APPLICATION INFORMATION UPDATE

Atrium Health
Medical Staff Services
Phone: 704-355-2147
Email: MSSproviderREQ@atriumhealth.org

Leave of Absence Return Request: To request a Return from a Leave of Absence, at any of the Atrium Health facilities please complete and submit this form. Please Note: You must provide information sufficient to demonstrate current competence, professional activities and all other applicable qualifications no later than 30 days prior to the conclusion of the leave of absence. Leave of absence and reinstatement are matters of courtesy, not of right.

Full Legal Name:	Title:	Specialty:
Primary Facility:	Department:	
Primary Office Address:	Phone:	Email:
Practice Manager Name:	Phone:	Email:

COVERING PROVIDER OR SPONSORING PHYSICIAN

Please indicate the practitioners who will provide 24 hour/7-day coverage for your patients at the facilities where you are requesting privileges.

CLASSIFICATION REQUEST

Please select the medical staff classification you are requesting at any of the Atrium Health facilities listed below.

Anson
Cleveland
Lincoln
Cabarrus
Pineville
Stanly
Union
University City
Carolinas Medical Center
Carolinas Rehabilitation

PROFESSIONAL PRACTICE

Please answer each of the following questions in full. If the answer to any question is “yes”, please provide a full explanation of the details on a separate sheet, and attach.

1. Has your license to practice in any profession in any state ever been, or is currently the subject of any process which could result in it being, voluntarily or involuntarily, denied, revoked, amended, modified, suspended, reduced, challenged, limited, placed on probation, not renewed, granted with condition, terminated, or relinquished?
   ________ Yes ________ No

2. Have you ever been asked to surrender your license in any state?
   ________ Yes ________ No

3. Have you ever been reprimanded or otherwise sanctioned by, or had conditions placed on your license by any licensure agency?
   ________ Yes ________ No

4. Has your state or federal Drug Enforcement Administration license or other controlled substance authorization ever been, or is it currently the subject of any process which could result in it being, voluntarily or involuntarily, denied, revoked, amended, suspended, reduced, challenged, limited, placed on probation, not renewed, granted with condition, terminated, or relinquished?
   ________ Yes ________ No

5. Have you ever had your right or privilege to participate in Medicare, Medicaid, or any other government sponsored program or any private or public medical insurance program suspended or terminated for any period of time?
_______ Yes _______ No

6. Have you ever been the subject of an investigation by any federal or state agency, private insurer or third party health insurance program?
_______ Yes _______ No

7. Have you ever been excluded or debarred from participation in federal healthcare benefits programs?
_______ Yes _______ No

8. Have you ever been convicted of a crime? If yes, please provide complete details about such instance(s). List of all convictions, including without limitations convictions pleas at *nolo contender* for driving while impaired. You do not need to list minor traffic violations such as parking citations or speeding tickets.
_______ Yes _______ No

9. Have you ever been convicted of any felony or any misdemeanor relating to the practice of your profession, other health care-related matters, third-party reimbursement, violence, or controlled substances violations?
_______ Yes _______ No

10. Have you been reported to the National Practitioner Data Bank by any medical malpractice payers, state licensing boards, hospitals and other health entities or professional societies?
_______ Yes _______ No

11. Has your employment, medical staff appointment, membership status, or clinical privileges or status as a participating provider in a managed care organization ever been voluntarily or involuntarily limited, reduced, revoked, refused, suspended, relinquished, diminished, denied, subject to probationary or other conditions (other than provisional staff appointment), or not renewed at any hospital, health care facility, entity, managed care organization, or institution?
_______ Yes _______ No

12. Have you voluntarily or involuntarily withdrawn your application or appointment, reappointment, clinical privileges, or participating provider status in a managed care organization, or resigned from the medical staff or provider staff before final decision by any hospital, entity, managed care organization or health care facility's governing board?
_______ Yes _______ No

13. Have you ever been the subject of an investigation at any hospital, health care facility, entity, or managed care organization?
_______ Yes _______ No

14. Are there presently any proceeding or investigations taking place at any hospital, health care facility, entity or managed care organization relating to your clinical competence or professional conduct?
_______ Yes _______ No

15. Have you ever been denied a request for membership or privileges at any hospital, entity, or other medical facility?
_______ Yes _______ No

16. Have you ever been the subject of focused individual monitoring relating to your clinical competence or professional conduct at any hospital, health care facility, entity, or managed care organization?
_______ Yes _______ No

17. Have you ever been the subject of professional misconduct proceeding or investigations which may be either closed or still pending, at any hospital, entity, or health care facility, including (i) the substance of the allegations; (ii) the substance of the finding; (iii) the ultimate disposition; (iv) any additional information concerning such proceeding or actions?
_______ Yes _______ No

HEALTH STATUS
If you have answered "yes" to any of the questions below, please give a full explanation of the details on a separate sheet and attach.

18. Are you currently a user of illegal drugs or do you currently abuse the use of legal drugs?
_______ Yes _______ No

19. *Do you have a physical or mental condition which could affect your motor skills or your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently?
_______ Yes _______ No

**Regardless of how this question is answered, the application will be processed in the usual manner. If you have answered this question affirmatively and are found to be professionally qualified for medical staff appointment and the clinical privileges requested, you will be given an opportunity to meet with the Credentials committee to determine what accommodations are necessary or feasible to allow you to practice safely.*

PROFESSIONAL LIABILITY
If the answer to any of the questions below is "yes", please provide a full explanation of the details of each and every matter on a separate sheet, and attach. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. See Professional Liability History on file with CHS below.

20. Does your liability policy cover the clinical privileges you wish to exercise?
_______ Yes _______ No

21. *Have any professional liability suits or claims been made against you?
_______ Yes _______ No

22. *Have any final judgments or settlements been made against you in professional liability?
_______ Yes _______ No

23. *Have any professional liability suits been filed against you that are presently pending?
_______ Yes _______ No

**Please include suits in which a judgment or settlement was made against a medical practice of which you are/were a member, or against an institution where you practiced or by whom you were employed in any matter in which you were involved.*

HISTORY
During your leave were you involved in any clinical activities? No Yes, If yes please provide details below;

CONTINUING MEDICAL EDUCATION
I attest I have met the requirement of the North Carolina Medical Board for Continuing Medical Education (CME) credits. I also attest that they are relevant to the specialty that I am practicing and upon request I will provide proof of such.

PEER REFERENCE
Please list a peer from within the same specialty area that has had recent experience in observing and working with the applicant who can provide adequate information pertaining to current professional competence, specific training or experience, ethical character, ability to perform the procedures requested, and health status.

Name: ____ Fax: ____________ Phone: ________________

Address: _______________________________________ Email: ____

PLEASE NOTE: *If the Leave of Absence was for health reasons, please provide a report from your physician indicating that you are physically and/or mentally capable of resuming a hospital practice and safely exercise the clinical privileges requested.*

__________ ***(please initial) By signing the Atrium Health Applicant's Consent and Release, I acknowledge that I am the person named in the various forms and hereby attest to the truth and accuracy of the information provided. Additionally, I understand that if someone else completed the practice update for me, I am responsible for ensuring that all answers are truthful and complete.***