TERREBONNE GENERAL MEDICAL CENTER
APPLICATION FOR UPDATE TO THE NON-CLINICAL ALLIED HEALTH STAFF

Instructions to Applicant

1. **All questions must be answered.**
2. **It is the responsibility of the applicant to produce adequate information to satisfy the Human Resources requirements of the Allied Health Professional's application process.**
3. **Chronological account of applicant's training and experience must be clearly stated. All periods of time from college MUST be accounted for.**
4. **Upon submission, the applicant will be contacted for further information.**

If assistance is needed, please contact the Human Resources Department at (985) 873-4628.

APPLICANT INFORMATION			
Date	**First Name**	**Middle Name**	**Last Name**
Maiden Name	**Job Title**	**Dept Reporting to:**	
Mailing Address			
City	**State**	**Zip Code**	
Home Phone	**Cell Phone**	**Work Phone**	
Marital Status	**Email Address**		
Agency/Company	**Agency/Company Address**		

CONTINUING EDUCATION (COURSES COMPLETED DURING THE LAST YEAR)	
Course Name	**Date of Completion**
Course Name	**Date of Completion**
Course Name	**Date of Completion**
Course Name	**Date of Completion**
Course Name	**Date of Completion**

I. LEGAL ACTIONS (If the answer to any of the following questions is yes, please provide a full explanation of the details.)

Have there been any malpractice suits, settlements, or arbitration proceedings involving your professional service over the past 7 years? ☐ Yes ☐ No

Have you ever been convicted of a crime? A conviction includes pleading guilty, paying fines, etc. Not all convictions result in jail time. ☐ Yes ☐ No

II. HEALTH STATUS (If you answer yes to any of the questions below, please give a full explanation of the details.)

Present health status: ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized any time during the past five years? ☐ Yes ☐ No

Do you have any chemical dependence; drug abuse or medical (physical or mental) problems that could affect the safety of patients or your ability to competently perform requested privileges? ☐ Yes ☐ No

Are you currently under any limitations, in terms of activity or workload? ☐ Yes ☐ No

III. PRIVILEGES DESIRED

Will you function under the supervision of a TGMC physician? ☐ Yes ☐ No

If yes, please complete the sponsoring physician form at the end of this application.

If no, please indicate the specific privileges you would like to exercise.

IV. Please answer each of the following questions. If the answer is yes, please provide a full explanation with details.

1. Has your employment, allied professional appointment or privileges to practice ever been voluntarily limited or suspended or diminished? ☐ Yes ☐ No

2. Has your employment, allied professional appointment or privileges ever been involuntarily limited or suspended, or diminished, revoked or refused at any hospital or other health care facility? ☐ Yes ☐ No

3. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (e.g., Medicare, Medicaid, and Blue Shield)? ☐ Yes ☐ No

4. To your knowledge, 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? ☐ Yes ☐ No

V. APPLICANT'S CONSENT AND RELEASE

I hereby apply for allied health privileges. I am willing to make myself available for interviews in regard to this application.

As an applicant, I have the burden of producing adequate information for proper evaluation of my application. I also agree to provide the hospital with updated, current information regarding all questions on this application as such information becomes available and such additional information as may be requested by the hospital or its authorized representatives. The failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

Information given or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to practice the allied health privileges requested. As a condition to making this application, any misrepresentation in, or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application. In the event that allied health privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary revocation of those privileges.

By applying for allied health privileges, I accept the following conditions during the procession and consideration of my application, regardless of whether or not I am granted the privileges requested and for the duration of my association with the hospital:

a) I extend absolute immunity to release from any and all liability, the hospital, its authorized representatives and any third party as defined in subsection b) below for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed made, requested or received by this hospital and its authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

1) applications for allied health privileges;
2) periodic reappraisals undertaken for increase or decrease in privileges;
3) proceedings for suspension or reduction of privileges or other disciplinary sanction;
4) summary suspensions;
5) other hospital, medical staff, department, service or committee activities;
6) matters or inquiries concerning my professional qualifications, credentials, clinical competence;
7) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

b) I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial and continued allied health privileges, as well as to inspect or obtain any and all communication, reports, records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representatives upon request.

I acknowledge that (1) the privilege to practice in this hospital is not a right of every licensed professional who submits an application; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules and regulations; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the Vice President whose decision shall be final; (4) I have the responsibility to keep this application current by informing the hospital, through the Human Resources Department, of any change in the areas of inquiry contained herein, including, but not limited to, any change in the filing of a lawsuit against me and any change in my status at any other hospital; (5) my continued association with the hospital and allied health privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital, as evidenced by treatment and continuous care and supervision of patients for whom I have responsibility, and acceptable performance of all responsibilities related thereto, as well as the other factors deemed relevant by the hospital.

During the term of this Agreement, applicants shall render Services to inpatients of the Hospital pursuant to the prior written orders of physicians on staff at the Hospital. Provider shall render such services in compliance with applicable statutes, regulations and rules of federal, state and other governmental bodies having jurisdiction over the Hospital, including but not limited to, the Health Care Financing Administration (HCFA) and Occupational Safety and Health Administration (OSHA); the reasonable policies, rules and regulations of the Hospital; the standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and currently accepted and approved methods and practices.

Date Applicant's Signature

Return completed application to:
Terrebonne General Medical Center
Human Resources Department
P.O. Box 6037
Houma, LA 70361-6037

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TO BE COMPLETED BY SPONSORING PHYSICIAN
***Privileges Requested (Please be specific)**

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I, _____ (Physician), certify that, to the best of my knowledge, the applicant is competent to perform the privileges as specified and agree to sponsor _____ (Allied Health Professional) as a member of the Allied Professional Staff at Terrebonne General Medical Center. I also agree to supervise and direct the applicant if that is required under applicable licensing requirements or under hospital bylaws or policies.

_____ _____

Date Signature of Sponsor