissal from the Allied Health Staff(s) and/or from employment.

In making this application for Appointment or Reappointment to the Allied Health Staff(s) of these Hospitals and/or Employment at a Clinic, I acknowledge that I have received the Bylaws, Rules and Regulations of the Medical Staff(s) of these Hospital(s) and/or Policies of the Clinic (if applicable); and that I shall abide by the principles of medical ethics of the American Medical Association and/or the American Osteopathic Associations and the Bylaws, Rules and Regulations of the Hospital(s) and Policies of the Clinic (if applicable). I agree to be bound by the terms thereof if I am appointed/employed.

By applying for Appointment or Reappointment to a Lincoln Hospital Allied Health Staff and/or employment by a Clinic, I hereby authorize the Lincoln Hospitals and/or Clinics and their Medical Staff(s) and representatives to consult with representatives and members of the 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, health status and ethical qualifications. I hereby further authorize and consent to the duplication and release by such entities to the Hospitals, Clinics, their Medical Staffs 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 and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for Allied Health Staff privileges or employment.

I hereby release from liability all representatives of the Lincoln Hospitals, Clinics and their Medical Staffs for their acts performed in connection with evaluating my applications and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to the Lincoln Hospitals, Clinics or their Medical Staffs concerning my professional competence, ethics, character and other qualifications for clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by the Lincoln Hospitals, Clinics or their Medical Staffs to other hospitals, medical associations or third party payers with established credentialing mechanisms upon request regarding any information the Hospitals, Clinics or their Medical Staffs may have concerning me. I hereby release from liability and hereby grant and extend absolute immunity to the Lincoln Hospitals, Clinics and their Medical Staffs and all of their employees and representatives for so doing.

I pledge to provide continuous care for my patients at the Lincoln Hospitals, to delegate the responsibility for the care of my patients' only to qualified practitioners and only to members of the respective Medical Staffs of the Lincoln Hospitals. I hereby agree that, if requested, I shall appear for interviews before the appropriate committee(s) of the Medical Staff(s).

I understand and agree that information involving my clinical privileges, competence, character, health status and ethical qualifications, including privileged and confidential credentialing and peer review information, will be shared by and among the Lincoln Hospitals and Clinics during the appointment, reappointment and/or employment processes and at any time thereafter including immediately upon the imposition of a summary suspension of my Allied Health Staff privileges at one or both Hospitals in accordance with Lincoln's Sharing of Peer Review Information Policy.

I understand and agree that I, as an applicant for appointment or reappointment to the Allied Health Staff of Lincoln Hospital and/or employment by a Clinic, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications for continued Allied Health Staff privileges and or employment and for resolving any doubts about such qualifications.

In addition, I agree to promptly (not later than thirty (30) days) notify the Chief Executive Officer of any Lincoln Hospital and/or Clinic at which I have privileges and/or employment, of my receipt of notice of any lawsuit or claim concerning my professional care or treatment of a patient, or of any circumstances arising subsequent to the date of this Agreement which would change any of the responses I have provided in my application.

The authorizations, commitments and releases granted herein shall continue in full force and effect and shall survive not only the application process for appointment and reappointment to the Allied Health Staff(s) of the Hospitals and/or employment at a Clinic, but also during and following the termination of my appointment to such Allied Health Staff(s) and/or employment by a Clinic.

_____ Dated this _____day of _____, 201___

Signature

_____

Printed Name

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
NORTH MOUNTAIN - DEER VALLEY

STATEMENT OF THE PHYSICIAN WHO EMPLOYS, SUPERVISES, COLLABORATES, OR SPONSORS THE ALLIED HEALTH PROFESSIONAL

(I hereby) request that _____ ("AHP") be granted permission to perform clinical activities and assist with procedures ("services") in accordance with the accepted scope of practice for AHP's category of practice.

I am familiar with AHP's qualifications, character, competence, and health status and believe that he/she is qualified to provide the Services requested. I further agree to supervise, to the extent the law requires AHP to be supervised, and to assume responsibility for supervising AHP, as set forth in the attached scope of practice.

As a responsible physician, I will provide Medical Liability Insurance: Yes____ No ____

If yes, medical malpractice insurance coverage is provided

by:_____("Carrier").

I agree to notify John C. Lincoln North Mountain or Deer Valley Hospital immediately upon notification from carrier of any change that may affect the coverage provided to AHP or me, or if any change occurs that would affect the Carrier.

I further agree to notify John C. Lincoln North Mountain or Deer Valley Hospital immediately, in writing, if my professional relationship with AHP is terminated or otherwise restricted in any way, and the reasons for such.

I am currently a member in good standing of the Medical Staff of John C. Lincoln North Mountain and/or Deer Valley Hospital. Any suspension or termination, temporary or permanent, of my membership or privileges at John C. Lincoln North Mountain or Deer Valley Hospital shall result in the suspension or termination of AHP's clinical activities at John C. Lincoln North Mountain or Deer Valley Hospital.

_____
Physician (Please Print)

_____ _____
Physician Signature Date

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
NORTH MOUNTAIN – DEER VALLEY

STATEMENT OF ALLIED HEALTH PROFESSIONAL

In consideration for my being granted permission to perform certain clinical activities and to assist with certain procedures in John C. Lincoln – North Mountain or Deer Valley (the "Hospital"), I hereby agree that I will not perform any clinical activities or assist with any procedures in the Hospital without proper medical supervision or direction by a physician on the Hospital's Medical Staff with appropriate privileges. I further agree not to perform any clinical activities or assist with any procedures which are beyond the scope of my training, experience, licensure/certification or the activities or procedures which I have been given permission to perform in the Hospital.

I further agree to maintain medical malpractice insurance coverage covering all of my activities in the Hospital. If such coverage is provided under a policy issued in my name, rather than the name of my supervising physician, I agree to notify the Hospital immediately upon notification from my medical malpractice insurance carrier of any change that may affect the coverage provided to me, or if any change occurs that would affect the carrier.

I further agree to notify the Hospital immediately, in writing, if my professional relationship with my supervising physician is terminated or otherwise restricted in any way, and the reasons for such.

Date:_____ _____
Allied Health Professional (Please Print)

_____
Allied Health Professional Signature

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
NORTH MOUNTAIN - DEER VALLEY

CONTINUING EDUCATION LOG

Allied Health Professional: _____

Please list below or attach a complete listing of all Continuing Education Programs (CME) you attended during the past two (2) years. You may use the reverse side if necessary. NOTE: Copies of certificates will NOT be accepted and programs should be directly related to your specialty.

DATE	COURSE	# OF HOURS

TOTAL NUMBER OF HOURS: _____

John C. Lincoln
HEALTH NETWORK

TO: Applicant

FROM: Leslie Robinson, MD
Chairman, Infection Control Committee

SUBJECT: **TB SKIN TEST**

The Arizona Department of Health Services (DHS) requires each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis at least once every 24 months or more often as required by the hospital's infection control committee. This evidence of freedom from infectious pulmonary tuberculosis can be established by a current report of a TB skin test.

If a medical staff or allied health member signs this attestation and cannot produce this evidence upon request, DHS has indicated that it will report the practitioner to AMB/OBEX or the appropriate licensing board.

If you need a TB skin test done, we can assist you through:

****John C. Lincoln North Mountain Hospital at:**

	Direct Dial #
Employee Health Services	602-870-6332
Becky Saria, Infection Control Practitioner	602-870-6060 X1320

The test is available between 7:30 a.m. and 4:00 p.m., Monday through Friday.

****John C. Lincoln Deer Valley Hospital at:**

	Direct Dial #
Employee Health Services	623-879-5499
Becky Saria, Infection Control Practitioner	602-870-6060 X1320

The test is available between 7:30 a.m. and 4:00 p.m., Monday through Friday. **Please bring this form with you if you have your TB test done at Deer Valley.**

***IF you have a history of a positive TB skin test, please contact the Medical Staff office at 602-331-5805 and we will provide you with a health questionnaire.**

Applicant must sign below:

I attest that I was evaluated for infectious pulmonary tuberculosis and am providing written results of a negative TB skin test or Chest x-ray results, if I have tested positive, showing that I am free from TB

Results dated: _____

_____ _____
Signature **Date**

John C. Lincoln
HEALTH NETWORK

M E M O R A N D U M

TO: New Applicants

FROM: Medical Staff Services

RE: **NPI Number**

Effective May 23, 2007, CMS will only accept your National Provider Identifier **(NPI)** number for electronic transactions for healthcare. All practitioners must have an NPI number. All claims submitted by the hospital must have the practitioners NPI number on it.

You can apply for your NPI number beginning May 23, 2005 by submitting an online application.
(https://nppes.cms.hhs.gov)

Please provide your NPI number below. ***PLEASE NOTE:*** this is not your Social Security Number or your Tax ID Number.

_____ _____

NPI Number ***PLEASE PRINT NAME***

John C. Lincoln
HEALTH NETWORK

POLICIES AND PROCEDURES

SECTION: COMPLIANCE

Topic: Reporting & Investigating Allegations of Suspected Improper Activities

Reviewed: New (9/06)

Last Revision:

Approval: Date: 11/06

1.0 Purpose

1.1 The Network is subject to numerous local, state and federal laws pertaining to all aspects of its operation. All employees are required to understand and abide by those laws which are applicable to them in the performance of their jobs. Additionally, all employees are required to comply with laws which prohibit health care fraud, abuse and waste. Examples of prohibited activities include, but are not limited to:

1.1.1 Intentionally or knowingly making false or fraudulent claims for payment or approval.

1.1.2 Claiming reimbursement for services that have not been rendered.

1.1.3 Filing duplicate claims.

1.1.4 “Up-coding” to more complex diagnoses or procedures than were actually performed.

1.1.5 Including inappropriate or inaccurate costs on Network cost reports.

1.1.6 Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not.

1.1.7 Billing for services or items that are not medically necessary.

1.1.8 Failing to provide medically necessary services or items.

1.1.9 Offering or receiving remuneration (such as a kickback, bribe or rebate) as an inducement to make a referral for the furnishing (or arranging for the furnishing) of any item or services.

1.1.10 Submitting false information for the purpose of gaining or retaining the right to participate in a plan or obtain reimbursement for services.

1.1.11 Billing excessive charges.

1.2 To set forth the Network's policy for detecting and preventing waste, fraud, and abuse.

1.3 To provide information regarding the provisions of the federal False Claims Act, the administrative remedies that could be imposed for false claims and statements, the state laws regarding penalties for false claims and statements, and the protection from reprisal, retribution, or retaliation that is available for anyone reporting suspected fraudulent activities in good faith. A description of the federal False Claims Act and its associated administrative remedies is included in the attached Exhibit.

1.4 To be in compliance with the provisions of Section 6032 of the Deficit Reduction Act of 2006 regarding the prevention of waste, fraud, and abuse.

1.5 To be in compliance with state laws regarding fraudulent activities, including the following:

1.5.1 Criminal Medicaid Fraud Penalties/Felonies 13-2310; 13-2311

1.5.1.1 **13-2310:** Any person who, pursuant to a scheme to defraud, knowingly obtains any benefit by fraudulent purposes is guilty of a class 2 felony.

1.5.1.2 **13-2311**: Any person who, pursuant to a scheme to defraud, falsifies or covers up material fact or uses any false documents are guilty of a class 5 felony.

1.5.2 Reporting Medicaid Fraud (Whistle blower protection) 23-1501; 38-531

1.5.2.1 **23-1501:** The disclosure by an employee that he/she has information that his/her employer or an employee of the employer, has violated, is violating or will violate the law, to his/her supervisor or another management representative of the employer who has the authority to investigate information provided.

Employee protection from retaliatory discharge following disclosure of information regarding a violation or a potential violation of the law.

1.5.2.2 **38-531:** Definition of terms, to include employee, former employee, personnel actions, etc.

1.5.3 Recipient Issues (Fraud) 36-2905.04; 39-161;13-2310

1.5.3.1 **136-2905.04:** A person shall not provide false or fraudulent information to the state.

1.5.3.2 **13-2310:** A person who, pursuant to a scheme to defraud, knowingly obtains any benefit by means of fraudulent promises is guilty of a class 2 felony.

Scheme to defraud serves to deprive a person of intangible right of honest services.

2.0 Policy:

2.1 The Network does not tolerate fraud, waste, abuse or unethical behavior in conducting business and delivering services to patients and families.

2.2 Network employees, contractors, and agents who prepare or submit claims should be alert so as to prohibit inaccuracies and other errors on claims.

2.3 The Network is committed to compliance with all federal and state laws and regulations. We expect that all employees shall act in a manner which upholds the law and are accountable for ethical behavior in their job performance.

2.4 Any employee of the Network who has knowledge of facts concerning the organization's activities that he or she believe may violate the law has an obligation, promptly after learning such facts, to report the matter to his or her immediate supervisor; to the Director of Compliance or to the JCL Compliance Hotline at (602) 870-6060, ext 5888.

2.5 Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Every effort will be made to protect the complainant's identity.

2.6 Employees are encouraged to put their names to allegations because appropriate follow-up questions and investigation may not be possible unless the source of information is identified. Concerns expressed anonymously will be investigated, but consideration will be given to: (a) the seriousness of the issue raised; (b) the credibility of the concern; and (c) the likelihood of confirming the allegation from attributable sources.

2.7 There will be no retribution or discipline for anyone who reports a violation or suspected violation in good faith.

2.7.1 Anyone filing a complaint must have reasonable grounds for believing the information disclosed indicates misconduct, dishonesty, unethical behavior, fraud or fraudulent behavior. Allegations which prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious offense and worthy of disciplinary action.

2.8 An employee who retaliates against someone who has reported a violation or suspected violation in good faith is subject to discipline up to an including termination of employment.

2.9 This policy applies to all John C. Lincoln employees, contractors, and agents.

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Exhibit 1

False Claims Act and Associated Provisions Description

The False Claims Act (the FCA) is a provision of federal law dating to the Civil War. The law was designed to prevent the submission of false or fraudulent claims to the US Government. In general, the FCA prevents the following activities:

- Knowingly presenting a false or fraudulent claim for payment by the federal government.
- Knowingly using a false record or statement to get a claim paid by the federal government.
- Conspiring with others to get a false or fraudulent claim paid by the federal government.
- Knowingly using a false record or statement to conceal, avoid, or decrease a payment due to the federal government.

Violation of the FCA can result in penalties of up to three times the amount of the federal government may have been defrauded, including civil penalties of $5,000 to $11,000 for each false claim.

The FCA also contains a *qui tam* provision that in some situations permits a private individual to sue those who defrauded the government and receive a percentage of any resulting recovery from the defendant.

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John C. Lincoln
HEALTH NETWORK
Honored by Experts. Honored to Serve.

PRACTITIONER CODE OF CONDUCT

Purpose:
This Code of Conduct shall apply to all practitioners with membership and/or clinical privileges to practice at John C. Lincoln North Mountain Hospital and John C. Lincoln Deer Valley Hospital (collectively "Hospitals"), all of whom are expected to adhere to the applicable Medical Staff Bylaws and Rules and Regulations. All practitioners are expected to treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner.

Definition:
"Practitioner" includes all professionals (including but not limited to physicians, dentists, psychologists and allied health professionals) with membership and/or clinical privileges to practice at the Hospitals.

Policy:
It is the policy of the Hospitals and their medical staffs to promptly respond to all adverse information received regarding its practitioners. Identified concerns or problems regarding issues pertaining to "professional performance" by practitioners shall be handled in a manner as outlined in the Professional Performance Report policy and/or pursuant to the Medical Staff Bylaws. For purposes of this policy, "professional performance" includes, but is not limited to, activities involving a practitioner's clinical practices, quality of care, behavior, competence and/or conduct.

Principles:
All practitioners are expected to:

- Support policies promoting cooperation, teamwork and mutual respect among all members of the Hospitals' team;
- Communicate with others clearly and completely, displaying respect for their dignity;
- Use conflict resolution skills in managing disagreements;
- Address concerns about clinical judgments with appropriate Hospital and/or Medical Staff personnel directly and privately;
- Address dissatisfaction with policies through appropriate grievance channels;
- Accept constructive criticism;
- Timely complete medical records in accordance with Medical Staff Rules & Regulations;
- Respond to clinical obligations in a timely manner; and
- Comply with all State/Government laws and regulations.

Behavior that unnecessarily impairs the effective delivery of high quality patient care is disruptive and unacceptable. Disruptive or unacceptable behavior includes, but is not limited to:

- Malicious or aggressive verbal communications or actions;
- Inappropriate physical contact with, or sexual harassment of others;
- Inappropriate comments that undermine a patient's trust in the healthcare team or hospital;
- Throwing instruments or other objects in a patient care setting;
- Impaired behavior resulting from alcohol or other substances;
- Threatening, vulgar, or abusive language and/or behaviors toward, or in the presence of patients, visitors, hospital employees and /or other practitioners;
- Demeaning, disrespectful or discourteous language and/or behavior towards others;
- Disrupting the Hospital committee, department or peer review functions; and
- Inappropriate comments written in a patient's medical record.

I agree to abide by the John C. Lincoln Health Network Practitioner Code of Conduct and understand that if my conduct falls below the standards described in such Code of Conduct, I may be subject to disciplinary action up to and including the termination of my Medical Staff membership and/or privileges.
Signature Date

Signature **Date**

_____
Printed Name

John C. Lincoln
HEALTH NETWORK

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Business Ethics and Corporate Compliance

Why have a plan about business ethics?

Every day, you represent John C. Lincoln Health Network to patients, clients, customers, vendors, payers and competitors. And every day, your decisions and behavior help build our organization's positive image and its good reputation. However, we all come across situations now and then where we need guidance to make the right decisions. To help you, we've established a corporate compliance program with policies that clearly state our position on important issues relating to how we conduct our business.

Why? Because it's the right thing to do and because our reputation depends on each of us following the highest ethical standards. Having a well-defined set of policies and procedures also helps ensure that, if problems do arise, they don't become crises or lead to severe penalties and damages for our organization.

Our policies are more than just a code of ethics. They're a condition of your employment. As an employee of John C. Lincoln Health Network, you're responsible for knowing these policies, observing them at all times, and reporting any violations or suspected violations.

Doing the Right Thing

John C. Lincoln Health Network, its subsidiaries and affiliates have other policies and procedures that apply to specific areas, functions or groups of employees. You must follow these policies and procedures and comply with all the laws that apply to the organization's business. Your supervisor will provide you with information about the policies and procedures that apply to you. He or she also will be there to help you find answers to any questions you have about them. Everyone wants to do what is right. If you don't understand what is expected of you, ask questions until you do.

If you are unsure of a policy on a business practice, or if you need to report something you believe to be deceptive or dishonest conduct, talk to your supervisor. If he or she can't resolve the issue, call the **Compliance Help Line, 602-331-5888**. You also can contact the Compliance Committee by sending a note via Outlook to "Comply" or e-mail **comply@JCL.com**. The Compliance Committee is made up of executives and managers who, with the help of a legal adviser, review our compliance policies and specific compliance situations that may arise. Your call or e-mail message will be treated with absolute confidentiality.

Above all, remember that following the highest ethical principles and complying with the law protects the most valuable thing we have, something we've all worked hard to build and maintain – John C. Lincoln's good name and reputation for doing the right thing.

THIS FORM IS FOR YOUR RECORDS- DO NOT RETURN

John C. Lincoln Co-Workers …

- Display good judgment and high ethical standards in all business dealings.

- Are truthful in all business dealings and avoid any behavior that could be interpreted as deception or fraud.

These two simple, yet most important, principles are the foundation of all our policies of business ethics.

The standards apply equally to everyone. There is no excuse for compromising them. How well employees follow these policies will be an important element that influences performance evaluations and consideration for position assignments and promotions. Failing to comply with these policies could result in termination or other disciplinary action, as well as civil penalties or criminal charges.

Managers and supervisors have an additional responsibility. They are responsible not only for their own conduct but also for ensuring that the employees that they supervise are familiar with our policies and follow them. The Compliance Committee maintains programs to keep managers current with our policies. Members of the Leadership Council are responsible for promptly advising the Compliance Committee or the vice president for Quality Management of any possible violation of our policies on business practices.

At least once a year, managers and supervisors must review these policies and procedures and any changes to them with their direct reports.

Conflict of Interest

Every employee has a duty of loyalty to John C. Lincoln Health Network. This means you must avoid any actions that might conflict with that duty, whether it involves your personal activities, your involvement with competitors, other organizations and suppliers or the business activities of your immediate family.

Some examples of actions that are conflicts of interest include:

- Realizing any profit or gain as a result of your position with John C. Lincoln, except, of course, from the organization's compensation and benefit programs.
- Spending a substantial portion of time during normal business hours pursuing non-Lincoln-related interests.
- Activities or personal interests that might influence or appear to influence the business decisions that you must make as part of your responsibilities to John C. Lincoln, if they're damaging to the organization's business, or if they lead to improper or illegal gain either for you or someone else.
- Holding a significant financial interest in any of our competitors or suppliers without the written consent of your supervisor. Also, you should not serve as an officer or director in a supplying or competing organization, receive payment from them or provide consultation or other services.

  Note: This rule does not apply to personal investments in shares or other securities in corporations traded on major securities exchanges as long as your investment does not exceed 5 percent of the outstanding shares of such a corporation.

If any member of your immediate family – spouse, parents, brothers, sisters or children – works for or consults with one of our suppliers or competitors, you must disclose this relationship to your supervisor or the Compliance Committee. They in turn will evaluate the situation and give guidance to avoid any appearance of doing something wront or inappropriate. If you have a concern about a possible conflict of interest involving another employee, contact the Compliance Committee via the help line or e-mail.

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John C. Lincoln Property

Proprietary information can be anything about our organization's products, services and operations that we would consider private and wouldn't want to share with a competitor. Proprietary information is as much John C. Lincoln property as a desk, computer or office supplies. Never discuss or share information that is specific to John C. Lincoln or that you think might be confidential with anyone outside of the organization or with anyone who might pass it along to a competitor. Use caution when discussing information with other employees – it could be confidential.

- Proprietary information includes data, pricing, contracts, finances and work products.
- Be aware that our computer system is one way that unauthorized access to John C. Lincoln's information can be gained. Therefore, it is important that you protect your computer passwords so others cannot access our system.
- Even if you leave John C. Lincoln, you're still responsible for maintaining the confidentiality of John C. Lincoln's information.
- John C. Lincoln provides office space, supplies and equipment so you can do your job. These items are John C. Lincoln property and are not intended for personal use.
- Unless you need them to do your work, never leave your office with John C. Lincoln assets such as computer equipment, office supplies, original materials, etc.

Work Environment

It is the policy of John C. Lincoln Health Network to maintain a work environment free from any form of harassment, including discrimination based on race, color, religion, national origin, gender, age, disability or veteran status.

Verbal and/or physical conduct that is used to intimidate or that has the effect of unreasonable interfering with an individual's work performance or creating a hostile or offensive environment will not be tolerated.

John C. Lincoln Health Network strictly prohibits any conduct that could be considered sexual harassment under our own guidelines and those established by the government. John C. Lincoln also strictly prohibits any form of retaliation against anyone who files a charge, brings forward a complaint or provides information in an investigation.

Marketing John C. Lincoln Services

We sell our services and products fairly and honestly. We never misrepresent our services or do anything to unfairly undermine the products or services of a competitor.

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Gifts

It is common to give gifts to some key customers now and then. That's just good business. But to avoid the appearance of conflicts of interest, it's important to use good judgment when you give gifts to customers. You should never provide gifts, loans or other benefits to make a sale to a customer, to get a contract or receive favorable terms from a supplier. It's fine, of course, to provide occasional meals or promotional items as long as they meet these three requirements.

1. They should be a natural part of marketing, educational or other ordinary business activity.

2. They should be modest in value.

3. They should not violate any laws.

Any dealings with suppliers must be aboveboard, professional and legal.

To avoid any appearance of wrongdoing or improper influence, you must follow our policy regarding gifts or offers of meals or entertainment from suppliers, vendors and potential providers of service. A gift may be accepted only if it meets all the following criteria:

- It is modest in value.
- One person does not receive an ongoing benefit.
- Business decisions are not affected by it in any way.
- All gifts and offers of meals or entertainment are disclosed in writing to your supervisor.

We have strict rules governing payments or gifts to government officials or political candidates to ensure Network funds are not used improperly or for illegal activities.

- It's against the law to use John C. Lincoln money to pay government officials to secure sales, contracts, grants or receive favorable treatment.
- Giving large gifts or providing extravagant entertainment for government officials is prohibited because it could look like an attempt to influence government decisions. Make sure any gifts, assistance or entertainment you provide to government representatives do not appear to compromise their principles.
- Corporate funds cannot be used to contribute to a political party, committee, organization or candidate.

Financial Matters

- Financial records are kept using generally accepted accounting principles. By following these principles, you help ensure all of the organization's financial records are complete and accurate and do not contain any false or misleading information.
- Employees may not establish "slush funds" for any reason. A "slush fund" would be any undisclosed or unrecorded funds or assets of money that belong to John C. Lincoln or any part of the Network. An example would be a petty cash fund that is not reported to Accounting. All assets, allowances, liabilities, income and expenses must be entered in the organization's financial records and must be correctly and completely described.
- All payments must be for the purpose stated.
- All reports you submit to governmental authorities must be accurate, and any transactions you make must be as authorized by management.
- If you have any concerns about the accuracy of financial records, contact your supervisor, the Compliance Committee or call the Compliance Help Line.

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Billing

- We will take care to assure that all billings to government payers, commercial insurance payers and patients are true and accurate. They will conform to federal and state requirements.
- As part of our documentation efforts, we will maintain current and accurate medical records. Our bills must be supported by documentation in the patient's medical record.
- We are committed to billing practices that uphold the mission of our Network.
- We expect our patient accounting and medical records employees to be role models. Our patient accounting and medical records leaders must ensure that those on their teams have sufficient information to comply with laws, regulations and Network policies. All employees must encourage everyone on their teams to report concerns, and they must never sacrifice ethical and compliant behavior in the pursuit of business objectives.
- Any employee who deliberately makes an incorrect report to a government agency or other payer could be subject to termination, loss of benefits, and civil and criminal penalties.

Care and Treatment of Patients

Our patient care policies, procedures and practices are designed to provide not only high quality clinical care but also to support the rights of our patients and clients and to conform to government and other regulatory requirements. It is the responsibility of the people providing clinical care and services – the clinical staff – to be sure that care is provided in accordance with these requirements:

- Care is ordered, when necessary, by a physician or other provider who is authorized to give such orders.
- Care ordered is medically indicated according to usual medical practice.
- Care is provided according to acceptable professional standards.
- Care is documented accurately in the medical record, including signs, symptoms and response to treatment.
- Any charges submitted are accurate, timely and consistent with the requirements above.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a law that applies to hospitals who provide emergency services. John C. Lincoln – and its employees – must comply with the act. For example:

- People who come to either John C. Lincoln hospital campus asking for treatment for an emergency medical condition, including labor and childbirth, must have at least a medical screening examination. Such people should be taken or directed to the Emergency Department.
- John C. Lincoln must accept a patient in transfer from another hospital if we have a specialized service needed by the patient which the transferring hospital does not have.
- John C. Lincoln does not transfer patients to other facilities without the consent of the patient or his/her representative.

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Fraud and Abuse

The laws governing Medicare, AHCCCS and other state and federal health programs strictly prohibit paying for referrals of Medicare of AHCCCS patients or accepting payment for supplying these referrals. It is also illegal to offer money to influence anyone to buy goods or services or to make false claims for Medicare or AHCCCS reimbursement.

Strict laws govern physician referrals under the Medicare and AHCCCS programs. A John C. Lincoln-designated attorney should review all agreements with referral sources to ensure they comply with legal requirements.

Antitrust

Under antitrust laws, certain agreements made with competitors or customers can be considered crimes if they lead to an unreasonable restraint of trade or a substantial reduction of competition. Sometimes it takes legal guidance to determine whether such an agreement might violate these laws.

We recognize, of course, that routine communications with competitors are often reasonable and appropriate. However, before you discuss any matter with a competitor that someone might think could result in reduced competition, discuss it with your supervisor. He or she will contact the right people to ensure you have the information you need.

As an organization, we need to have access to general information about our competitors and to maintain and improve our business. At the same time, we must comply with antitrust laws regulating the kinds of agreements we can establish with customers, competitors and others.

To comply with antitrust laws and our own business ethics policies, use only generally available industry sources to obtain information about current or potential competitors, not information received from “inside” sources.

Safety and the Environment

You share the responsibility of helping maintain a safe and healthy work environment with all other co-workers of John C. Lincoln Health Network. We will work with you to meet federal, state and local health and safety laws, including the rules and regulations of the Occupational Safety and Health Administration (OSHA).

As an organization, we are committed to protecting the environment in all our operations.

- If you notice a condition you believe may be harmful to human health or the environment, report it to your supervisor immediately.
- If you are responsible for handling hazardous substances and infectious waste, make sure you follow all the proper procedures. Also, make sure contractors hired to dispose of the materials do their job properly.

You are our front line in promoting good corporate environmental practices, and we depend on you to report any potential problems at our facilities and operations so we can correct them.

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Requests from Government and Law Enforcement Agencies

We cooperate with any reasonable request from any governmental agency concerning our operations. Remember, a request for information by a law enforcement agent does not mean that a crime has been committed or even that the agent thinks a crime has been committed. If a law enforcement agent contacts you directly, keep these points in mind:

- Any response by you is entirely voluntary.
- You have the right to speak or refuse to speak.
- You have the right to speak to an attorney before deciding to be interviewed.
- If you agree to be interviewed, you can insist that an attorney be present.
- You have the right to ask that the interview take place on work time and at your place of work.

If an investigator from a government agency contacts you, we ask that you call the vice president for Quality Management immediately. This should be done before responding to any requests that are outside the ordinary scope of routine reports regularly made to governmental authorities.

Important Numbers

Compliance Help Line (confidential voice mail) - 602-331-5888

Director of Compliance - 623-434-6200, option 1, ext 301191

Compliance Committee Members

Executive Vice President and CEO, JCLNM and JCLDV Hospitals

Senior Vice President and Chief Financial Officer

Senior Vice President, Physician Network Development

Vice President, Corporate Compliance and Quality Management

Vice President, Human Resources

Vice President and Chief Information Officer

Director of Compliance

Director of Chargemaster and Coding

Director of Network Finance

Director of Medical Staff Services, JCLNM

Network Controller

Compliance Coordinator

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Universal
Background Screening

Request for Background Check

Account #002827

Social Security Number

			—			—				

Date of Birth - used for identification purposes only

		—			—				
MONTH		DATE			YEAR				

First Name	**Middle Name**	**Last Name**
Other Names Used (maiden name, AKA names, etc.)		

Current Residential Address		
City	**State**	**Zip Code**

List each CITY, STATE and ZIP CODE (if known) where you have lived during the past seven years:

City	State	Zip Code	From Date	To Date	
					[ ]
					[ ]
					[ ]
					[ ]
					[ ]

Driver's License Number	**State of Issue**

FCRA NOTICE AND ACKNOWLEDGMENT

IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT

NOTICE REGARDING BACKGROUND INVESTIGATION

John C Lincoln - Credentialing Services ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include, but is not limited to: employment and education verifications; social security number verification; criminal and civil court records; personal interviews; driving records; and/or any other public records or any other information bearing on your character, general reputation, personal characteristics and trustworthiness. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report.

The report will be generated by Universal Background Screening (4000 North Central Avenue, Suite 1000, Phoenix, AZ 85012, 1-877-263-8033) or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired, throughout your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York residents only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION (above) and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT (separate document) and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Universal Background Screening, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma residents only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. [ ]

California residents only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. [ ]

Signature _____ Date _____

Printed Name _____ Social Security Number (SSN) _____