

Thank you for your interest in medical staff membership at Presbyterian Hospital of Rockwall (PHR). Enclosed is an initial appointment application for Allied Health membership.

CHECKLIST OF REQUIRED DOCUMENTATION FOR MID-LEVEL AHP APPLICANTS TO RETURN

1. Completed Texas Standard Credentialing Application (TSCA) Application

- The application can be downloaded from the Texas State Department of Insurance website at www.tdi.state.tx.us/forms.
- The current version of the TSCA must be submitted (TDI Rev. 01/07)
- The release must be signed & dated within the past 12 months.
- For any affirmative responses in Section II ‘Disclosure Questions’, please provide a detailed explanation and appropriate supporting documentation.
- The names and full contact information for 3 peer references must be provided (pages 4-5 on TSCA). Please NOTE the requirements listed below for acceptable peer references.

References must from individuals other than family or affiliated by marriage who must have personal knowledge of the applicant’s recent professional performance, ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by law), and the ability to work cooperatively with others.

A maximum of one (1) person from the same group practice may be used as a peer reference. The peers do not have to be of the same specialty, but should hold the same or higher degree of study. The peers must have observation of the practitioner within the past 3 years.

2. Completed Hospital Addendum

- Pages 2-5 must be returned.
- Attach a recent photo attached to page 2 of the Hospital addendum (i.e. passport photo or Polaroid)
- Your supervising physician(s) must complete statement on Page 3 of application. Each supervising physician must complete a supervising physician statement. You may copy this page as necessary.

3. Completed Privileges Form

- Your supervising physician(s) must complete sign your requested privilege form. Each supervising physician must sign your privilege form. You may copy this page as necessary.

4. Curriculum Vitae

5. Current Copies of the following documents:

- Texas State License
- Education (Degree)
- PPD Test Result (Copy of skin test read or chest x-ray; If skin test, must have been read within past 12 months)
- Board certification (if applicable)
- ACLS/PALS/NRP card (if applicable)
- Malpractice liability insurance face sheet (\$100,000 / \$300,000 minimum liability coverage)
- Texas Drivers License/ TXI ID or Military ID or Passport

6. \$150.00 Application Fee (non-refundable)

**Please return your completed application packet to—
Medical Staff Office
Texas Health Presbyterian Hospital Rockwall
3150 Horizon Road
Rockwall, TX 75032**

Questions? Please contact Medical Staff Services at (469) 698-1572 or Alice.Willis@phrtexas.com

**HOSPITAL ADDENDUM
TO THE TEXAS DEPARTMENT OF INSURANCE (TDI) STANDARDIZED CREDENTIALING
APPLICATION**



SECTION ONE - PERSONAL INFORMATION

LAST NAME: _____	FIRST NAME: _____	SPECIALITY: _____												
CELLULAR: ____/____/____	PREFERRED METHOD OF CONTACT													
PAGER: ____/____/____	<p><i>(please ✓)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;">PRIMARY</td> <td style="width:33%;">SECONDARY</td> <td style="width:33%;">TERTIARY</td> </tr> <tr> <td><input type="checkbox"/> PAGER</td> <td><input type="checkbox"/> PAGER</td> <td><input type="checkbox"/> PAGER</td> </tr> <tr> <td><input type="checkbox"/> CELL PHONE</td> <td><input type="checkbox"/> CELL PHONE</td> <td><input type="checkbox"/> CELL PHONE</td> </tr> <tr> <td><input type="checkbox"/> OFFICE</td> <td><input type="checkbox"/> OFFICE</td> <td><input type="checkbox"/> OFFICE</td> </tr> </table>		PRIMARY	SECONDARY	TERTIARY	<input type="checkbox"/> PAGER	<input type="checkbox"/> PAGER	<input type="checkbox"/> PAGER	<input type="checkbox"/> CELL PHONE	<input type="checkbox"/> CELL PHONE	<input type="checkbox"/> CELL PHONE	<input type="checkbox"/> OFFICE	<input type="checkbox"/> OFFICE	<input type="checkbox"/> OFFICE
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EMAIL: _____														

HEALTH STATUS SUMMARY

(Please ✓ one answer to each question below. Indicate comments as necessary in comment section):

What is your current health status? Good Fair Poor

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

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

History of alcohol or drug dependency? NO YES

Comments: _____

CONTINUING MEDICAL EDUCATION

1. Have you met the minimum continuing education requirements for renewal of your license in the past two years? Yes No

2. Please list or attach a list of the CME/CEU credits attained relative to your specialty during the past two years.

PROGRAM TITLE	DATES ATTENDED	CREDIT HOURS/CATEGORY

APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing.

Photocopies of this agreement shall be as binding as the original.

APPLICANT'S PRINTED NAME _____

APPLICANT'S SIGNATURE _____ DATE ____/____/____

PRACTICE INFORMATION

Supervising Physician (if applicable): _____

Practice or Group Name: _____

Primary Office Address: _____ Office Mgr. Name _____

_____ Designate as Mailing Address
 (✓ if desired)

Phone #: _____ Fax #: _____

SUPERVISING PHYSICIAN STATEMENT

***THIS SECTION TO BE COMPLETED BY SUPERVISING PHYSICIAN.**

I hereby verify that Dr. / Mr. / Ms. _____ is employed by and / or under my supervision in the capacity of:

Clinical Psychologist Physician's Assistant Advanced Nurse Practitioner RN Surgical Technician MA

Other: _____

and that he / she is competent to perform the privileges requested.

He / she will be under my direction at all times, and I agree to assume full responsibility for his / her actions in dealing with my patients while at Presbyterian Hospital of Rockwall. I agree to see my patients, who are in the hospital, every 24 hours. I also agree to notify the Hospital if this person should ever leave my employment.

_____	_____	_____/_____/_____
PHYSICIAN NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE

_____	_____	_____/_____/_____
PHYSICIAN NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE

_____	_____	_____/_____/_____
PHYSICIAN NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE

_____	_____	_____/_____/_____
PHYSICIAN NAME (PRINT)	PHYSICIAN'S 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.

Printed Name

____/____/____
Date

Signature

Initials

BACKGROUND VERIFICATION AUTHORIZATION

As a provider of medical services, Presbyterian Hospital of Rockwall requests your permission to conduct an investigation on your background which may include procurement of information regarding your state licensure, medical education, residencies, malpractice history, criminal history, employment history and background. As part of its investigation, PHR may obtain consumer reports from consumer reporting agencies. Under the Fair Credit Reporting Act (FCRA), PHR is required to obtain your written authorization prior to procuring such consumer reports. Please indicate your consent by signing below.

Please note: Credit histories are not part of the background check performed on physicians. The term “consumer report” applies to any type of information collected and compiled by a third party, but in this case, does not and will not include credit histories.

I, _____, hereby 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.

APPLICANT NAME (PLEASE PRINT)

APPLICANT SIGNATURE

DATE