



Administration P.O. Box 1323 Pasco, WA 99301-1323 (509) 547-2204 Fax (509) 547-9329
 Medical 515 W. Court St. Pasco, WA 99301-1323 (509) 547-2204 Fax (509) 545-3960
 Medical Staff Office PO Box 1323 Pasco, WA 99301-1323 (509-543-1921 Fax (509) 542-8836

Dear Prospective Candidate:

Thank you for considering Community Health Center La Clinica. Evaluation of this application consists of two parts. First is to determine your eligibility for appointment. Second is the application/credentialing and privileging process. Enclosed is the pre-application for employment/affiliation with Community Health Center La Clinica, which is the first part. Please complete the forms and either fax or mail them back to me at your earliest convenience. Be sure to enclose copies of

- current license(s) (all states),
- DEA certificate,
- professional liability insurance face sheet,
- ECFMG/USMLE certificate (if applicable),
- professional school diploma,
- evidence of successful completion of an approved residency program in the specialty in which you will seek clinical privileges including copies of certificates,
- evidence of board certification status, and
- your Curriculum Vitae (which includes specific dates of your training and work history, as well as **documentation of all time spans from completion of your professional education through the present time**)

The fax number is **509-542-8836** and the return address is:

Community Health Center La Clinica

Attn: Yadira Alonzo

PO Box 1323

Pasco, WA 99301

Once I have received the pre-application, and the credentials committee has approved me to do so, I will mail the complete application packet to the address indicated on the pre-application form. The pre-application phase can take up to 30 days, or longer in rare situations.

Please note that the credentialing and verification process is very time-intensive and processing your complete initial application will take up to 90 days. We trust that you will appreciate the need for thoroughness in reviewing your pre-application and application.

If you have any questions please do not hesitate to contact me.

Sincerely,

Yadira Alonzo

Yadira Alonzo

Medical Staff Administrative Assistant

/ya

Enclosures: Pre-application & Attestation
Release of Information

Pasco Dental
515 W. Court St.
P.O. Box 1323
Pasco, WA 99301-1323
(509) 547-2209
(509) 544-8768 Fax

Kennewick Clinic
5219 W. Clearwater, Suite 6
Kennewick, WA 99336
(509) 783-4454
(509) 783-6601 Fax

**Nueva Esperanza Community
Counseling Services**
720 W Court St. Suite 8
Pasco, WA 99301
(509) 545-6506
(509) 546-0520 Fax

Self-Help Housing
2508 E. Adelia St.
P.O. Box 1323
Pasco, WA 99301-1323
(509) 546-0740
(509) 546-2166 Fax

**North Franklin Social
Service Center**
6950 Road 170
Basin City, WA 99343
(509) 269-4115
(509) 269-4115 (fax)

**Kennewick Family Dental
Center, La Clinica**
5601 W. Clearwater, Suite 109
Kennewick, WA 99336
(509) 374-1243
(509) 374-2272 (Fax0

Community Health Center La Clinica

Candidate Evaluation Questionnaire

(Note: If attaching a CV, simply reference CV in appropriate areas, be sure all information requested is listed on CV.)

| | | | |
|---|-----------------------|-------------------------|--|
| I. 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: () | |
| Date of Birth: | | Social Security Number: | |
| II. MEDICAL/PROFESSIONAL EDUCATION: | | | |
| Medical / Professional School: | | Start Date: | Graduation Date: |
| | | | Degree Received: |
| Mailing Address: | | | |
| Phone Number(s): | | | |
| Fax Number: | | | |
| III. INTERNSHIP & RESIDENCY: | | | Does Not Apply <input type="checkbox"/> |
| Institution: | Phone Number: | Program Director: | |
| Address: | City: | State: | Zip Code: |
| Type of Internship: | Specialty: | From: | To: |
| Institution: | Phone Number: | Program Director: | |
| Address: | City: | State: | Zip Code: |
| Type of Residency: | Specialty: | From: | To: |
| IV. FELLOWSHIPS: | | | Does Not Apply <input type="checkbox"/> |
| Institution: | Phone Number: | Program Director: | |
| Address: | City: | State: | Zip Code: |
| Course of Study: | | From: | To: |
| Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.) | | | |
| V. STATE LICENSES (Use separate sheet, if necessary): | | | |
| State: | License/Cert Number: | Expiration: | |
| State: | License/Cert Number: | Expiration: | |
| VI. DEA CERTIFICATION: | | | Does Not Apply <input type="checkbox"/> |
| Number: | Expiration: | | |
| VII. CURRENT HOSPITAL AFFILIATIONS (Use separate sheet, if necessary): Does Not Apply <input type="checkbox"/> | | | |
| Name and Address: | Phone Number: | | |
| | Fax Number: | | |
| Name and Address: | Phone Number: | | |
| | Fax Number: | | |
| VII. PEER REFERENCE: (Two peers who are directly familiar with your work, see list of acceptable specialties.) | | | |
| Name and Address: | Phone Number(s): | | |
| | Fax Number/E-mail: | | |
| Name and Address: | Phone Number(s): | | |
| | Fax Number/E-mail: | | |
| Name and Address: | Phone Number(s): | | |
| | Fax Number/E-mail: | | |
| VIII. BOARD STATUS: (Certified? <input type="checkbox"/> yes <input type="checkbox"/> no) | | Date Certified: | |
| Name of Board: | | Expiration Date: | |
| IX. LOCUM TENENS / CONTRACTED SERVICES STATUS: | | | |
| Do you have any obligations, contractual or otherwise, for your services (e.g. locums firms, employment firms, or etc.)? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| If "YES" please list the name of firm/agency, contact name, phone number, fax number, and length of commitment; use separate sheet if necessary. | | | |
| Name and Address: | Phone Number: | Fax Number/E-mail: | |
| Contact Name | Length of Commitment: | | |

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 <input type="checkbox"/> NO <input type="checkbox"/> |
| | b. | Other professional registration or certification in any jurisdiction | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | c. | Specialty or subspecialty board certification | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | d. | Membership on any hospital medical staff | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | e. | Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc. | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | f. | Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | g. | Professional society membership or fellowship | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | h. | Participation/membership in an HMO, PPO, IPA, PHO or other entity | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | i. | Academic Appointment | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | j. | Authority to prescribe controlled substances (DEA or other authority) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. | Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 4. | Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| | a. | Do you have notice of any such anticipated charges? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | b. | Are you currently under governmental investigation? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| C. AFFIRMATION OF ABILITIES | | | |
| 1. | Do you presently use any drugs illegally? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 2. | Do you have, or have you had in the last two 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. <u>If the answer to this question is yes</u> , 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document on a separate sheet the current status and a brief summary including your role.) | | | |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 judgement (court-ordered damage award) in a professional lawsuit? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. | Are there any such claims being asserted against you now? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. | Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage? | | YES <input type="checkbox"/> NO <input type="checkbox"/> |

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 _____

| |
|--|
| Healthcare Organization: - Community Health Center La Clinica |
| And/or Designated Agent: |

CREDENTIALS UPDATE 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, and 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 the disciplinary reporting and 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. For healthcare organizations, I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies.
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 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 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.

Print Name
Here:

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).***