ANYTOWN HOSPITALS AND HEALTH SYSTEM
CREDENTIALING CHECKLIST

___________________________ ________________________ ________________________
Name Specialty NPI

Date application received ________________ Received by: _________

☐ Initial application ☐ Reappointment application Prior Board approval date: _________________________

	Verification source	Date verif. (recd.)	Eff. Date	Exp. Date	Verif. by
Attestation date _____________	Application				
Disclosure questions—issues identified? ___yes ___no					
License Verification State _____ #_____________ State _____ #_____________ State _____ #_____________ State _____#_____________	 _________________________ _________________________ _________________________ _________________________	 _______ _______ _______ _______	 _______ _______ _______ _______	 _______ _______ _______ _______	 _______ _______ _______ _______
License Disciplinary Action? ___yes ___no					
DEA Certificate # _________________	NTIS				
Malpractice Insurance Coverage Carier: _________________________________ Amounts: _______/_________	Cover sheet _____ or Letter _____ **Verify that insurance does not expire prior to appointment**				
Board certification (180 days) __yes __no ___in process/eligible Specialty: __________________________ Specialty: __________________________ Specialty: __________________________	CertiFACTS online	_______ _______ _______	_______ _______ _______	_______ _______ _______	_______ _______ _______
NPDB/HIPDB Report (180 days) Identified issues? _____yes _____no	NPDB/HIPDB database				
OIG Exclusions report Identified issues? _____yes _____no	OIG online exclusions list				
GSA Exclusions report Identified issues? _____yes _____no	Excluded Parties List System				

	Verification source	Date verified (received)	Verified by	Comments
Education Medical School: ____________________________ Master's Degree:___________________________ Internship: ________________________________ Residency: ________________________________ Fellowship: _______________________________ Fellowship: _______________________________	_____________ _____________ _____________ _____________ _____________ _____________	____________ ____________ ____________ ____________ ____________ ____________	__________ __________ __________ __________ __________ __________	
Work history/hospital privileges Gaps > 6 months? ______yes ______no ____ ____ ____ ____ ____	_____________ _____________ _____________ _____________ _____________	____________ ____________ ____________ ____________ ____________	__________ __________ __________ __________ __________	
Malpractice claims history				
References ____ ____ ____	Letter from peer Letter from peer Letter from peer	____________ ____________ ____________	__________ __________ __________	

ADDITIONAL DOCUMENTS

DOCUMENT	RECEIVED?		DOCUMENT	RECEIVED?
CV			Current photo ID w/attestation	
Privilege sheet (complete and signed by applicant and chair)			Procedural sedation form (if applicable)	
Documentation for core privileges			Expectations document	
Medicare/Champus statement (Date signed: _____________)			Managed care forms	
CME (relative to privileges requested)			AMA profile (if applicable)	
ECFMG certification (if applicable)			ATLS documentation (for Trauma/EM)	
ACLS/PALS (if applicable) Expiration date: ________________			Faculty appointment verification (effective date:___________)	
Military verification (date faxed: _______________)			Privilege Criteria Acceptable (____New graduate)	
FPPE Plan: Reviewed and Assigned by Department Chair			CHBC completed by HR Date cleared: ________________	

Credentials Committee Date:__________________

Executive Committee/Board Approval Date: __________________ 180 day timeframe met? _____yes _____no

ANYTOWN HOSPITALS AND HEALTH SYSTEM

123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

May 10, 2012

University of Mississippi School of Medicine
Division of Student Services and Records
2500 North State Street
Jackson, MS 39216-4505

RE:	**Test, Test, M.D.**
Date of Birth:	01/01/1971
Dates of Attendance:	01/01/1996 to 01/01/2000
Degree Received:	Doctor of Medicine

Dr. Test has applied for appointment to the medical/allied health Staff of Anytown Hospitals and Health System. He indicates earning a Doctor of Medicine with University of Mississippi School of Medicine. Please confirm the information he provided by answering the following questions. We have attached a signed consent for release of information signed by Dr. Test.

	Yes	**No**
Are the education program dates correct? If **no**, what are the correct dates: From: __________ To: __________	☐	☐
Was the program completed satisfactorily? If **no**, please explain:	☐	☐
Would you recommend Dr. Test for medical staff membership? If **no**, please explain:	☐	☐
Is Test's health status adequate to exercise clinical privileges and responsibilities of medical staff membership? If **no**, please explain:	☐	☐

Signature Printed Name/Title Date

For any questions or concerns please contact **Jane Smith** at **601-123-4567**. Please return the completed verification form by fax to **601-123-8910** or by email to **jane.smith@anytown.org**.

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services
601-123-4567
FAX 601-123-8910

May 10, 2012

University of Mississippi Medical Center
Graduate Medical Education
2500 N. State St.
Jackson, MS 39216

RE: **Test, Test, M.D.**
Dates of Affiliation: 01/01/2000 to 01/01/2001

Dr. Test has applied for appointment to the medical staff of University Hospital and Health System. He indicates he completed his Pediatric Endocrinology Fellowship Program with University of Mississippi Medical Center. Please confirm the information he provided by answering the following questions. We have attached a consent for release of information signed by Dr. Test.

	Yes	**No**
Are the education program dates correct? If **no**, what are the correct dates? From: __________ To: ______________	☐	☐
Was the program completed satisfactorily? If **no**, please explain: ____	☐	☐
Was this program ACGME or AOA-accredited at the time of the applicant's training?	☐	☐
Was training in procedural sedation included as part of the applicant's program?	☐	☐
Was training in laser principles (in accordance with privileges requested) Included as part of the applicant's training?	☐	☐
Was there any disciplinary action taken against the applicant during training? If **yes**, please explain: ____	☐	☐
Would you recommend Dr. Test for medical staff membership? If **no**, please explain: ____	☐	☐

30632

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services
601-123-4567
FAX 601-123-8910

Is Test's health status adequate to exercise clinical privileges and responsibilities of medical staff membership? ☐ ☐

If **no**, please explain:

____

______________________________ ______________________________ ______________

Signature | Printed Name/Title | Date

For any questions or concerns please contact **Jane Smith** at **601-123-4567**. Please return the completed Fellowship Program verification form by fax to **601-123-8910** or by email to **jane.smith@anytown.org**.

30632

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services
601-123-4567
FAX 601-123-8910

May 10, 2012

John Doe, M.D.
123 N. Water St.
Anytown, USA 12345

Re: Test Test, M.D.

Dear Sir or Madam:

Dr. Test has applied for membership and/or clinical privileges at Anytown Hospitals and Health System. The applicant has listed you as a professional reference and indicated that you have extensive experience observing or working with him/her.

In order to evaluate this request appropriately, and as part of the credentialing process, we need to have you complete the attached questionnaire.

Also included are copies of his/her signed release and requested privileges.

Your prompt reply will be greatly appreciated.

Sincerely,

Jane Smith
Medical Staff Services
Anytown Hospitals and Health System

Enclosures: Release Form
Reference Questionnaire
Copy of Requested Privileges

30647

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

EVALUATION FOR MEDICAL/ALLIED HEALTH STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

Name of Applicant: Test Test, M.D.

Department to which the applicant is applying:______________

All items must be addressed for this evaluation to be complete.

1. How long have you known the applicant? _______________

2. In what capacity? (Please check those applicable)
   a. Teacher/Director of Training ☐
   b. Department or Service Chief Primary facility ☐
   c. Other (please specify) ☐

3. Do you feel you have sufficient knowledge of the applicant to render a comprehensive evaluation? ☐ Yes ☐ No

If your answer to number 3 above was "no", the following questions may be left unanswered or answered in part.

4. EVALUATION: This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner with a similar level of training, experience and background as this applicant.

	POOR	FAIR	GOOD	SUPERIOR	UNKNOWN
Basic Medical Knowledge					
Professional Judgment					
Sense of Responsibility					
Clinical Competence					
Technical Skill					
Cooperativeness, Ability to Work with Others					
Medical Record Currency					
Quality of Medical Records					
Patient Management					
Ability to Understand, Speak and Write English					
Participation in Medical Staff Affairs					
Practitioner/Nursing Relationship					
Practitioner/Patient Relationship					
Practitioner/Practitioner Relationship					

If you answer "yes" to any of the following questions, please provide an explanation on a separate sheet of paper and attach.

5. ACTIONS TAKEN
   a. During the time noted in Question 1, has this practitioner ever been subject to any disciplinary action, such as imposition of consultation requirements, review, suspension or termination? ☐ Yes ☐ No

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

Name of Applicant: Test Test, M.D.

b. To your knowledge has the practitioner ever been under investigation by any governmental or other legal body? ☐ Yes ☐ No

6. To the best of your knowledge does this practitioner meet the criteria for and is he/she competent to perform the clinical privileges requested (see attached)? ☐ Yes ☐ No

7. Conduct and Health Status
Have you ever observed the practitioner to exhibit any behavior, drug, alcohol, or physical or mental impairment which has, or reasonably could have been, expected to interfere with the practitioner's ability to exercise the clinical privileges requested in a safe and effective manner that is consistent with the prevailing standard of practice? (If yes, please explain) ☐ Yes ☐ No

8. RECOMMENDATIONS (Please check one)
☐ Recommend without reservation
☐ Recommend with the following reservation____
☐ Do not recommend

9. GENERAL IMPRESSION
As a result of my observation of the practitioner, my general impression of the applicant is:

____

____

10. Is this evaluation based on personal knowledge? ☐ Yes ☐ No

Is this evaluation based on review of internal quality monitoring processes? ☐ Yes ☐ No

Please provide relevant practitioner-specific data compared to aggregate data and morbidity and mortality data if available.

11. What is the best time to contact you by telephone? Time __________ Phone ________________

Test Test
Name

____
Date

____
Signature

____
Title

For any questions or concerns please contact **Jane Smith** at **(601) 123-4567**. Please return your completed peer reference evaluation by fax to **(601) 123-8910** or by email to **jane.smith@anytown.org**.

30647

ABMS® Board Certification Credentials Profile

A service provided by the American Board of Medical Specialties

New Search | Search Results | Feedback | Save Physician | Print

Viewed:5/10/2012 9:41:43 AM CST

DOB: private

Status: private

Certification

American Board of Surgery

Surgery - General			***Status: Certified***
Active	Time-Limited	Recertification	10/19/2001 - 07/01/2012
Expired	Time-Limited	Initial Certification	03/30/1992 - 07/01/2002

Surgical Critical Care - Subspecialty			***Status: Certified***
Active	Time-Limited	Recertification	10/18/2002 - 07/01/2013
Expired	Time-Limited	Initial Certification	10/23/1992 - 07/01/2003

Meeting Maintenance of Certification (MOC) Requirements

American Board of Surgery

Yes (For more information click here)

For some ABMS Member Boards, physicians who achieved Board Certification before those Boards established their MOC programs are not required to participate in MOC. To obtain information regarding whether a specific physician is required to participate in MOC please contact the pertinent ABMS Member Board http://www.CertificationMatters.org/abms-member-boards.aspx.

Education

1985 MD (Doctor of Medicine)

Location

Private

Notice: It is up to the user to determine if the physician record obtained from this service is that of the physician being sought.

The information as presented by this service is approved for business use and is valid to meet the primary source verification requirements for credentialing as set by JCAHO, NCQA, URAC and other accrediting agencies.

The ABMS physician specialty certification data provided by CertiFACTS On-Line is proprietary and copyrighted by the American Board of Medical Specialties (ABMS®) and subject to the intellectual property laws of the United States. © 2006, ABMS, All Rights Reserved.

The Powered by ABMS Direct Connect and ABMS Official Display Agent logos are registered trademarks of the American Board of Medical Specialties.

Current Date: 5/10/2012 **Data File Release Date:** 5/07/2012

Drug Enforcement Administration (DEA) Datafiles -Both

Registrant Profile

for

Address:

UMMC DEPT OF SURGERY
2500 N STATE STREET
JACKSON

State and Zip: MS 39216

DEA Number:

Business Activity Code: C

Business Activity Sub Code: 0

Drug Schedule: 22N 33N 4 5

Drug Codes:

Expiration Date: 3/31/2014

Payment Indicator: P

Print

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services
601-123-4567
FAX 601-123-8910

May 10, 2012

Medical Assurance Group
123 N. Water St.
Anytown, USA 12345

RE: Insurance Verification and Claims History

The practitioner listed below has made application for appointment/reappointment to the medical/allied health staff at Anytown Hospitals and Health System. Release statement for the applicant is attached. Please provide a **ten-year claims history** for the practitioner listed.

Test Test, M.D.
99999-99999

For questions or concerns please contact Janet Smith at **(601) 123-4567**. Please return the insurance verification and claims history by fax to **(601) 123-8910** or by email to jane.smith@anytown.org.

30645

ANYTOWN HOSPITALS AND HEALTH SYSTEM

123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

May 10, 2012

University of Mississippi
Human Resources
100 Grove Circle
Oxford, MS 12345

RE:	**Test, Test, M.D.**
Dates of Employment:	01/02/2001 to Present
Position:	Professor

Dr. Test has applied for appointment to the medical/allied health professional staff of Anytown Hospitals and Health System. Test indicates that he is currently employed by University of Mississippi as a Professor. Please confirm the information he provided by answering the following questions. We have attached a consent for release of information signed by Dr. Test.

	Yes	**No**
Is the information provided above correct?	☐	☐
If **no**, please explain.		
Is Dr. Test currently in good standing with University of Mississippi?	☐	☐
Has Dr. Test ever been suspended?	☐	☐
If **yes**, please explain.		
Do you consider Dr. Test to be clinically competent in his specialty?	☐	☐
Does Dr. Test comply with organizational policies and procedures?	☐	☐
Do you consider Dr. Test's professional skills, clinical competence, personal qualifications, character, and reputation such as to recommend affiliation?	☐	☐
Do you know any reason, including Dr. Test's health, that would prevent him from being able to exercise the responsibilities and clinical privileges as a member of the medical/allied health staff?	☐	☐
If **yes**, please explain:		

____________________ ____________________ ____________________

Signature   Printed Name/Title   Date

For questions or concerns please contact Jane Smith at **(601) 123-4567**. Please return the completed employment verification form by fax to **(601) 123-8910** or by email to jane.smith@anytown.org.

30652

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

May 10, 2012

Conemaugh Health System
Medical Staff Services
1086 Franklin Street
Johnstown, PA 15905-4305

RE:	**Test, Test, M.D.**
Dates of Employment:	01/01/2001 to Present
Position:	Physician

Test has applied for appointment to the medical/allied health staff of Anytown Hospitals and Health System. He indicates a previous affiliation with Conemaugh Health System as a Physician. Please confirm the information he provided by answering the following questions. We have attached a consent for release of information signed by Dr. Test.

Position: ☐Active ☐ Associate ☐Courtesy ☐ Other: ______________________________

Affiliated Since: ______________________________ With a Specialty In: ______________________________

	Yes	No
Is Dr. Test a member in good standing of the medical/allied health staff in your hospital?	☐	☐
Has Dr. Test ever been suspended?	☐	☐

If **yes**, please explain.

____

Do you consider Dr. Test to be clinically competent in his specialty?	☐	☐
Have Dr. Test's privileges ever been curtailed in any way?	☐	☐

If **yes**, what were the circumstances?

____

Has Dr. Test complied with hospital rules and regulations regarding medical records, attendance, etc.?	☐	☐
Do you consider Dr. Test's professional skills, clinical competence, personal qualifications, character, and reputation such as to recommend affiliation?	☐	☐
Do you know any reason, including Dr. Test's health, that would prevent him from being able to exercise the responsibilities and clinical privileges as a member of the medical staff?	☐	☐

If **yes**, please explain:

____

____

______________________ ______________________ ______________________

Signature Printed Name/Title Date

For questions or concerns please contact Jane Smith at **(601) 123-4567**. Please return the completed Current Affiliation verification form by fax to **(601) 123-8910** or by email to jane.smith@anytown.org.

If Dr. Test has provided patient care at Conemaugh Health System within the past two years, please complete Attachment A - Request for Patient Volumes or forward it to the appropriate individual for completion.

30639

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services 601-123-4567
FAX 601-123-8910

Attachment A – Request for Patient Volumes

May 10, 2012

Conemaugh Health System

RE: **Test, Test, M.D.**

To Whom It May Concern:

In accordance with Joint Commission and CMS recommendations, and as part of Anytown Hospitals and Health System credentialing process, new applicants must provide quantitative and qualitative data pertaining to requested privileges for the 24 months preceding their application. Please complete the form fields below and return this form to the contact listed below.

Assessment Period: and the preceding 24 months

Privilege(s) requested:	Please list ***volume*** of procedures performed for each during the time period noted above. For core privileges please list ***volume*** of provision of inpatient or outpatient services reflective of the scope of privileges requested:	Were outcomes acceptable? (If no, please explain below.)
Core Internal Medicine Privileges		**Yes** **No**
Procedural Sedation		**Yes** **No**
		Yes **No**
		Yes **No**
		Yes **No**
		Yes **No**

To the best of your knowledge does this practitioner meet the criteria for and is he competent to perform the clinical privileges requested?

☐ **Yes** ☐ **No**

30639

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-123-8910

Have you ever observed the practitioner to exhibit any behavior, drug, alcohol, or physical or mental impairment which has, or reasonably could have been, expected to interfere with the practitioner's ability to exercise the clinical privileges requested in a safe and effective manner that is consistent with the prevailing standard of practitioner? (Is yes, please explain)

☐ **Yes** ☐ **No**

Recommendations (Please check one)

_____ Recommend without reservation

_____ Recommend with the following reservation ____________________________________

_____ Do not recommend (please provide explanation)

_________________________________ ________________
Signature Date

_________________________________ ______________________
Printed Name Title

EXPLANATIONS (if necessary):

For any questions or concerns please contact **Jane Smith** at **601-123-4567**. Please return **Attachment A – Request for Patient Volumes** by fax to **601-123-8910** or by email to **jane.smith@anytown.org**.

30639

AMA Physician Profile

Name and Mailing Address:

JOHN Q. PUBLIC MD
HOMETOWN MEDICAL CENTER
123 MAIN ST
ANYCITY, IL 12345-9876

Primary Office Address:

SPECIALTY MEDICAL CENTER
123 MAIN ST
ANYCITY, IL 12345-9876

Birthdate: 01/01/1960
Birthplace: ANYTOWN, IL UNITED STATES OF AMERICA

Phone: 1-234-555-1212

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: FAMILY PRACTICE
Secondary Specialty: UNSPECIFIED
**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: MEMBER

____________________ All Information from this Point Forward is Provided by the Primary Source ___________________

<u>Current and/or Historical Medical School:</u>

UNIV OF IL MED SCH AT CHICAGO, CHICAGO IL 12345
Degree Awarded: YES
Degree Year: 1998

UNIV OF IOWA, IOWA SCH OF MED, IOWA CITY IA 52242
Degree Awarded: NO
Degree Year: 1996

©2012 by the American Medical Association

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: LA STATE UNIV HP-SHREVEPORT — **State**: LOUISIANA
Specialty: INTERNAL MEDICINE — 07/1999 – 06/2001
(VERIFIED)

Institution: EARL K LONG MED CTR — **State**: LOUISIANA
Specialty: INTERNAL MEDICINE — 07/1998 – 06/1999**
(VERIFIED)

****INCOMPLETE TRAINING: Program reports specialty training as "Incomplete."**

Institution: LA STATE UNIV HP-SHREVEPORT — **State**: LOUISIANA
Specialty: CARDIOVASCULAR DISEASE — 07/2001 – 06/2004
(VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction:	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
LOUISIANA	MD	07/01/1999	05/31/2012	ACTIVE	UNLIMITED	04/21/2010
ILLINOIS	MD	7/01/2004	12/31/2012	ACTIVE	UNLIMITED	06/30/2010

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1234567891	06/30/2006	NOT RPTD	NOT RPTD	NOT RPTD	05/30/2010

©2012 by the American Medical Association

AMA Physician Profile

ECFMG Certification:

Applicant Number:

Note: **The Education Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
XXXXXX389	22N 33N 4 5	11/01/2012	04/30/2010
Address:	123 Main Street, Anycity, IL 12345-9876		
XXXXXX174	2N 33N 4 5	11/01/2012	04/30/2010
Address:	5678 Central Ave., Anotherville, IL 12654-3210		

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.**

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS®) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification, and Federal DEA registration.

Certifying Board: AMERICAN BOARD OF FAMILY PRACTICE
Certificate: FAMILY PRACTICE
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
TIME LIMITED	01/01/2001	12/31/2012	RE-CERT	04/14/2010
TIME LIMITED	01/01/1994	12/31/2002	RE-CERT	04/14/2010
TIME LIMITED	01/01/1987	NONE REPORTED TO DATE	INITIAL	04/14/2010

Note: **For certification dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information. **Indicates an expired certificate.**

***This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2012 American Board of Medical Specialties. All rights reserved.**

AMA Physician Profile

Physician's Recognition Award:

THIS PHYSICIAN HOLDS AMA PHYSICIAN'S RECOGNITION AWARD CERTIFICATE (AMA PRA), VALID THROUGH 01/01/2010. THE AMA PRA CERTIFICATE RECOGNIZES PHYSICIANS WHO COMPLETE AT LEAST FIFTY HOURS OF CONTINUING MEDICAL EDUCATION ANNUALLY.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanctions(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the Physician Profile is intended to assist with credentialing. Appropriate use of the data contained in the AMA Physician Masterfile by an organization meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and Federal DEA registration.

If you note any discrepancies, please log onto our web site (www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800-665-2882
312 464-5900(fax)

If you have any questions or need additional information about the AMA Profile Service, please call 1-800-665-2882.

©2012 by the American Medical Association

I certify that I have viewed the original document corresponding to the photocopy above and can attest that the person who presented the document, ___________________________________,
(applicant's name)
was positively identified as the person in the picture.

____ ___________________
Hospital Representative Signature Date

____ ___________________________________
Printed Name Title

PLEASE DO NOT REMOVE FROM COMMITTEE ROOM

CREDENTIALS COMMITTEE
May 10, 2012

****Privileged and Confidential Peer Review Information****

PERSONAL INFORMATION

Provider Name & Title	Test Test, M.D.

BOARD CERTIFICATION

Board Certification	Board Cert - Current American Board of Thoracic Surgery NO.: 9999999

EDUCATION/AFFILIATION INFORMATION

Medical School Information	Medical/Dental School University of Mississippi School of Medicine From: 01/01/2000 To: 01/01/2001
Internship Information	Internship University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Residency Information	Residency University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Fellowship Information	Fellowship University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Professional Degree	Master's Degree University of Mississippi School of Medicine, M.D. From: 01/01/2000 To: 01/01/2001

LICENSE/REGISTRATION/INSURANCE INFORMATION

State License(s) Information	License - MS Professional Mississippi State Board of Medical Licensure NO.: 999999
Federal DEA License Information	DEA - Federal Drug Enforcement Administration NO.: 99999999
ATLS	
ACLS	
PALS	
Malpractice Insurance Info.	Medical Assurance Company of Mississippi Policy #: 99999-99999 Enrolled: 01/01/2001 Coverage: 1M/3M Expires: 12/31/2011
Malpractice History	1/1/2011 - Failure to Diagnosis

FPPE

Procedure/Privileges	***Requirements***	***Proctor***
Core - Cardiothoracic Surgery	1 concurrent & 4 retrospective case reviews	Test Test, M.D.

REVIEWS AND ATTESTATIONS

License is current and unrestricted.	X
DEA (if applicable) is current and unrestricted.	X
No federal sanctions identified.	X
NPDB/HIPDB report reviewed, no issues identified.	X
Information from prior clinical practice settings reviewed.	X
Nothing identified suggesting problems with clinical practice, behavior, or adherence to medical staff rules identified.	X
No prior investigations, disciplinary action, or other issues identified through prior hospital affiliations and/or peer references.	X
No evidence of health status problems that would impair ability to exercise privileges requested.	X
Other:	

CREDENTIALS COMMITTEE RECOMMENDATIONS
TO MEDICAL EXECUTIVE COMMITTEE
FOR NEW APPLICANTS

May 10, 2012

CREDENTIALS COMMITTEE: April 24, 2012

Privileged and Confidential*

PERSONAL INFORMATION

Provider Name & Title	Test Test, M.D.

BOARD CERTIFICATION

Board Certification	Board Cert - Current American Board of Thoracic Surgery NO.: 9999999

EDUCATION/AFFILIATION INFORMATION

Medical School Information	Medical/Dental School University of Mississippi School of Medicine From: 01/01/2000 To: 01/01/2001
Internship Information	Internship University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Residency Information	Residency University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Fellowship Information	Fellowship University of Mississippi Medical Center From: 01/01/2000 To: 01/01/2001
Professional Degree	Master's Degree University of Mississippi School of Medicine, M.D. From: 01/01/2000 To: 01/01/2001

FPPE

Procedure/Privileges	*Requirements*	*Proctor*
Core - Cardiothoracic Surgery	1 concurrent & 4 retrospective case reviews	Test Test, M.D.

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-1238910

May 10, 2012

Test Test, M.D.

Dear Provider:

Your appointment and privileges at Anytown Hospitals and Health Systems were approved by the Medical Executive Committee and Board on May 10, 2012**,** with an effective date of 05/10/2012 through 04/30/2014. On behalf of the administrative staff of Anytown Hospitals and Health Systems, I would like to welcome you. I would also like to take this opportunity to offer the assistance of our entire staff to help you in assuring the best possible care for our patients. We are here to assist you and our patients in any way possible.

For your convenience, you may access information about our organization and The Anytown Hospital from the intranet at http://medstaff.anytownhospital.edu/credentialing.html. We encourage you to review the information available. You will be able to access links to the Hospital Policy and Procedures Manual, Medical Staff Bylaws & Rules and Regulations, and the Medical Staff Policy and Procedures Manual from this site. The informational items provided on the site should assist you in understanding some of our procedures. Should you have any questions about these, please contact this office and we will be glad to help you.

As a privileged provider, you may be subject to focused professional practice evaluation requirements. The medical staff services office will contact you and your evaluator regarding the requirements and time frames related to this process.

This institution is glad to have you as a member of our select group of providers. We in administration are available and anxious to assist you anytime, day or night, in your practice here. Please feel free to call on us.

Again, I would like to welcome you and invite you to visit and meet the administrative team of The Anytown Hospital.

Sincerely,

John Doe
Interim Chief Executive Officer
University Hospitals and Health System

Focused Professional Practice Evaluation Plan

Practitioner Name: Test Test, MD	Department/Specialty: Pediatrics / Cardiology	Approval Date:

Reason for FPPE: ☐ New appointment ☐ New privilege(s)

Did provider complete formal residency or fellowship training in a program sponsored by AHHS within the past one (1) year from the date of application? ☐ **Yes** ☐ **No**

Privilege	**Methodology for FPPE & Amount Required**		**Types of cases for review (if applicable)**	**Eval due date**	**Evaluator/Proctor**
	Concurrent Review	**Retrospective Review**			
Core Privileges: **Pediatric Cardiology Core Privileges**	**1**	**4**		30 Days	
Non-Core privileges: **Administration of Sedation and Analgesia**	**1**	**1**		30 Days	

FOR USE BY MEDICAL STAFF SERVICES ONLY

External Review Required:	☐ No peer evaluator ☐ No objectivity ☐ None required: objective expertise available
External Reviewer Contact Information:	

Extensions to initial FPPE period granted:	Date: __________	Reason: ____________________
	Date: __________	Reason: ____________________
	Date: __________	Reason: ____________________
	Date: __________	Reason: ____________________

Plan reviewed and approved by department chair:	Signature: ____________________ Date: ____________

ANYTOWN HOSPITALS AND HEALTH SYSTEM

REAPPOINTMENT CREDENTIALING CHECKLIST

Test Test, M.D. 999-99-9999 Pediatrics/General Pediatrics

Date recd ___________

Credentials Committee ________ Executive Committee/Board Approval Date: _________

Reappointment dates 1/1/2012 – 12/31/2013

	Verification source	Date recd.	Eff. Date	Exp. Date	Verif. by
Attestation Date of attestation: _____________	Application		N/A	N/A	
Disclosure questions—issues identified? ___yes ___no	Application		N/A	N/A	
References					
	Letter from Peer		N/A	N/A	
	Letter from Peer		N/A	N/A	
Outside Affiliations					

Notes	**Addressed**

Privilege Additions (Name of Priv)	**Volume/ required information**	**FPPE Plan**

Privilege Deletion (Name of Priv)	**Privilege Deletion (Name of Priv)**	**Privilege Deletion (Name of Priv)**

	Verification source	Date verif. (recd.)	Eff. Date	Exp. Date	Verif. by
License Verification State Mississippi 99999	MSBML Online _________________________ _________________________	________ ________ ________	02/22/1999	06/30/2012	___ ___
DEA Certificate BS9999999	NTIS				
Malpractice Insurance Medical Assurance Company of Mississippi 99999-9999				01/01/2012	
Board certification __yes __no ___in process/eligible American Board of Pediatrics`	CertiFACTS online	________ ________ ________	_10/19/1999/ / /	02/28/2012	____ ____ _
NPDB/HIPDB Report (180 days) Identified issues? _____yes _____no	NPDB/HIPDB database		N/A	N/A	
EPLS/GSA report Identified issues? _____yes _____no	EPLS/GSA online exclusions list		N/A	N/A	
OIG Exclusions report Identified issues? _____yes _____no	OIG online exclusions list	Monthly	N/A	N/A	N/A
Claims history (past 5 years) Medical Assurance Company of Mississippi _________________________ _________________________	_________________________ _________________________ _________________________	________ ________ ________	N/A N/A N/A	N/A N/A N/A	___ ____ __

Signatures	Completed
Privilege sheet signed by chair	
Privilege sheet signed by Division Chief	
Privilege sheets signed by Pediatric Credentials Representative	
Privilege sheets signed by Trauma director	
Privilege sheet signed by Laser Safety Committee Chair	

ANYTOWN HOSPITALS AND HEALTH SYSTEM
123 Main St.
Anytown, USA 12345

Medical Staff Services

601-123-4567
FAX 601-1238910

December 7, 2011

Test Test, M.D.
Department of Family Medicine

Dear Dr. Test:

I am pleased to inform you that on December 7, 2011, the Board approved the recommendation of the Credentials Committee and Medical Executive Committee to reappoint you with clinical privileges as delineated by your department chair in the department of Family Medicine. Your appointment is effective January 1, 2012 through December 31, 2013. Your privilege listing is available on the AHHS intranet by accessing Healthcare>Provider Privileges.

If you have any questions about your appointment and/or privileges, please contact the Medical Staff Services office at 601-123-4567.

Sincerely,