# SCHNEIDER REGIONAL MEDICAL CENTER
## 9048 SUGAR ESTATE
## ST. THOMAS, U.S.V.I 00802

# APPLICATION FOR TELEMEDICINE/ TELERADIOLOGY PRIVILEGES
(USED FOR URGENT PATIENT NEED AND LOCUM TENENS)

**COMPLETE THE APPLICATION IN FULL. PRINT OR TYPE ALL RESPONSES. ATTACH ADDITIONAL SHEETS IF THERE IS INSUFFICIENT SPACE ON THIS FORM TO COMPLETE YOUR RESPONSE. SUBMIT THE COMPLETED, SIGNED FORM TO THE MEDICAL STAFF OFFICE AT RLS HOSPITAL. IF YOU HAVE QUESTIONS, PLEASE CALL (340) 776-8311, EXTENSION 2270.**

## PERSONAL INFORMATION

**Name of Applicant:** _____ **Sex:** M ☐ F ☐
Last First Middle

**Date of Birth:** _____ Social Security Number: _____ NPI _____

**Office Address:** _____
Street Address
_____ Phone: (____)_____
City State Zip

**Home Address:** _____
Street Address
_____ Phone: (____)_____
City State Zip

## LICENSES/REGISTRATION

- **Attach copy of current US Virgin Islands license to practice**
- **Attach copy of current DEA Registration**

## PROFESSIONAL LIABILITY INSURANCE

- **Attach copy of certificate of professional liability insurance**

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? ☐ Yes ☐ No

***If yes, provide list and status on separate sheet, including name of insurance carrier if different from the one listed on your certificate of insurance.***

## MEDICAL AND POSTGRADUATE EDUCATION

| | | |
|---|---|---|
| Medical School | Degree | Date of Graduation |
| Internship Training | Type | Inclusive Dates |
| Residency Training | Type | Inclusive Dates |
| Fellowship Training | Type | Inclusive Dates |

## BOARD CERTIFICATION

| SPECIALTY BOARD | INITIAL CERTIFICATION DATE | EXPIRATION DATE | RE-CERTIFICATION DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***If you are not currently board certified, please provide complete explanation of your current board status (i.e., expected date of completion) on a separate sheet.***

## HEALTHCARE ORGANIZATION AFFILIATIONS

(INCLUDE HOSPITALS, AMBULATORY CARE CENTERS, SURGICAL CENTERS, ETC.)

***List all healthcare organizations where you currently (or within the past five years) have had medical staff membership and/or clinical privileges (attach additional sheet if necessary).***

| HEALTHCARE ORGANIZATION NAME | LOCATION | STAFF CATEGORY | DATES |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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## DISCIPLINARY ACTIONS

***Have any of the following ever been, or are any currently in the process of being, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, currently under investigation, or voluntarily relinquished? If yes, provide full explanation on a separate sheet.***

☐ Yes ☐ No Medical License in any state
☐ Yes ☐ No DEA registration
☐ Yes ☐ No Membership on any healthcare organization medical staff

☐ Yes ☐ No Clinical privileges at any healthcare organization
☐ Yes ☐ No Prerogatives/rights on any medical staff
☐ Yes ☐ No Do you have any "Adverse Action Reports" on file with the National Practitioner Data Bank?
☐ Yes ☐ No Have you been reprimanded, sanctioned, censured, excluded, suspended or disqualified by Medicare, Medicaid, any other federal organization or any other health plan for which you provide services.

Have you ever been convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐ Yes ☐ No
***If you answered yes to the above question, please provide full explanation on a separate sheet.***

## HEALTH INFORMATION

1. Will practicing to the fullest extent of your licensure, qualifications and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients?
2. During the last ten years, have you been under the influence of alcohol during working hours or have you used illegal drugs? If "YES", please provide details.

## PROFESSIONAL REFERENCES

List the names of two individuals who have worked extensively with you or have been responsible for professional observation of your work. Their experience of your practice must be recent (within three years). Do not include names of current partners/associates.

**Name***:* _____

**Address:** _____
Street Address
_____ Phone: (____)_____
City State Zip Fax: (____)_____

**Name***:* _____

**Address:** _____
Street Address
_____ Phone: (____)_____
City State Zip Fax: (____)_____

## CREDENTIALS VERIFICATION RELEASE FORM

INFORMATION RELEASE/ACKNOWLEDGMENTS

In making application for the granting of clinical privileges means permission from RLS Hospital to provide specific healthcare services to its patients. I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications ("peer review information") by and between RLS Hospital and other healthcare organizations and individuals with whom I have been associated, or at which I have held membership or applied for clinical privileges. Such organizations may include, but are not necessarily limited to, hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations, (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents) for the purposes of evaluating this application regarding my professional competence, training, experience, character, conduct and judgment, ethics and ability to work with others. I understand that due care will be taken to safeguard the privacy of patients and the confidentiality of patient records, and peer review information from being further disclosed beyond those persons at RLS Hospital who have a need to review this information for credentialing purposes. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

To the fullest extent permitted by law, I hereby release all persons and entities, including RLS Hospital, its officers, employees and agents engaged in quality assessment, peer review, credentialing and privileging, and all persons and entities providing peer review information by representatives of RLS Hospital, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for clinical privileges in RLS Hospital.

During the application period, I also agree to notify RLS Hospital in writing, within five (5) days of receiving any written notice of an adverse action including, any final adverse action as such action may be defined under the Healthcare Quality Improvement Act of 1986, any filed and served malpractice suit or arbitration action; receipt of a notice of claim; any accusation filed, temporary restraining order or interim suspension order sought or obtained in connection with my professional competence; any form of restriction, probation, suspension or revocation of licensure or clinical privileges; a report to the National Practitioner Data Bank; any revocation of DEA licensure; a conviction of any crime; any action against my certification under Medicare or Medicaid programs or any cancellations, non-renewal, or material reduction in medical liability insurance policy coverage.

I hereby affirm that I have had made available to me and agree to abide by (1) the medical staff bylaws; (2) the rules and regulations and (3) the policies and procedures of RLS Hospital applicable to my activities in connection with the credentialing process. I also agree to abide by all applicable federal and state laws and regulations. I also affirm that the information submitted in this application and any addenda thereto is current and true to the best of my knowledge and belief and is furnished in good faith. I understand that any omission or misrepresentations may result in denial of my application or termination of any privileges, employment or physician participation agreement. Finally I understand that this application will not be processed until deemed completed by RLS Hospital.

Print Name Here: _____

Signature: _____
STAMPED SIGNATURE IS NOT ACCEPTABLE)

Date: _____