NAME:

Please indicate below the Medical Staff membership/privileges for which you are applying. One invoice is being supplied for all MHS facilities for your convenience. Payment must be included with your application.

Good Samaritan Hospital	
□ Physician (Active Staff & Locums only) (Initial or Reappointment)	200.00
□ Expedited	500.00
(Courtesy Staff-no fee required)	
□ Allied Health Professional (Initial or Reappointment)	200.00
□ Expedited	300.00

Tacoma General-Allenmore/ Mary Bridge Children's Hospital	
□ Physician (Initial Appointment)	250.00
□ Physician (Reappointment)	100.00
□ Expedited	450.00
□ Allied Health Professional (Initial or Reappointment)	100.00
□ Expedited	250.00

Auburn Medical Center	
□ Physician (Initial Appointment)	250.00
□ Physician (Reappointment)	100.00
□ Expedited	450.00
□ Allied Health Professional (Initial or Reappointment)	100.00
□ Expedited	250.00

MultiCare Connected Care - CIN	
□ Physician (Initial or Reappointment)	NC
□ Allied Health Professional (Initial or Reappointment)	NC

Total amount enclosed:	**$**

Please make one check payable to MultiCare Health System

Please send payment to:

Medical Staff Office
MultiCare Health System
315 Martin Luther King Jr Way
MS: 315-C3-CRD
Tacoma, WA 98405

Please note: Fees or dues are non-refundable. Your MHS application will not be processed until payment is received.

The Medical Staff fees are established by the Medical Executive Committee, as reflected in the Bylaws of the Medical Staffs at Good Samaritan Hospital, Tacoma General Allenmore, Mary Bridge and Auburn Hospitals. If you have any questions concerning credentialing fees and dues, please refer to the respective Medical Staff Rules.

Thank you for requesting an application for Medical Staff membership or credentialing at MultiCare Health System. Please review carefully the enclosed elements necessary to begin processing.

Checklist (please complete) Current copies of the following documents must be submitted with this application. If your application for DEA and/or malpractice insurance are pending, please forward application and send those documents as soon as possible.

- ☐ Washington Practitioner Application (WPA)
- ☐ Attestation Questionnaire Form
- ☐ MultiCare Health System Authorization & Release Form
- ☐ Immunization Form
- ☐ Medicare/TRICARE Physician Acknowledgment Statement
- ☐ Membership/Privileges Hospital Request and Orientation Information
- ☐ Provider Handbook and Problem List Attestation
- ☐ DEA Attestation (if applicable)

Please enclose copies of the following documents, as applicable, to support your application:

- ☐ Copy of current government issued identification (such as drivers license, passport or military ID)
- ☐ Current passport photo (2 x 2 inches in size)
- ☐ Current Curriculum Vitae
- ☐ Current DEA Certificate (if applicable)
- ☐ Current professional liability insurance coverage certificate (minimum of 1 Million/3 Million)

Privileges:

Proof of current clinical competency is required for the privileges requested. This documentation may include:

- ☐ Procedure List: procedures performed, number performed, name of hospital or facility
- ☐ Certificates of training
- ☐ New graduate Residents/Fellows may provide a copy of procedure logs from prior two years

All Information Must Be Printed in Black Ink, Typed or Electronically Generated

Incomplete applications will not be accepted. The timeframe for verification may increase if issues are identified, information is missing or requires clarification, or professional peer references can not be obtained promptly. Please notify your professional references that they will be contacted by MultiCare on your behalf.

If you have any questions regarding this request or the credentialing and privileging process at MultiCare Health System, please contact:

Tacoma (Tacoma General Allenmore & Mary Bridge) Medical Staff Services Office: 253-403-1085
Good Samaritan Hospital Medical Staff Services Office: 253-697-1906
Auburn Medical Center Medical Staff Services Office: (253) 545-2510

PRACTITIONERS' RIGHTS: A Practitioner has the right to submit clarifying information, when information is obtained during the credentialing process that conflict with credentialing application information. A Practitioner has the right to be notified of their application status. A Practitioner has the right to review his/her credentialing file. The review must be arranged through Medical Staff Services personnel, who will be present during the review. If during the review the practitioner identifies information that he/she feels is no longer applicable or is incorrect, he/she will be allowed to write a written addendum that will become a part of the practitioner file. The addendum must be signed and dated by the practitioner to certify the accuracy of the information provided. A copy of the addendum will be given to the Medical Director/Department Chair and/or President of the Medical Staff to determine whether a review is necessary.

MEDICARE / TRICARE
PHYSICIAN ACKNOWLEDGEMENT STATEMENT

NOTICE TO PHYSICIANS: Medicare/TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under federal law.

ACKNOWLEDGEMENT OF RECEIPT DATE: _____

PHYSICIANS NAME (please print) _____

SIGNATURE: _____

The above acknowledgment will be maintained by MultiCare Health System and will be made available to the Professional Review Organization of Washington upon their request.

Per 42 CFR 412.46, inpatient PPS (prospective payment system) hospitals are required to obtain only one signed acknowledgment for physicians who are being granted admitting privileges at the hospital before or at the time the physician admits his/her first patient.

MEDICAID PARTICIPATION STATEMENT

Are you a Medicaid participant? Please circle: ☐YES or ☐NO

Please note: Medicaid participation is not a requirement for Medical Staff membership.

Print Name _____ Date _____

Signature_____

PLEASE NOTE: Completion of this form is mandatory. You will not be granted privileges at a MHS facility without this form being completed and returned.

Information and Education

The Provider Handbook

The Provider Handbook is housed on the medical staffs' (Tacoma General Allenmore Hospital, Mary Bridge Children's Hospital, Good Samaritan Hospital, and Auburn Medical Center) web page. The Provider Handbook is an essential instructional resource including:

- **Patient Safety -** Emergencies; Rapid Response Teams; National Patient Safety Goals; Medication Safety and Labeling Medical Equipment; Universal Protocol: Side/Site Marking & "Time-Out"; Hand-off Communication; Falls Risk and Prevention
- **Physician Clinical Documentation -** Access to MultiCare Connect (EPIC) Electronic Health Record; Physician Online Documentation "Field Manual"; Import and/or Copying Rules; E-Clarification; Top Clinical Documentation Tips for Quality and Coding; H&P; Summary Problem List; Admission Note; Present on Admission vs. Hospital Acquired Condition; Progress Notes; Post Procedure Notes; Discharge and Discharge Criteria; Admission Orders; Orders; Dictation; Authentication of Transcription; *See also Best Practice Use of the Problem List, below*
- **Clinical Essentials -** Patient/ Family Education; Culturally Appropriate Care; Pain Management; Advance Directives; Organ Donation; Informed Consent; Abuse/Neglect; HIPAA/Confidentiality; Restraints; Infection Prevention; Sedation; Unusual/Sentinel/Never Events and Disclosure
- **Improving Outcomes -** MHS Performance Improvement Plan; Evidence Based Care; Core Measures; Publicly Reported Data; Professional Practice Evaluation; Accreditation and Survey Readiness; The MultiCare Difference
- **Ethics -** Code of Ethical Behavior; Patient Rights; Patient Complaints; Quality, Safety of Care

Best Practice Use of the Problem List / Intelligent Medical Objects (IMO)

Expectations for Problem List Documentation in our electronic health record, MultiCare Connect (EPIC), is outlined in the policy, "Electronic Health Record Etiquette: Best Practice Use of the Problem List." The Problem List is a patient level shared list of active problems that informs and influences clinical decision making during current and future encounters. The Problem List can serve as the "Table of Contents" for a patient's medical narrative and communicates the important clinical aspects of a patient's ongoing care to the entire medical care team over time. Given the importance of the Problem List and to assist in finding appropriate clinical terminology Intelligent Medical Objects (IMO) is a tool within MultiCare Connect (Epic) to help select visit/encounter diagnoses or cross encounter problems more easily and more precisely.

- Please access the Provider Handbook at www.multicare.org. (Go to the menu tab "*For Providers",click on "Resources"* and then click on *"MHS Provider Handbook.")*
- Please access the complete policy, "Electronic Health Record Etiquette: Best Practice Use of the Problem List" via the MHS Intranet under "Policies".
- Please access the educational video for IMO and the Problem List via the following link: http://mhsbv5/Education/IMO/videolauncher/

Please sign and date below to indicate your receipt of the information above, and understand that it is your responsibility to review the resources in their entirety.

Return this document, along with your application for membership and/or privileges, to the Medical Staff Services Office.

Print Name _____

_____ _____

Signature Date

IMMUNIZATION CHECKLIST
MEDICAL AND ALLIED HEALTH STAFF
(Non-employed practitioners only)

Name: _____ Date: _____

Please provide documentation of the required immunizations listed below.

REQUIREMENTS

☐ Measles, Mumps, Rubella: Provide proof of immunity to measles, mumps, and rubella:
- Any combination of monovalent or trivalent vaccinations to equal:
  - Two (2) doses of measles and two (2) doses of mumps, and one (1) dose of rubella.
  - Special considerations: The person must have been at least twelve (12) months of age at the time the first vaccine was received. Vaccines must be spaced at least 4 weeks apart.
- If no vaccination records exist or they are incomplete, lab titers are accepted. They must show results for measles, mumps, and rubella individually.
  - If a lab titer is equivocal or negative, subsequent vaccinations must be documented to show immunity.
  - For an equivocal or negative measles or mumps titer, two (2) doses of MMR post titer must be documented.
  - For an equivocal or negative rubella titer, one (1) dose of MMR post titer must be documented.

☐ Varicella (chicken pox): Provide proof of immunity to chickenpox:
- Two (2) varicella vaccines.
  - Must be spaced at least 4 weeks from each other, and the first one must have been given at 12 months of age or greater.
- A positive lab titer. A negative or equivocal titer can be treated by two (2) doses of varicella vaccine at any point before or after the titer.
- Documentation from a Provider of history of chicken pox disease at the time of disease.

☐ Hepatitis B: Provide proof of positive Hepatitis B antibody by titer, or a signed Hepatitis B Waiver.

☐ Hepatitis C: Provide proof of positive Hepatitis C antibody by titer for staff working in Operating Room or Labor & Delivery.

☐ Pertussis: Provide proof of one (1) Tdap vaccination.

☐ Flu Vaccination: Staff in direct patient care positions or in direct patient contact are offered a choice of taking the flu vaccine(s), flu mist if available, or wearing a mask when in patient contact. Staff who engage in direct patient care or are in direct patient contact are required to meet MHS policy "Influenza Immunizations for Employees, Volunteers, Providers and Non-Employee Staff" prior to providing services or being in contact with patients while in any MHS patient care facility."

☐ PPD Testing: MultiCare accepts both QuantiFeron (blood testing) and tuberculin skin testing (TST).
- For QuantiFeron testing: a negative test in the previous twelve (12) months, or
- For TST: An initial two (2) step TST with subsequent annual TST's thereafter is required.
  - All TST documentation must include date placed, date read and millimeter reading.
  - A two (2) step consists of two TSTs, placed at least 7 days apart, but within the same 12 month period.
  - If at any point there are more than 13 months between TSTs either a QuantiFeron lab test must be done, or a new two (2) step TST.
- If at any time in the testing process there is a positive TB screening the following is required:
  - A positive test is defined as:
    - ° QuantiFeron: a "positive" or "weak positive" lab result
    - ° TST: an induration of 10mm or greater
  - A chest x-ray related to the positive TB screen
  - It is recommended that anyone with a positive TB screen be evaluated by his/her primary care provider for possible treatment of latent TB infection (ie izoniazid).
  - A TB symptom checklist must be done at the time of the positive screen, and annually thereafter.
    - ° If at any time symptoms of TB develop, there must be an evaluation by a provider, to include a chest x-ray.
    - ° Annual chest x-rays in asymptomatic people are not required.
  - Other considerations:
    - ° All positive TB screens completed in Pierce County are tracked by the Pierce County Health Department.
    - ° For those people who have had a positive TST but cannot locate the documentation - A QuantiFeron lab test is preferred. When not possible, at a minimum there must be documentation of a negative chest x-ray and a provider treatment plan.
    - ° For those people with an allergy to TST solution or for those people who have had BCG (vaccination or medical treatment): A QuantiFeron lab test is preferred, as it is considered a more definitive screen. However, complying with the above process for positive TB screen is sufficient.

Request for Hospital Membership / Staff Status
Bylaws Receipt
Orientation

Name: _____ Specialty: _____
Date: _____

I am applying for:
- ☐ Medical Staff Membership and/or Privileges – check hospital below
- ☐ Allied Health Staff Membership and/or Privileges - check hospital below
- ☐ Physician or Allied Health Outpatient Privileges only

☐ Tacoma General Allenmore Hospital (includes Day Surgery of Tacoma and Covington) *
☐ Active Staff ☐ Courtesy Staff ☐ Affiliate Staff ☐ AHP Staff

☐ Mary Bridge Children's Hospital *
☐ Active Staff ☐ Courtesy Staff ☐ Affiliate Staff ☐ AHP Staff

☐ Good Samaritan Hospital (includes GSH Ambulatory Surgery Center)
☐ Active Staff ☐ Courtesy Staff ☐ Affiliate Staff ☐ AHP Staff

☐ Auburn Medical Center
☐ Active Staff ☐ Courtesy Staff ☐ Affiliate Staff ☐ AHP Staff

For more information about Staff Status eligibility, prerogatives and responsibilities, please refer to the Bylaws, Rules and Regulations for the hospital to which you are applying, located at this website: http://www.multicare.org/home/medical-staff-bylaws

By my signature below, I acknowledge receipt of access to the Bylaws, Rules and Regulations of the MultiCare Hospital to which I am applying and understand that it is my responsibility to review the documents.

Signature: _____ Date: _____

* **Physician Orientation is mandatory for medical staff membership and privileges at Tacoma General Allenmore Hospital and Mary Bridge Children's Hospital, as well as for ARNPs and Physician Assistants.** If you are an employed provider, this will be facilitated by Provider Services.

If you are a non-employed physician, ARNP, or PA-C, you must schedule your own orientation by contacting Daisy Cordiner in the Tacoma Medical Staff Services Office at 253-403-3844. Orientation is held 8:00 a.m. to 12 p.m. on the first and fourth Wednesday of each month, and must be completed within 30 days of your appointment approval. Providers who fail to schedule and complete orientation within this timeframe may be subject to administrative suspension.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ Complete the application in its entirety using black or blue ink. Keep an unsigned and undated copy of the application on file for future requests. When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 11 and 13. Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application: (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

** All sections must be completed in their entirety. **

II. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number:	Pager Number:	Cell Phone :	E-Mail Address:
Birth Date:	Birth Place (city, state, country):		Citizenship:
Social Security Number	☐ Male ☐ Female	Languages spoken by Practitioner	
Have you ever voluntarily opted-out of Medicare? ☐Yes ☐No			

NPI:	Medicare UPIN:	Medicare Number: (WA)	Medicaid Number(s):	L & I Number(s):

Specialty:	Sub specialties:
Other Professional Interests in Practice, Research, etc.:	

III. PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting

☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile

☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code: #	Org. NPI:
Telephone Number:	Fax Number:		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number:		
E-mail Address:	Fax Number:		
Credentialing Contact (if different from above):	Telephone Number:		
E-mail Address:	Fax Number:		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

If you are a PCP, do you provide OB services? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No

Have you limited your practice in any way (e.g. 18 years or older?)

☐Yes ☐No If yes, please explain:

_____

_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No

If yes, please provide the name and specialty below:

_____

_____

Please list languages spoken by office staff:

_____

_____

Office Hours

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday:_____

Do you provide 24 hour coverage? ☐Yes ☐No

If no, please explain how your patients obtain advice and care after hours:

_____

_____

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group e **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Effective Date at Secondary Practice location (MM/YY) _____

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Secondary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI:
Telephone Number:	Fax Number:		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:	Administration Telephone Number:		
Credentialing Contact (if different from above):	Telephone Number:		
E-mail Address:	Fax Number:		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No
If you are a PCP, do you provide OB services? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____
Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____
Please list languages spoken by office staff:
_____
_____

Office Hours

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday:_____
Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____

A. Inpatient Coverage Plan (for those without admitting privileges)	**Does Not Apply** ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group e — **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

IV. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

V. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

VI. UNDERGRADUATE EDUCATION (*Do not abbreviate*)

Does Not Apply ☐

College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date:
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received		Graduation Date
Mailing Address:	City:	State:	Zip Code:

VII. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date: (mm/yyyy)	Degree Received:
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date: : (mm/yyyy)	Graduation Date: : (mm/yyyy)	Degree Received:
Mailing Address:	City:	State:	Zip Code:

VIII. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION

Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

IX. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

X. RESIDENCIES (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

XI. FELLOWSHIPS (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

XII. PRECEPTORSHIP (Attach Additional Sheet if Necessary)				Does Not Apply ☐
Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number		Email Address	
Dates Attended (mm/yyyy - mm/yyyy):	Training:		Department Chairman:	

XIII. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)			Does Not Apply ☐	
Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number		Email Address	
Dates Attended (mm/yyyy - mm/yyyy):	Position:		Faculty Director:	

XIV. BOARD CERTIFICATION				Does Not Apply ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? ☐ Yes ☐ No If so, list certification and date:				
If you participate in a specialty which does not have board certification, please indicate specialty:				

XV. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XVI. HOSPITAL, MILITARY AND OTHER INSTITUTIONAL AFFILIATIONS **Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Primary Admitting Hospital:	Department
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ can admit to for all locations	
Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ can admit to for all locations	
Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ can admit to for all locations	

B. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

C. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves	
Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Can you admit/follow clients of primary, secondary, other practice locations? **Does Not Apply** o o **Primary practice admits only** o **Secondary practice admits only** o **can admit to for all locations**	

D. APPLICATIONS IN PROCESS (*Do not abbreviate*)

Hospital/Institution:	Phone Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

E. PREVIOUS HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

XVII. WORK HISTORY (*Do not abbreviate*. Do not list if already listed under Hospital Affiliations)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.

Name of Current Practice / Employer:	Contact Name:			Telephone Number: Fax Number:	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)

Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:				Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:				Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:				Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

XVIII. GAPS IN HISTORY Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):
	From (mm/yyyy):	To (mm/yyyy):
	From (mm/yyyy):	To (mm/yyyy):

XIX. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	ZIP:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City	State:	ZIP:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	ZIP:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional) ( )	

XX. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

XXI. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. CURRENT INSURANCE CARRIER:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)			
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - ***To be completed by the practitioner***

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date:_____

Type or Print name here_____

XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Does Not Apply ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

XXII. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

XXIII. CME ATTESTATION STATEMENT

I hereby certify that I have met all Washington State licensure requirements for continuing education in the field of my specialty and have documentation, which I will furnish upon request.

XXIV. CRIMINAL BACKGROUND ATTESTATION STATEMENT

I acknowledge that a criminal background check will be made through the Washington State Patrol Criminal Identification System regarding my record for convictions or offenses against person, adjudication of child abuse in a civil action, and disciplinary board final decisions, as authorized by the Child/Adult Abuse Information Act, RCW 43.43.830 et seq.

PRINT:

SIGNATURE: _____
(Stamped signature is not acceptable)

DATE: _____

Medical & Allied Health Professional Staff Applicant Notice

Pursuant to the requirements of RCW 43.43.834, MultiCare Health System (MHS) must ask you to complete the following Disclosure Statement. Please answer fully and accurately. Background inquiries will be made to the Washington State Patrol and other criminal history and federal exclusion data bases, state or federal law enforcement agencies, courts, and/or licensing agencies.

APPLICANTS MUST SIGN A RELEASE AUTHORIZING SUCH BACKGROUND INQUIRIES. Failure to do so or to provide a complete Disclosure Statement shall prevent the applicant from being granted medical or allied health professional staff membership and privileges.

1. Have you ever been convicted of any crime(s)? ☐Yes ☐ No

If 'YES", please identify the offense(s), provide the date(s) of the conviction(s), the name of the court (e.g., King County Superior Court) and the sentence(s) imposed.

_____

_____

2. Have you ever been:
   a. convicted of any crime against children or other persons;
   b. convicted of crimes relating to financial exploitation If the victim was a vulnerable adult;
   c. convicted of crimes related to drugs as defined in RCW 43.43.830;
   d. found In any dependency action under RCW 13.34.040 to have sexually assaulted or exploited any minor or to have physically abused any minor;
   e. found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;
   f. found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult; or
   g. found by a court in a protection proceeding under chapter 74.34 RCW to have abused or financially exploited a vulnerable adult?

☐Yes ☐No

If your answer is "YES", please describe the circumstances) and provide the date(s) of the finding(s) and the penalty(ies) Imposed.

_____

_____

3. Have you ever had findings made against you in any civil adjudication proceeding' for any of the following:

☐	Yes	☐	No	Domestic Violence
☐	Yes	☐	No	Abuse
☐	Yes	☐	No	Sexual Abuse
☐	Yes	☐	No	Neglect
☐	Yes	☐	No	Exploitation of a child or vulnerable adult
☐	Yes	☐	No	Financial exploitation of a child or vulnerable adult

'Civil adjudicative proceeding includes judicial or administrative proceedings as well as findings by DSHS or *the Department of Health that you have not administratively challenged or appealed.*

If "YES", please identify the specific finding(s), which agency or court made the finding(s), the date(s) of the finding(s) and the penalty(ies) imposed.

_____

_____

I declare under the penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. I understand that if I am granted membership and/or privileges, I am subject to termination for any inaccuracy or omission in the Disclosure Statement. I have signed this Disclosure Statement on the date shown below.

Print Name _____ Date _____

Signature_____

RCW = Revised Code of Washington and WAC = Washington Administrative Code . Full text of the RCW and WAC referenced above can be accessed at http://slc.leg.wa.gov

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.

7. I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.

8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.

11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.

12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

I hereby certify that I have met all Washington State licensure requirements for continuing education in the field of my specialty and have documentation, which I will furnish upon request.

I acknowledge that a criminal background check will be made through the Washington State Patrol Criminal Identification System regarding my record for convictions or offenses against person, adjudication of child abuse in a civil action, and disciplinary board final decisions, as authorized by the Child/Adult Abuse Information Act, RCW 43.43.830 et seq.

PRINT:

SIGNATURE: _____
(Stamped signature is not acceptable)

DATE: _____

*Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).

DEA Prescribing Status / Attestation

☐ DEA PENDING

I attest that I have applied for a Federal DEA registration in order to prescribe controlled substances in the state of Washington. Since my DEA certificate is pending, I understand that until I have supplied MHS Medical Staff Services with a copy I may not prescribe controlled substances at any MHS facility. In addition, I understand that if a patient I am treating requires controlled substances prior to my obtaining appropriate registrations; I will consult a physician with appropriate and valid DEA registration to facilitate the order. I agree to supply a copy of my valid DEA within 90 days of the committee approval date.

Name of physician prescribing on my behalf: _____

☐ DEA CHANGE OF ADDRESS PENDING

I attest that I have applied for a change of address to my Federal DEA registration in order to prescribe controlled substances in the state of Washington. However, since Washington state registration status of my DEA certificate is pending, I understand that until I have supplied MHS Medical Staff Services with a copy I may not prescribe controlled substances at any MHS facility. In addition, I understand that if a patient I am treating requires controlled substances prior to my obtaining appropriate registration; I will consult a physician with appropriate and valid DEA registration to facilitate the order. I agree to supply a copy of my valid, updated DEA within 90 days of the committee approval date.

Name of physician prescribing on my behalf: _____

☐ LOCUM TENENS

I understand that I may not prescribe controlled substances at any MHS facility without a DEA certificate with WA State registration. In addition, I understand that if a patient I am treating requires controlled substances I will consult a physician with appropriate and valid DEA registration to facilitate the order.

Name of physician prescribing on my behalf: _____

_____

Name (please print)

_____ _____

Signature Date

You may quickly update/change your DEA address
and/or schedules online at
http://www.deadiversion.usdoj.gov/drugreg/index.html2