SURGICARE OF BROOKLYN

(347) 599-2100
(347) 599-2633
313 43rd Street, Brooklyn, NY 11232

SCOB, LLC Credentialing Application

Dear Dr. _____

Thank you for your interest in SCOB, LLC. Enclosed is our application for membership and privileges at our facility. To begin the process of your application, please submit all the requested documentation listed on this checklist. The Credentialing Staff will make initial requests for verification of information. If replies are not received within a reasonable period, you will be notified for necessary follow-up of outstanding information.

Please be aware these documents are crucial in starting and completing your credentialing process:

Documents	Check
Current Curriculum Vitale (Resume)	
Governmental Issued ID (Driver's License or Passport)	
Current NY State Medical License, current NY Registration	
CMSC Application (Completed, Signed, and Dated)	
Current NY Drug Enforcement Administration License	
Current Professional Liability coverage (Minimum $1M/3M) with CMSC, LLC as Certificate Holder **No Binders or Declarations** Copies of Past 10 years of Malpractice coverage	
Current Hospital Appointment Letter and Delineation of Privileges	
Medical Education Diplomas – Medical School / ECFMG Certificate (If Applicable)	
Residency/Fellowship Training Program Diplomas (Clear Copies)	
Current ACLS/BCLS for Anesthesia Providers. BCLS for Surgeons.	
Completed and Signed Delineation of Privileges Request Form (In back of Application)	
Attach evidence of training/certification for privileges request	
Board Certificates (Evidence of board applicable/upcoming test date/Certification)	
Proof of Continuing Medical Education (CME) Within 2 years – Copies of Certificates	
NY State Infection Control Course dated within past 36 months.	
Health Status Form/Physical completed by your personal Physician	
TB Test Documentation (Chest X-ray – past 5 yrs, QFT Gold or PPD within last 10 months)	
Flu Shot Record for the current Flu Season	
Titers – Bloodwork / Lab work (Measles, Mumps, Rubella, Varicella, etc.) – within past 5 years	
Letter of Supervising Physician (PAs/NPs Only)	
Other Documentation	

In order to promptly process/grant privileges, please submit all requested documentation and required forms **(Please make sure copies are clear to avoid delay)**. If you have any questions or need assistance, please do not hesitate to contact the facility. Our office personnel are always available to work with you as you complete the application process.

Applicant's Signature: _____ **Date:** _____ **1 / 12**

Please Print Name: _____

Application for Appointment
Medical Staff (MD, DO, PA)

Application must be filled out completely and clearly (Any fields left blank might cause a delay in processing).

Personal Profile			
*Print First Name:	M.I:	*Last Name:	Degree:
Department:		Specialty	
*SSN (Required):		Gender:	*D.O.B:
Home Address:		City:	
State:		Zip:	
Marital Status:		Birth Place:	Ethnicity:
*Cell Phone/Home Number:		Email Address:	
*NPI:	NY Medicaid#:	Medicare#:	Tax ID:

Education Profile	
College/University:	
Degree:	Date of Graduation:
Address:	

Medical School (In Chronological Order)		
Medical College/University:		
Degree:	Date of Graduation:	
Address:		
If you are Foreign Medical Graduate, do you have E.C.F.M.G Certificate?	Yes, ECFMG No:	No

Internships and/or Residencies: (Please submit copies of all certifications)		
Institution:	Department/Specialty:	
Address:	Inception Date:	Completion Date:
Program Director:		
Institution:	Department/Specialty:	
Address:	Inception Date:	Completion Date:
Program Director:		
Institution:	Department/Specialty:	
Address:	Inception Date:	Completion Date:
Program Director:		

Fellowships or Other Training (Please submit copies of all certifications)		
Institution:	Department/Specialty:	
Address:	Inception Date:	Completion Date:
Program Director:		
Institution:	Department/Specialty:	
Address:	Inception Date:	Completion Date:
Program Director:		
Any Teaching Appointments? Yes No	Institution/State:	

Applicant's Signature: _____ **Date:** _____

Please Print Name: _____

Fellowships or Other Training (Please submit copies of all certifications)

Are you Board Certified?	YES	NO	If Yes, Name of Board:
Are you Board Admissible?	YES	NO	If Yes, Name of Board:
Please list Professional Societies:			

Office Practice Locations and Information

Name of Primary Practice/Address:			Circle Practice Type:	Solo	Group	Clinic Other
Phone #:	Answering Service:		Fax#:			
City:	State:		Zip Code:			
Manager Name:			Is this your Billing Office?	Yes	No	

Office Hours:	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Secondary Practice:			Circle Practice Type:	Solo	Group	Clinic Other
Phone #:	Answering Service:		Fax#:			
City:	State:		Zip Code:			
Manager Name:			Is this your Billing Office?	Yes	No	

Office Hours:	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Center/Surgical Center/Institution Membership (List past and Present Facilities)

1.Facility Name:		Status:
Full Address:		
Phone Number:		Fax Number:
Department Chairman:		
Start Date:	End Date:	Reason for Leaving:
2.Facility Name:		Status:
Full Address:		
Phone Number:		Fax Number:
Department Chairman:		
Start Date:	End Date:	Reason for Leaving:

Applicant's Signature: _____ **Date:** _____

Please Print Name: _____

SCOB, LLC Credentialing Application

Center/Surgical Center/Institution Membership (List past and Present Facilities)			
3.Facility Name:		Status:	
Full Address:			
Phone Number:		Fax Number:	
Department Chairman:			
Start Date:	End Date:	Reason for Leaving:	

Licensure (Please provide clear copies of Valid Current License)			
State: NY	Date Issued:	License #:	Date of Expiration:
NY DEA	Date Issued:	Registration #:	Date of Expiration:

Please submit any copies of special Competence Certification. (If applicable)

Supply at least (3) professional references. The named individuals must have personal knowledge, gained through clinical interaction, of your professional practice over a reasonable amount of time. PLEASE COMPLETE EVERY FIELD, including fax number and/or email address, this might cause a delay in your credentialing if we do not have reliable contact information. clinical interaction, of your professional practice over a reasonable amount of time.

References (Please Print Clearly)	
1.Name:	Specialty:
Office Address:	
Phone Number:	Fax Number:
Email Address:	
2.Name:	Specialty:
Office Address:	
Phone Number:	Fax Number:
Email Address:	
3.Name:	Specialty:
Office Address:	
Phone Number:	Fax Number:
Email Address:	

PROFESSIONAL HISTORY (Please check appropriate box)		
IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.		
A) Have you been named as a defendant in any criminal proceeding?	Yes	No
B) Has your membership or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked or not renewed at any center or health care facility?	Yes	No
C) Have you voluntarily requested limitation, reduction, or restriction of clinical privileges, or have you voluntarily resigned your appointment at any center or institution?	Yes	No
D) Has your license to practice your profession in any jurisdiction ever been voluntarily or involuntarily limited, suspended, revoked, denied, subjected to probationary conditions or relinquished, or have challenges or proceedings toward any of those ever been instituted?	Yes	No

Applicant's Signature: _____ **Date:** _____ **4 / 12**

Please Print Name: _____

PROFESSIONAL HISTORY (Please check appropriate box)

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.

E) Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, suspended, reduced, relinquished or not renewed; or have proceedings toward any of those ends ever been instituted?	Yes	No
F) Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare, Medicaid)?	Yes	No
G) Has your present malpractice insurance carrier excluded any specific procedures from your coverage?	Yes	No
H) Have any malpractice suits been filed against you, which are presently pending?	Yes	No
I) Have any judgments or settlements been made against you in malpractice cases?	Yes	No
J) Have any limitations been placed on your scope of practice with your insurance carrier?	Yes	No
K) Have you voluntarily changed your scope of practice with your insurance carrier? (Major Surgery vs. Minor Surgery)	Yes	No
L) Has any restrictions, limitations or supervision been required by any state agency in any state?	Yes	No

HEALTH STATUS

If you answer "Yes" to any of these questions, please give a full explanation on a separate sheet, and attached During the past year have you:

1. Do you have a physical or psychological condition that could affect your ability to exercise your clinical privileges or would require an accommodation in order for you to exercise the privileges requested safely and competently?	Yes	No
2. Are you taking medication, or under any therapy, that is reasonably likely to affect your Professional or medical duties, affect your clinical judgment or motor skills?	Yes	No
3. Are you presently, or have you ever been, under treatment for dependence of alcohol or drugs?	Yes	No
4. Are you currently under any limitations, in terms of activity or work load	Yes	No
5. Are you currently under the care of a physician or psychologist?	Yes	No
6. Have you had or developed any chronic or recurring illness, major physical disability or mental health problems that would affect your ability to practice in the area in which privileges are sought?	Yes	No

I certify that I am in sound physical and mental health and am in no way impaired to perform the privileges for which I have applied and/or been granted.

Applicant's Signature: _____ **Date:** _____

Please Print Name: _____

DECLARATION & RELEASE

I, the undersigned, attest that I have to the best of my knowledge and judgment truthfully answered every question on this application. I fully understand that any deliberate mis-statement of the truth to any question on this application will constitute cause for immediate denial of my appointment or cause for my summary dismissal from the Medical Staff of SCOB, LLC.

In making this application for appointment to the Medical Staff of this center, I acknowledge my obligation to provide continuous care and supervision of my patients. I acknowledge receipt of, have read and agree to abide by the current Bylaws, Rules and Regulations of the Medical Staff and the governing body of SCOB, LLC. I further agree to be bound by the terms thereof if I am granted membership and clinical privileges.

By applying for appointment to the Medical Staff, I hereby signify my willingness to appear for interviews concerning my application. I hereby authorize the center, its medical staff and their representatives to consult with administrators and members of the medical staff of other centers or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the center, its medical staff and its representatives of all documents, including medical records at other centers, that may be relevant to any evaluation on my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the center and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the center, or its medical staff, and good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff membership and clinical privileges, and hereby consent to the release of such information.

I understand and agree that I, as an applicant for medical staff membership and privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

Applicant's Signature: _____ **Date:** _____

Please Print Name: _____

FOR MEDICAL STAFF OFFICE USE ONLY
(Please continue to next page)

FOR FACILITY REVIEW AND APPROVAL

Appointment Recommendation:

Recommended: Credentialing File reviewed by the Medical Director and Physician Advisory Committee members and medical staff appointment/clinical privileges recommended and approved with privileges in the physician's respective specialty. Approved by the Board of Managers.

Comments, if denied:

Notification details:

Medical Director Signature: Date:

COMMITTEE	APPROVED	DEFERRED	DATE
Physician Advisory Committee Member Signature			
Member of the Center Board Signature			

PROFESSIONAL LIABILITY INSURANCE INFORMATION: *List all carriers in the past 10 years:* ***Please attached copies of the Liability Insurance listed below.***

1. Carrier		
Policy Number	Original Eff. Date	
Mailing Address:	City/State	Zip Code
Telephone #	Fax #	
Per Claim Amount	Aggregate amount	Expiration Date
2. Carrier		
Policy Number	Original Eff. Date	
Mailing Address:	City/State	Zip Code
Telephone #	Fax #	
Per Claim Amount	Aggregate amount	Expiration Date
3. Carrier		
Policy Number	Original Eff. Date	
Mailing Address:	City/State	Zip Code
Telephone #	Fax #	
Per Claim Amount	Aggregate amount	Expiration Date

Applicant's Signature: _____ **Date:** _____ **7 / 12**

Please Print Name: _____

WORK HISTORY

Institution Name/Address:	
Phone Number:	Fax Number
Institution Name/Address:	
Phone Number:	Fax Number

CLAIMS/LITIGATION HISTORY

If you have no claims, please write "0" in the space provided

PLEASE PROVIDE THE FOLLOWING INFORMATION: _____ **TOTAL:** _____

A. Number of Professional Liability Claims or Litigation **filed** _____.
B. Number of Professional Liability Claims or Litigation **pending** _____.
C. Number of Professional Liability Claims or Litigation **settled with payment of Indemnity** _____.
D. Number of Claims Closed without **Indemnity Payment** _____ .

Malpractice Claims Information

Please complete this form if you reported any professional liability activity on your application.
*A separate sheet must be used for **each** professional liability incident.*

Name of Patient:			
Relationship to Patient (attending physician, consultant, etc.):			
Allegation:			
Your Status: (Circle)	Primary Defendant	Co-Defendant	Other (Specify)
Date of Incident:		Date Claim or Suit Filed	
Location of Incident:		County/State where filed:	
Insurance Carrier:		Defense Attorney: (Phone Number)	
Claim Status: _____Open	_____Closed		
If closed, indicate method of closing:			
_____ Dismissed		Date: _____	
_____ Settled with prejudice		Date: _____	
_____ Judgment for defendant		Date: _____	
_____ Judgment for plaintiff		Date: _____	
Amount of settlement or judgment paid on your behalf:		**$** _____	

I certify that all of the information on this sheet is true and correct.

Applicant's Signature: _____ **Date:** _____ **8 / 12**

Please Print Name: _____

AUTHORIZATION AND CONSENT

Applicant Name: _____

By applying for appointment or reappointment to the Medical Staff, I hereby indicate my willingness to appear for interviews in regard to my application, and I hereby authorize SCOB, LLC, the Center, its Medical Staff and their representatives to consult with others who may have information bearing on my competence and qualifications, including center executive and members of the Medical Staff of other centers or institutions with whom I have been associated, past and present malpractice insurance carriers, and any other individuals who may have information bearing upon my competence, character and ethical qualification. I hereby consent to the inspection by SCOB, LLC, the center, its Medical Staff and its representatives of all records and documents that may be material to an evaluation of my professional qualifications, ethics and competence to carry out the clinical privileges requested, as well as my medical qualifications for staff membership. I understand that as part of this inspection, the center may obtain information from other agencies verifying eligibility to participate in federal and other governmental programs, either as part of my credentialing or at any time while I am a Member of the Medical Staff. Information obtained may include the status, background and circumstances of my participation in any federal, state, or other governmental payer program and may include information concerning, my application to, participation in or disqualification from any such program.

By my signature below, I acknowledge that I have read and I understand the foregoing disclosure. I hereby release from liability any and all individuals and organizations who provide information to SCOB, LLC, the Center and its Medical Staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for Medical Staff appointment or reappointment and clinical privileges, and I consent to the release of such information to SCOB, LLC, SCOB, LLC and its Medical Staff to other Centers, Medical Associations and appropriate persons on request regarding any information the Center and the Medical Staff may have concerning me, as long as such release of information is done in good faith and without malice, and I release from liability SCOB, LLC, this Center and its Medical Staff and their employees and agents for doing so.

BYLAWS ATTESTATION

I hereby acknowledge receipt and have read of the Bylaws, Rules and Regulations of the Medical Staff of SCOB, LLC (CENTER) and I will abide by the center policies and procedures and the Medical Staff Bylaws and Rules and Regulations. I understand that it is my responsibility to read and comply with all information contained in these documents as well as any revisions made to it.

CODE OF CONDUCT CONFIRMATION OF RECEIPT

ACKNOWLEDGEMENT OF RECEIPT OF THE SCOB, LLC COMPLIANCE PROGRAM'S CODE OF CONDUCT.

I hereby confirm that I have been provided a copy of SCOB, LLC Code of Conduct and that I have read and understood it. I understand that SCOB, LLC expects me to conduct all of my business related activities while in the employ of SCOB, LLC in accordance with the principles set forth in the Code and that failure to do so on my part may lead to disciplinary measures being taken against me up to and including termination.

Applicant's Signature: _____ **Date:** _____ **9 / 12**

Please Print Name: _____

I, _____ (print name), acknowledge that I have received a copy of the CODE OF CONDUCT. By signing my name below, I acknowledge that I have read, reviewed, understand, accept and agree to comply with the information contained in the manual and guidelines provided to me by CENTER.

I understand the manual and guidelines are not intended to cover every situation, which may arise, but is simply a general guide.

PATIENT CONFIDENTIALITY / INFORMATION ACCESS / PHYSICIAN PASSWORD AGREEMENT

NAME:_____ DEPARTMENT: _____

SOCIAL SECURITY NUMBER (Last 4 digits only): _____

Employment or Medical Staff Membership at SCOB, LLC provides access to information that is confidential in nature. Access to confidential information places the center, medical staff and employees in a special position of trust and professional responsibility.

Therefore, it is expected and mandatory that all confidential information, and any individually identifiable personal health information of patients and employees (whether in electronic or paper form) be retained in the designated work and storage areas and secured at all times. Only those employees / Medical Staff Members having authorization and "need to know" shall be afforded access to confidential information or shall attempt to access or disclose confidential information. Confidential information includes individually identifiable health information and all other information described below.

"Confidential Information" and "Individually Identifiable Personal Health Information" as used in this policy shall be meant to include, but not be limited to:

- Patient status and medical condition
- Patient financial status and accounts
- Patient medical records (whether current or past or in electronic media or on paper)
- Patient social security number, phone numbers, address, date of birth etc.
- Employee confidential information
- Employee health records
- Computer programs and applications
- Computer and software access "passwords"

Unauthorized access and/or disclosures of the above information is considered a serious violation of appropriate conduct and in the event of such a violation, disciplinary action may be taken by SCOB. LLC up to and including termination of relationship. Depending on the nature of the violation, legal or governmental actions may also be initiated against the employee.

Employee / Medical Staff Member agrees not to disclose their passwords; to access or disclose confidential information not directly related to their specific job function; not discuss confidential information in a public area or with others not directly involved in a patient's care. Employee further agrees that following separation of the relationship with SCOB, LLC, employee or Medical Staff Member will not, either directly or indirectly disclose confidential information nor disclose passwords to any person or entity.

I, the undersigned, hereby acknowledge that I have read and understand this Patient Confidentiality, Information Access, and Employee Password Agreement and understand my obligations with regard to access and/or disclosure of confidential information and passwords.

Applicant's Signature:_____ **Date:** _____ **10 / 12**

Please Print Name: _____

SCOB, LLC Credentialing Application

CONTINUING MEDICAL EDUCATION ATTESTATION

SCOB, LLC Medical Staff Bylaws requires evidence of continuing medical education (CME) credits.
You must submit evidence of CME credits within your professional field at the time of your initial appointment.

Please provide evidence of CME credits within your professional field – 20 Contact hours.

CENTER-ORIENTATION AND MANUAL TRAINING

General Policy:	
Patient Safety	
Risk Management	
Regulatory Agency Overview	
Abuse (Child-Domestic-Elder-Sexual)	
Workplace Violence Prevention Program	
Dress Code	
Code of Conduct	
Safe Patient Handling	
Chain of Command	
Cultural Competence	
General overview of Quality Assurance & Performance Improvement Activities	
Environment of Care:	
Workplace Safety (accidents/injuries procedures, Safety Hazards)	
Security, Access control, Workplace Violence Prevention, ID Compliance	
HAZMAT/The Right to Know Law & OSHA Training	
Life/Fire Safety/Fire Drills, ILSM & NO smoking P & P, fire plan and drills.	
Medical Equipment-equipment safety, incidents etc...	
Utilities-Electrical Equipment, Emergency Power - Generator	
Emergency Management/Planning & Center Incident Command System	
Emergency Codes & Radiation Safety/ C-arm use, use of Dosimetry Badge	
Infection Prevention & Control:	
Proper PPE	
One Syringe, One Needle, One Patient	
Latex Allergy	
Patient Rights and Responsibilities	
Advance Directives	
Center-Specific Policies and Procedures	
Code /MH Cart Location and Use	
Medical Record Requirements	
Dictation	

I have received and reviewed "The CENTER-Education and Orientation Manual", I am aware that CENTER Policies and Procedures can be reviewed or requested by contacting the Administrator.

Applicant's Signature: _____ **Date:** _____ **11 / 12**

Please Print Name: _____

COMMUNICATION POLICY

All of us at SCOB, LLC take pride in the strides we have made to improve patient care, our facilities and our work environment. We want the community to know about our progress but communicating change to the public is not an easy task. We make sure to communicate through new stories, television interviews, newsletters, advertising and direct community contacts, but there is much more to be done. And all of us must help.

Each of us plays a crucial role in telling our story to the community. The work we do and everything we say about SCOB, LLC reflects on each and every one of us. Good words build understanding and confidence; negative words tear them down. As a result, all of us who serve as staff or trustee have an obligation to serve with pride and talk about our experiences. We are a team. And when there is a problem, we have an obligation to bring it to the attention of our teammates so that it can be addressed. Unless otherwise advised, discussing issues or problems to media or other members of the community is prohibited.

To help ensure everyone's rights and responsibilities are clear, the SCOB, LLC Governing Board has established the following communication policies for itself, each affiliate and all staff:

1. Patient confidentiality is absolute. No information regarding patients should ever be shared with the media or anyone else, other than the immediate family, upon patient's agreement, with appropriate HIPAA release. Requests for information should be referred to the Administrator.
2. Personal attacks by any staff member or Board Member are unacceptable. They will result in the disciplinary action up to and including termination of relationship.
3. Neither trustees nor staff members are authorized to initiate contact with the media or respond to a media inquiry about center or affiliate affairs. Prior notice and approval by the Administrator are required.

In sum, it is a condition of employment or appointment at SCOB, LLC ., or any other SCOB, LLC affiliate to communicate with each other and the public, when required, in a positive manner and to desist from public statements that damage the reputation of SCOB, LLC or each other. If in doubt as to the meaning of this policy, or any matters relation communication, contact the SCOB, LLC Administrator.

DELINEATION OF PRIVILEGES (DOP) FORM

DEPARTMENT: _____

Instruction for completing the DOP:

Attached to this application please find your Delineation of Privileges; check privileges requested at each location (first column). At the discretion of the Medical Director or Physician Advisory Committee additional training certificate or case log may be required.

Leave BLANK those for which you do not want privileges. By signing this form you are attesting that you have met the required experience for each of the procedures listed. * Please read privileges thoroughly and provide appropriate documentation when needed to avoid delay in credentialing.

Thank you, please submit application via email to Surgicaladministrator@cmscny.com

Applicant's Signature: _____ **Date:** _____ **12 / 12**

Please Print Name: _____