YALE NEW HAVEN HOSPITAL

Recommendation for Appointment to the Clinical Fellow Staff

APPLICANT- PLEASE COMPLETE THE FOLLOWING:

NAME			
	Last *First* *Middle*		
DEGREE TYPE	☐ MD ☐ DO ☐ DDS ☐ DMD ☐ OTHER (specify) _____		
SOCIAL SECURITY #			
DATE OF BIRTH		**PLACE OF BIRTH**	
DEPARTMENT		**SECTION**	
MEDICAL SCHOOL		**MONTH/YEAR GRADUATED**	
ECFMG # (if applicable)			
REQUESTED START DATE			
POSTGRAD.YEAR: _____for year beginning _____(mo/yr), (# years in clinical training since graduation from medical school)			

DEPARTMENT- PLEASE COMPLETE THE FOLLOWING
FUNDING SOURCE
EMPLOYER
HOSPITAL ADDRESS (building & room #)
HOSPITAL PHONE #
HOSPITAL FAX #
IS THIS PROGRAM ACGME APPROVED? YES ☐ NO
THIS APPLICANT IS A (check all that apply): **Graduate from a school approved by the Council on Medical Education and Hospitals of the American Medical Association or by the American Dental Association** **☐ Foreign medical school graduate who has passed an appropriate qualifying examination (ECFMG certificate required)** **☐ Postdoctoral Fellow**
MALPRACTICE INSURANCE (check one): ☐ University Hospital
Signature of Department Chief:

APPLICANT- PLEASE COMPLETE THE FOLLOWING:

Fellows Are Not Required To Have A Connecticut Medical License To Practice Within Their Fellowship Program

Please provide proof of Advanced Cardiac Life Support/Basic Life Support certification if you have it (not required)

NPI #				
CT STATE LICENSE # (IF APPLICABLE)				
OTHER STATE LICENSE # (IF APPLICABLE)				
CT CONTROLLED SUBSTANCE REGISTRATION # (IF APPLICABLE)				
FEDERAL DEA # (IF APPLICABLE)				
BOARD CERTIFICATION (IF APPLICABLE)	*Board Name & Specialty*	*Date Certified*	*Exp. Date*	*Certificate # (if applicable)*
	1.			
	2.			
	3.			
RACE *(optional)*	*In order to comply with various governmental reporting requirements, we must request that applications for medical staff membership provide information concerning their racial/ethnic background. Please check where appropriate (you may elect not to complete this portion):* **Black Hispanic White, not of Hispanic Origin Asian or Pacific Islander** **American Indian/Alaskan Native I elect not to complete this portion**			
GENDER *(optional)*	**Male Female**			
HOME ADDRESS (IN CT)				
OFFICE ADDRESS (IN CT)				
HOME PHONE # (IN CT)				
MOBILE PHONE #				
YALE EMAIL ADDRESS				
YALE FAX #				
YNHH BEEPER #				

I understand that I cannot submit a bill to Medicare or other payor for services rendered within the scope of my clinical fellow (postdoctoral) training. I certify the information provided is true and complete.

Printed Name *Signature* *Date*

PRACTICE HISTORY INFORMATION

If you answer "yes" to any of the following questions, you must supply full details on a separate sheet. If not applicable, select "no".

1.	**STATE LICENSURE** Regarding your license to practice your profession in any jurisdiction:	
a.	Has your application for a professional license ever been denied?	Yes No
b.	Has your license ever been limited, suspended or revoked?	Yes No
c.	Has the relevant licensing board ever investigated your professional practice or censured or sanctioned you for matters having to do with professional practice?	Yes No
d.	Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board?	Yes No
e.	Have you ever been fined or otherwise sanctioned by a state licensing board?	Yes No
f.	Have you ever voluntarily surrendered your license?	Yes No
2.	Have you ever been, or are you currently, under investigation or involved in any proceeding or other disciplinary matter involving your practice before any state licensing board?	Yes No
	CONTROLLED SUBSTANCE PRESCRIBING	
3.	Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation or has your authority to prescribe ever been under investigation?	Yes No
4.	Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily…	
a.	limited by the agency?	Yes No
b.	suspended?	Yes No
c.	revoked?	Yes No
d.	surrendered?	Yes No
e.	denied renewal?	Yes No
	PROFESSIONAL MEMBERSHIPS	
5.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization?	Yes No
6.	Have you ever been sanctioned or subject to disciplinary action by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked?	Yes No
	EDUCATION	
7.	In medical/professional school, internship, residency, post graduate training or fellowship, were you ever suspended, placed on probation, subject to disciplinary action, formally reprimanded or asked to resign?	Yes No
8.	Did you ever voluntarily resign or withdraw from any of the above programs?	Yes No
	COMPLIANCE	
9.	Has your eligibility to participate in the Medicare or Medicaid or any commercial insurance program ever been suspended or terminated or have you ever been threatened with exclusion or debarment from Medicare or Medicaid?	Yes No
10.	Have you ever been the subject of an investigation by any federal or state agency, including those agencies responsible for administering and overseeing the Medicare and Medicaid programs, or by any commercial insurance company, related to your professional practice, conduct or billing for health care services?	Yes No
11.	Have you ever been listed by the OIG (Office of Inspector General), GSA (General Services Administration), OFAC or any State (including the Connecticut Department of Social Services) as debarred, excluded or otherwise ineligible for Federal health program participation or otherwise sanctioned by the Federal government, including being listed on the EPLS (Excluded Parties List System)?	Yes No

12. Have you ever been charged by any local, state or federal authority, official or agency, entered a plea of guilty or no contest or been convicted of any of the following:		
a. crimes or offenses related to the delivery of or billing for health care services under the Medicare or Medicaid program?	Yes	No
b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care?	Yes	No
c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government?	Yes	No
d. obstruction of justice?	Yes	No
e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance?	Yes	No
f. any other felony or misdemeanor crimes or offenses (excluding only motor vehicle speeding violations and parking tickets)?	Yes	No
HEALTH CARE FACILITY MEMBERSHIP & PRIVILEGES		
13. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility?	Yes	No
14. Have you ever been the subject of a professional review action or any disciplinary action at any hospital or health care facility and/or have you ever been a party to a hearing under any set of medical staff bylaws?	Yes	No
15. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn?	Yes	No
16. Have there been any adverse professional actions or other disciplinary actions ever been made against you related to disruptive behavior or unprofessional conduct?	Yes	No
HEALTH / BEHAVIORAL		
17. Are you presently using or dependent any controlled substance or alcohol?	Yes	No
18. Are you presently using illegal controlled substances (i.e. controlled substances for which you do not have a prescription from your healthcare provider or that you are using contrary to the prescribed dosages) or are you presently dependent upon alcohol?	Yes	No
19. With or without reasonable accommodation, do you have any physical, mental or emotional condition or dependency that would compromise your ability to competently and safely exercise the clinical privileges requested?	Yes	No
20. Has formal disciplinary action or professional review action ever been imposed on you?	Yes	No
LIABILITY HISTORY Please note that minimum insurance limits for the Medical Staff of $1 million per occurrence and $3 million in the aggregate is required (proof of insurance coverage is required).		
21. Have you ever been reported to the National Practitioner Data Bank by any individual or organization for any reason?	Yes	No
22. Has any malpractice or professional liability claim been brought against you? ***If yes**, please complete the attached "Claim/Suit Report" for each case and describe the case indicating the following: a. date and details of the incident(s) b. your role in the incident(s) c. current status of the claim d. if settled, amount paid e. if pending, amount being sought f. professional liability insurer involved	Yes	No
23. Have you ever been denied professional liability coverage or has your professional liability coverage ever been revoked or not renewed by action of the insurer?	Yes	No

Name _____

Authorization & Release

The terms of this Authorization and Release are applicable to all Yale New Haven Health System affiliated entities (each, a "YNHHS Affiliate").

By requesting an application and/or applying for appointment, reappointment, clinical privileges at, or employment by, one or more YNHHS Affiliates or otherwise in connection with third party payor credentialing matters, I accept and agree to the conditions set forth in this Authorization & Release, (1) regardless of whether appointment, clinical privileges or employment is granted, (2) throughout the term of any appointment or reappointment term or clinical privileges or employment that are granted, (3) even if my appointment or privileges are revoked, reduced, restricted, suspended, or otherwise affected as part of one of the YNHHS Affiliate's professional review activities, and (4) with respect to any communications with third parties before, during or after the term of my appointment, reappointment, clinical privileges or employment.

I understand and agree that acceptance of this application/reappointment application does not constitute approval of membership on the Medical Staff of any YNHHS Affiliate and grants me no rights or privileges of membership until such time as I receive written notice of membership status. I understand that this application will not be processed until all requested information has been received and the application has been deemed complete in accordance with the Medical Staff Bylaws of the relevant YNHHS Affiliate. I understand and agree that it is my responsibility to provide correct and complete information in connection with this application.

OBTAINING INFORMATION FROM ANY THIRD PARTY

I hereby authorize each and all of the YNHHS Affiliates, as well as each of their respective representatives, employees, agents and members, as applicable, to contact and gather information from other YNHHS Affiliates and from third parties, including, but not limited to, my prior associates and anyone else regarding any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications.

INFORMATION SHARING

I hereby authorize the YNHHS Affiliates and its authorized employees and representatives to share any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications relevant to my medical staff appointment, clinical privileges and/or employment (if applicable), including but not limited to my primary source verification information, peer review information, Ongoing Professional Practice Evaluation ("OPPE") and Focused Professional Practice Evaluation ("FPPE"), application and health information records, including but not limited to demographics, immunization, titer and PPD records and information, obtained during the course of initial appointment, reappointment and/or while I am a medical staff member of and/or employed (if applicable) by such YNHHS Affiliate.

If I am a member of, or applying to be a member of, the Yale Medicine, I consent and agree with the following: I hereby authorize the YNHHS Medical Staff Administration Department to share my appointment and reappointment application(s) with Yale Medicine.

I agree to sign the necessary consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the YNHHS Affiliates as required by the respective Medical Staff Bylaws or other policies relevant to each YNHHS Affiliate.

I agree that the information about me as described above may be shared at any time (not just while my initial or reappointment application is pending) and may be used by the YNHHS Affiliates for Medical Staff credentialing and peer review (as applicable to YNHHS hospitals), health plan credentialing and recredentialing, medical practice group credentialing and recredentialing, and to assist the YNHHS Affiliates in making determinations regarding medical staff membership, privileging and employment (if applicable).

I consent to and authorize YNHHS Affiliates and their representatives, employees and agents to allow the YNHHS Medical Staff Administration Department and accrediting agency or body access to my credentialing and recredentialing files as requested and, further, to permit such organizations, agencies and bodies to review said files to confirm compliance with applicable contracts.

ABIDE BY MEDICAL STAFF BYLAWS

I have read and agree to abide by the Medical Staff Bylaws, Rules & Regulations and relevant policies (which shall include Infection Control, Safety and Standard Precautions, HIPAA Privacy and Security policies, and any policies governing my clinical specialty or workspace) of each of the YNHHS Affiliates (as applicable) and their respective Medical Staffs. I understand that if I have not already received copies of the Medical Staff Bylaws, Rules & Regulations, or policies applicable to my practice at the YNHHS Affiliates, it is incumbent upon me to contact the relevant entity to request a copy of such documents before signing this Authorization & Release.

I agree to provide for continuous care for my patients, to practice in accordance with my clinical privileges as delineated for each YNHHS Affiliate (as applicable) and to obtain consultations as appropriate.

MISREPRESENTATIONS AND OMISSIONS

I declare under penalty of law that all statements, answers, and information contained in or submitted in conjunction with this application are true, correct and complete to the best of my knowledge. I understand that the discovery of any falsification, misrepresentation, or omission of any fact(s) by me will be sufficient cause for the relevant YNHHS Affiliate to cease processing of my application and/or to deem any appointment, privileges, or other credentials previously granted to me to be automatically relinquished, with no hearing or appeal rights. I agree to inform the relevant YNHHS Affiliate(s) in writing, with or without request, within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

Name _____

I agree to defend and indemnify the YNHHS Affiliates, and their representatives, employees, agents and Medical Staff members, for any damages that incur as a result of any false or misleading information provided by me or any material omissions made by me in conjunction with my request for an application, my application for appointment or reappointment, or my application for clinical privileges, or in conjunction with my failure to comply with any provisions of the respective Medical Staff Bylaws, Rules or Regulations, or policies that require me to notify the YNHHS Affiliates about changes to my qualifications that occur during the term of any appointment or clinical privileges granted to me.

IMMUNITY

To the fullest extent permitted by law, I hereby release from liability and agree not to sue all representatives, employees, agents and Medical Staff members of the YNHHS Affiliates for any action, recommendation, report, statement, communication and/or disclosure that is made, taken or received in the course of appointment, re-appointment or peer review activities. I further release from liability and agree not to sue any and all individuals and organizations who communicate or otherwise provide information to any YNHHS Affiliate and its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications for membership and privileges on the Medical Staffs of the YNHHS Affiliates.

ATTESTATION

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below is my own.

Signature and Date