



REAPPOINTMENT APPLICATION FOR ALLIED HEALTH PROFESSIONAL MEMBERS

INSTRUCTIONS FOR COMPLETING REAPPOINTMENT PACKET

1. Update your Texas Standard Credentialing Application.
2. Complete additional attached forms for Texas Health Presbyterian Rockwall.
3. Return your completed application packet via mail to the Medical Staff Office within 30 days. Please utilize the checklist below for items include in your packet.

CHECKLIST OF ITEMS TO RETURN FOR YOUR REAPPOINTMENT APPLICATION

1. Completed TSCA Application (www.tdi.state.txu.us/forms/form9credential.html)
2. Completed PHR Application Attachments (PAGES 2-8)
3. Completed Delineation of Privileges Request Form
4. Attach current photo to PAGE 2 of the PHR Application Attachments
5. Copy of current TB testing / NOTE: Skin tests must be read within past 12 months
6. Detailed explanation for any affirmative responses on TSCA
7. Copy of your current malpractice insurance certificate
8. Return Reappointment fee \$75.00 (non-refundable)

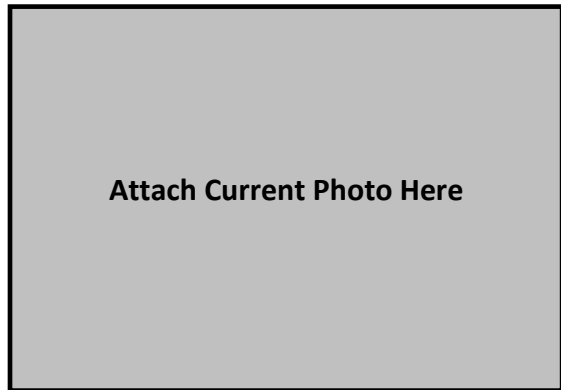
*****Please be advised that Reappointment Application must be returned within 30 days from the receipt of application packet*****

RETURN MAILING ADDRESS

**Medical Staff Office
Texas Health Presbyterian Hospital Rockwall
3150 Horizon Road
Rockwall, TX 75032**

*****If you do not seek reappointment at Presbyterian Hospital of Rockwall, please notify our office by completing PAGE 9 of this packet.*****

Medical Staff Office - Texas Health Presbyterian Hospital Rockwall
Phone: 469-698-1572 - Fax: 469-698-1791 - Email: Alice.Willis@phrtexas.com



Print Applicant's Name and Professional Suffix (PA, NP, PhD)

Specialty

Supervising Physician(s) Name

CONTACT INFORMATION

NAME OF APPLICANT:	
Primary Office Address:	
City, State, Zip	
Primary Office Phone:	
Primary Office Fax:	
Applicant E-mail:	
Credentials Contact:	
Contact Phone:	
Contact Fax:	
Contact E-mail:	

*****MANDATORY UPIN/NPI INFORMATION FOR BILLING OFFICE*****

UPIN:	
NPI:	

*In an effort to expedite your application, the above contact information is requested.
 If there are any delays with your application, the above contact person will be notified.*

CME ATTESTATION

Presbyterian Hospital of Rockwall Medical Staff Bylaws requires continuing medical education (CME) credits in the same amount as required by the state for licensure.

Have you met the minimum continuing education requirements for renewal of your license in the past two years?

Yes No

I hereby certify I have completed the required continuing medical education. If audited, I will be able to provide documentation of the seminars or courses I attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the Medical Staff.

Physician Signature

Date

HEALTH STATUS ATTESTATION

1. What is your current health status? GOOD FAIR POOR

2. Do you have any physical or mental health problems that would affect your clinical judgment and/or motor skills? YES NO

3. Are you taking any medications that would affect your clinical judgment and/or motor skills? YES NO

4. Since your last appointment, have you experienced any alcohol and/or drug dependency? YES NO



BACKGROUND VERIFICATION AUTHORIZATION

I authorize Presbyterian Hospital of Rockwall to conduct an investigation, as necessary, of my state licensure, medical education, residencies, malpractice history, criminal history, employment history and background, which may include, but may not be limited to, procuring consumer reports from consumer reporting agencies.

Signature: _____ Date: _____

POLICY: MANAGEMENT OF THE DISRUPTIVE PRACTITIONER ACKNOWLEDGMENT

I have received and read a copy of the policy regarding management of the disruptive practitioner and agree to abide by this policy at all times. This policy is available at www.presbyterianrockwall.com under 'Medical Staff Services.'

SIGNED INITIALS: [] _____

COMPLIANCE PROGRAM ACKNOWLEDGMENT STATEMENT

I acknowledge that I have been made aware of the Compliance program and its purpose and intent. I understand that my participation in or lack of is critical to the overall success of **Presbyterian Hospital of Rockwall (PHR)** and its strategic goals. It is further understood that I will abide by all policies and procedures set forth. Secondly, I have received a copy of the Standards of Conduct and will abide by them and utilize them as they relate to the provision of care to the patients of PHR. Finally, it is understood that any violation of compliance policies and procedures may adversely affect my medical staff privileges. This training is available at www.presbyterianrockwall.com under 'Medical Staff Services.'

Signature: _____ Date: _____

AUTHOR IDENTIFICATION

As required by Medicare licensing regulations, a signature must be kept on file for all individuals documenting in the medical record to identify each signature.

Signature

Initials

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CONTACT INFORMATION FOR REFERENCES

******TO AVOID DELAYS IN REAPPOINTMENT, PLEASE INCLUDE FAX NUMBERS ******

- ***Please list (3) peer references and current contact information below.***
- ***Please provide peers that have current clinical contact and will be able to respond to the Medical Staff Office in a timely fashion. If you are in a group practice, at least 2 of your references must be outside of your group practice.***

(1) Peer Reference: _____
Address: _____
City/State: _____
Zip: _____
Phone Number: _____
Fax Number: _____

(2) Peer Reference: _____
Address: _____
City/State: _____
Zip: _____
Phone Number: _____
Fax Number: _____

(3) Peer Reference: _____
Address: _____
City/State: _____
Zip: _____
Phone Number: _____
Fax Number: _____

DEA CERTIFICATE REGISTRATION OF SIGNATURE FORM

Presbyterian Hospital of Rockwall requires DEA numbers and signatures on record in the Pharmacy. This is in compliance with State and Federal regulations for dispensing controlled substance orders to inpatients, outpatients, and emergency room patients.

Please complete the information below and return with your reappointment application packet. ***If you do not have DEA, please print your name below and indicate NONE for registration number.***

PRINTED NAME

APPLICANT SIGNATURE (AS SIGNED ON ORDERS)

DEA REGISTRATION NUMBER
(NUMBER ON DEA REGISTRATION FORM)

EXPIRATION DATE OF DEA REGISTRATION
(AS LISTED ON REGISTRATION FORM)

THIS FORM WILL BE FORWARDED TO THE PHARMACY.



REQUEST FORM FOR NON-REAPPOINTMENT

I do not wish to be reappointed to Presbyterian Hospital of Rockwall.

Reason: _____

Resignation Request effective now or at end of current appointment period? _____

Name: _____

Signature: _____ Date: _____

Please return via fax at 469-698-1791 or by mail to:

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Rockwall, TX 75032**

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