Ephraim McDowell Health

CooperativeCare Centralized Application Processing Service

Pre-Application Request for Credentialing Package

☐ Ephraim McDowell Regional Medical Center (EMRMC)	☐ Ephraim McDowell Fort Logan Hospital (EMFLH)
☐ Ephraim McDowell Ambulatory Surgery Center (ASC)	☐ Ephraim McDowell Health Resource (Clinic/employed)
☐ Cooperative Care (EM employee/dependent health plan)	☐ Central Kentucky Physicians, Inc. (IPA)
Primary Hospital where practitioner will request privileges:	☐ EMRMC ☐ EMFLH
Joining a Practice or Group? ☐ No ☐ Yes	Anticipated Start Date:
Name / Location of Practice or Group:	

MAIL THE APPLICATION PACKAGE TO:

APPLICANT INFORMATION - *All Items Must Be Completed*

Last Name:		First:	Middle:
Other Name(s) Used: ☐ N/A		Primary Practice Specialty:	
☐Male ☐Female	Date of Birth:	☐Physician ☐Oral Surgeon ☐Podiatrist ☐Dentist ☐Other:	
Primary e-mail Address:		Secondary e-mail:	
Home Address:		Unit/Apt#: ☐ N/A	
City:	State:	Zip:	Telephone:
Fax:	Cell:		Pager:

CONTACT INFORMATION

Current **MAILING** Address (if different from above): ☐ N/A		
City:	State:	Zip:
Current **OFFICE** Address ☐ N/A:		
City:	State:	Zip:
Office Phone #:	Office Fax #:	
Office Contact Person:	Contact's e-mail Address:	

PROFESSIONAL LICENSURE INFORMATION

Kentucky License #:	Expiration Date:	Unlimited License: ☐Yes ☐No
Other State Licenses (State(s) and Number(s)):	Other License Expiration Date(s):	
If not licensed in Kentucky: Date of Application to the Kentucky Board of Medical Licensure:		

PRACTICE INFORMATION

CAQH(Council for Affordable Quality Healthcare) #:	Are you a Kentucky Medicare Member? ☐Yes ☐No
Has CAQH data been maintained or recently updated? ☐Yes ☐No Date Last Updated:	Are you a Kentucky Medicaid Member? ☐Yes ☐No
	Kentucky MCD #:

PROFESSIONAL EDUCATION / POST GRADUATE TRAINING

If Foreign Medical Graduate, ECFMG #		
MEDICAL PROFESSIONAL SCHOOL:		
Degree Received:	Dates Attended: From:	To:
FELLOWSHIP – Did you successfully complete the program? ☐Yes ☐No ☐In Process ☐N/A		
NAME:		Anticipated Completion:
RESIDENCY – Did you successfully complete the program? ☐Yes ☐No ☐ In Process ☐N/A		
NAME:		Anticipated Completion:

INTERNSHIP – Did you successfully complete the program? ☐Yes ☐No ☐N/A	
NAME:	
BOARD CERTIFICATIONS - *Include certification by boards duly organized and recognized by the American Board of Medical Specialties, American Osteopathic Association, American Board of Podiatric Specialties, General Dentistry, Oral & Maxillofacial Surgery, or the Board specific to your Allied Health Professional Licensure.* ☐N/A	
Name of Issuing Board:	Specialty:
Current/Active Certification: ☐Yes ☐No	
Name of Issuing Board:	Specialty:
Current/Active Certification: ☐Yes ☐No	Other board certification(s)? ☐Yes (Add below) ☐No

Only physicians, podiatrists, oral surgeons and dentists are qualified for *Membership on the Medical Staff* , and only if they have:

- an **unlimited license** to practice in the Commonwealth of Kentucky;
- completed an **approved residency** in a specialty or sub-specialty program recognized by the ABMS, AOAB, ABPS (podiatrists), or ABGD/ABOMS (dentists/oral surgeons);
- **certification** by the appropriate board or are "board-eligible" and become certified within the timeframe stipulated by the respective board, but not more than five (5) years after the date of meeting eligibility;
- **maintained board certification** continuously,
- ability to **document their background** as a graduate of an approved, recognized medical, osteopathic, podiatric or dental school.

All applicants (including **Allied Health Practitioners** requesting Privileges in their scope of practice) must be able to provide:

- proof of **Medical Liability Insurance** with an A.M. Best rating of B+ or above in the amounts of at least $1million/$3 million;
- their **experience, training and demonstrated competence** in their field of practice;
- assurance to adhere to the **ethics of their profession**;
- proof of continuous **professional development**,
- attestation of an understanding of and sensitivity to **diversity**, and a **responsible attitude** toward patients and their profession, their good **reputation**, and the ability to **work with others**;
- assurance of their ability to **safely and competently perform the clinical privileges** requested, with sufficient adequacy to ensure that any patient treated by them in the Hospital will be given a **high quality of medical care**.

No aspect of privileges shall be denied on the basis of gender, race, age, creed, national origin, or on the basis of any other criterion unrelated to the delivery of quality patient care in the System's facilities, to professional qualifications, to the System's purposes, needs and capabilities, or to community needs.

ATTESTATIONS

Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program (e.g., Medicare/Medicaid)? ☐ No ☐ Yes Have you ever opted out of participation? ☐ No ☐ Yes

Please indicate the specialty(ies) in which you are requesting privileges (for privilege request forms):

☐ I am not applying for Hospital Privileges.

Please initial each statement below:

_____By submitting this completed pre-application form, I understand that this form will be reviewed by the facility (ies) indicated above, and if all criteria is met and no Exclusive Contracts are in place for my requested privileges, I will be sent an initial appointment application.

_____I understand that submission of this pre-application form will in no way obligate the facility (ies) to which I am applying for privileges, to afford me membership and/or privileges.

_____I hereby acknowledge that in the even this pre-application is denied, I will not receive an application for appointment. I further acknowledge and agree that denial is not a professional review action and does not entitle me to any fair hearings or review rights under the facility's (ies') Medical Staff Bylaws, nor is it considered to be reportable to the National Practitioner Data Bank.

_____I certify that to the best of my knowledge, the information above is complete and accurate, and acknowledge that any omission and/or misrepresentation shall constitute a voluntary withdrawal of my application for initial appointment.

Signature: _____ Date:_____

Print Name:_____

Please return this form to:
MEDICAL STAFF SERVICES – EPHRAIM MCDOWELL HEALTH
217 SOUTH THIRD STREET - DANVILLE, KY 40422