INSTRUCTIONS FOR NEW APPLICATIONS AND REAPPOINTMENT APPLICATIONS FOR CLINICAL PRIVILEGES AT

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Applicant: _____ Department: _____

Please return this form with your application packet.

Mark each location you are requesting clinical privileges for at this appointment/reappointment:

____ University of Mississippi Medical Center Main Campus

____ University of Mississippi Medical Center Grenada

____ Holmes County Hospital & Clinics

Please include the following documentation with your **initial application packet**:

- Copy of Driver's License and/or Passport
- Copy of updated Curriculum Vitae
- Copy of Current Emergency Care Training Certificates (ACLS, ATLS, PALS or BLS)
- Signed privilege forms and any supporting information required
- List of CME hours from the past two years unless a recent graduate
- Current email addresses for each peer reference listed unless currently at UMMC
- Advanced Practice Providers, please include a copy of your Collaborating Physicians

Please include the following documentation with your **reappointment application**:

- Copy of updated Curriculum Vitae
- Signed privilege forms and any supporting information required
- List of CME hours from the past two years
- Current email addresses for each peer reference listed unless currently at UMMC
- Advanced Practice Providers, please include a copy of your Collaborating Physicians

Please check one:

☐ Original Application

☐ Reappointment

Mississippi Participating Physician Application

This application is submitted to UNIVERSITY OF MISSISSIPPI MEDICAL CENTER, herein, this Managed Care Entity [1].

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application.**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birthday Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).	
Social Security #:	Gender [2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity [2] (voluntary):	
Subspecialties: **Internal Medicine**		

III. PRACTICE INFORMATION

Practice Name (if applicable): University Physicians, PLLC			Department Name (if Hospital based):	
Primary Office Street Address: 2500 N. State St.			Primary Office Mailing Address if different from Street Address:	
City: Jackson	State: MS	County: Hinds	Zip: 39216	City: State: County: Zip:
Telephone Number: 601-815-2005			FAX Number: 601-815-0434	
Office Manager/Administrator: Tina Bennett			Telephone Number: 601-815-4775	
			Fax Number: 601-815-0434	
Name Affiliated with Tax ID Number: University Physicians, PLLC			Federal Tax ID Number: 20-8512947 and 64-6008520	

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:
	State: ZIP:
Office Manager/Administrator:	Telephone Number:
	FAX Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Tertiary Office Street Address:	City:
	State: ZIP:
Office Manager/Administrator:	Telephone Number: ( )
	FAX Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Handicap Access: ☑ Yes ☐ No	24 Hour Coverage: ☑ Yes ☐ No
Will you accept new patients? ☑ Yes ☐ No	Back office Telephone Number: ( ) N/A

Please identify other networks in which you participate:

Aetna, AHS, BCBS, First Choice, CIGNA, Coventry, Health Link, MS Physician Care Network, Multiplan, NaphCare, Inc., PPO Plus, UnitedHealthcare, Windsor Medicare

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	**Address**	**Reason for Denial or Deselection**

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? ☐ Yes ☐ No

If Yes, please list:

Medical Group(s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No
Do you intend to serve as a specialist? ☐ Yes ☐ No
If Yes, please list specialty(s):

Please check all that apply:
☐ Solo Practice ☐ Single Specialty
☑ Group Practice ☑ Multi Specialty

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☑ No
If so, please list:

Name:	Type of Provider:	License Number:

Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) ☐ Yes ☐ No

Name:	Mississippi Medical License Number:

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you **do not** perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ NO If Yes, specify limitations:

Do you participate in EDI (electronic date interchange)? ☑ Yes ☐ No
If so, which Network**?**

Do you use a practice management system/software: ☐ Yes ☑ No
If so, which one?

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

Has your office received any of the following accreditation's, certifications, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) ☑ Medicare Certification
☑ Mississippi Department of Health Licensure ☐ Other:

IV. BILLING INFORMATION

Billing Company: University Physicians, PLLC

Street Address: PO Box 24146

City: Jackson

State: MS ZIP: 39225

Contact: Tina Bennett

Telephone Number: 601-925-6805

Name Affiliated with Tax ID Number: University Physicians, PLLC

Federal Tax ID Number: 20-8512947

V. OFFICE HOURS – Please indicate the hours your office is open:

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holidays 24 HOUR COVERAGE

VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company: University Hospitals and Health System Access Center

Telephone Number: ( ) 601-984-1000

Fax Number: ( )

Mailing Address: 2500 N. State St.

City: Jackson

State: MS ZIP: 39216

Covering Physician's Name: N/A Telephone Number: ( ) N/A

Covering Physician's Name: N/A Telephone Number: ( ) N/A

Covering Physician's Name: N/A Telephone Number: ( ) N/A

Covering Physician's Name: N/A Telephone Number: ( ) N/A

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:
N/A	N/A	N/A

Do you have a CLIA Certificate?	Do you have a CLIA waiver?
☐ Yes ☐ No	☐ Yes ☐ No
Certificate Number: N/A	Certificate Expiration Date: N/A

IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

Medical School:	Degree Received:	Date of Graduation (mm/yy)

Mailing Address:	City:	
	State & Country:	ZIP:

Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy)

Mailing Address:	City:	
	State & Country	ZIP:

X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

Institution:	Program Director:	

Mailing Address:	City:	
	State & Country:	ZIP:

Type of Internship:		

Specialty:	From: (mm/yy)	To: (mm/yy)

XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution:	Program Director:	

Mailing Address:	City:	
	State & Country:	ZIP:

Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?

☐Yes ☐No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?
☐Yes ☐No (If "No", please explain on separate sheet.)

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:
- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	**Specialty:**	**Certification Number**:	**Date Certified/ Rectified:**	**Expiration Date (if any):**

Have you applied for board certification other than those indicated above?
☐ Yes ☐No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If Yes, Provide details.

XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: ☐ Yes ☐ No
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:	
Unlimited? ☐ Yes ☐ No If "No", please explain on separate sheet			
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Visa Number:	Date Issued:	Valid Through:

Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:

XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

State	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active:
			☐ Yes ☐ No

XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Are you an Officer or Director of any of the professional organizations listed above?
If Yes, please list: ☐ Yes ☐ No

XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	

If you do not have hospital privileges, please explain.

B. PREVIOUS AFFILIATIONS **(Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of other Hospital/institution:	City:	
	State:	ZIP:
From: (mm/yy) To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:	City:	
	State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:
		Fax Number:
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Name of Practice/Employer:	Contact Name:	Telephone Number:
		Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )
		Fax Number: ( )
Mailing Address:		City:
		State: / ZIP:
From: (mm/yy)		To: (mm/yy)

Section B.

Professional Liability Action Explanation

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

I. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.):

Allegation:

Is/was there any insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If Yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgement rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgement rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled, no judgement rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

SECTION C.
Certification

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is not Acceptable)

Section D.

Attestation Questions

Please answer the following questions "Yes" or "No". If your answer to any question is "Yes" please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending**?**

Yes ☐ No ☐

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending**?**

Yes ☐ No ☐

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?

Yes ☐ No ☐

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes ☐ No ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?

Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)

Yes ☐ No ☐

10. Have any judgements or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?

Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?

Yes ☐ No ☐

12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written Notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (**A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)**

Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

Section E.
Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively. "Healthcare Organizations"), for the purpose of evaluating this applications and any recredentialing application regarding my professional training, experience, character, conduct and judgement, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, 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.

During such time as this application is being processed, I agree to update the application should there by any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including , without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here:_____

Physician Signature: _____Date_____
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:
- ***Mississippi Association of Health Plans***
- ***Mississippi State Medical Association***
- ***Mississippi Hospital Association***

[3] The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

ADDENDUM

- PAGE 13 –
MISSISSIPPI PARTICIPATING PHYSICIAN APPLICATION

CONSENT, RELEASE and ATTESTATION

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
(University Hospitals & Health System, UMMC – Grenada, Holmes County Hospital & Clinics)

PLEASE READ THE FOLLOWING CAREFULLY:

I certify that the above information is correct and recognize that **University of Mississippi Medical Center (UMMC)** is relying upon my truthfulness and completeness in my statements and that this reliance is a substantial factor in considering my application

I understand that any misrepresentation on this application will be cause for immediate relinquishment of clinical privileges.

I understand I may not be considered for the medical/allied health staff of UMMC if my application is deemed incomplete.

I understand that a failure or refusal to sign a consent, release or authorization, or withdrawal of the same shall constitute a material omission from the application which shall result in the application being incomplete and the medical staff office may decline to process it.

I understand that the discovery of information of criminal history may constitute cause for immediate rejection of this application.

I authorize UMMC or their agents to investigate all information and references given herein and, further, I authorize all former employers, associates, or organizations to provide the requested information. I further agree not to make any claims or demands, or allege any damages, either personally or professionally, resulting from the release, dissemination, and discussion of my application and all information and references contained therein by and between parties reasonably entitled to review and consider the same.

As the applicant, I have the burden of producing adequate information for proper evaluation of my application. I also agree to provide the hospital with updated current information regarding all questions on this application for as such requested by the hospital or it's authorized representatives. Failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

Information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to practice with the clinical privileges requested and I further certify that all information provided is current, correct and complete. As a condition to making this application, any misrepresentation or misstatement in, or omission from this application whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment and clinical privileges. In the event that appointment or privileges have been made prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment and privileges.

By applying for appointment and clinical privileges, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted appointment or privileges, and for the duration of such appointment or re-appointments as I may be granted.

(a) To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the hospital, its authorized representatives and any third parties as defined in subdivision (c) below, with respect to any acts, communications or documents, recommendations or disclosures involving me, performed, made, requested or received by the hospital and it's authorized representatives to, from, or by any third party, including otherwise privileged or confidential information, relating, but not limited to the following:

(1) applications for appointment or clinical privileges, including temporary privileges;

(2) evaluations concerning reappointment or changes in clinical privileges;

(3) proceedings for suspension or reduction of clinical privileges or for revocation of medical/allied health staff appointment, or any other disciplinary sanction;

(4) summary suspension;

(5) hearings and appellate reviews;

(6) medical care evaluations;

(7) utilization reviews;

(8) other activities relating to the quality of patient care or professional conduct;

(9) matters or inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal background, ethics or behavior; or

(10) any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

The foregoing acts, communications and documents shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

(b) Authorization to Obtain Information:

I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on my satisfaction of the criteria for initial and continued appointment to the medical/allied health staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representatives upon request.

(c) Definitions:

(1) The term "hospital and its authorized representatives" means the hospital and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's credentials, or acting upon the applicant's or appointee's application or conduct in the hospital; the members of its Board and their appointed representatives; the Chief Executive Officer or his designees; other hospital employees; consultants to the hospital; the hospital's attorneys; associates or designees; and all appointees to the medical/allied health staff who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials, or acting upon his application or conduct in the hospital.

(2) The term "third parties" means all individuals, including appointees to the hospital's medical/allied health staff, and appointees to the medical/allied health staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives ***and persons or agencies employed or retained by the institution to assist it in the application process***.

I acknowledge that Medical/Allied Health staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each individual who has been given an appointment to the medical staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought, and shall be provisional for the time period determined by the Board. I shall have the burden of establishing my qualifications for and competence to exercise the clinical privileges requested. Recommendations of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

I have the responsibility to keep this application current by informing the Health Systems, through the Chief Executive Officer, of any change in the areas of inquiry contained herein, including but not limited to any change in my professional

liability insurance coverage, the filing of a lawsuit against me and any change in my medical/allied health staff status at any other hospital or health care facility.

I have received and had the opportunity to read a copy of the bylaws of the hospital and such hospitals policies and directives as are applicable to the appointees to the medical/allied health staff, including the bylaws and rules and regulations of the medical staff presently in force. I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force during the time I am appointed or re-appointed to the medical/allied health staff or exercise clinical privileges at the hospital.

If appointed or granted clinical privileges, I specifically agree to: keep confidential any and all passwords used to access confidential patient data; refrain from fee splitting or other inducements relating to patient referral; refrain from delegating responsibility for diagnosis or care of hospitalized patients to any other practitioner who is not qualified to under take this responsibility or who is not adequately supervised; refrain from deceiving patients as to the identity of any practitioner providing treatment or services; seek consultation whenever necessary or required; abide by generally recognized ethical principles applicable to my profession; provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and , accept committee assignments and such other duties and responsibilities as shall be assigned to me by the hospital Board and medical staff.

I also understand that I may review information submitted by me in support of my application and that UMMC will notify me if any information variances materially affect consideration of my application during the credentialing process and that I may submit proposed corrections to any erroneous information received during the credentialing process if it varies from information provided by me to the entity.

I understand and acknowledge by my signature below that I have received the following notice:
Medicare 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 applicable Federal laws.

Date_____ Signature_____

University of Mississippi Health Care

University Hospitals and Health System

Expectations of Practitioners Granted Privileges at University Hospitals and Health System

This document describes the expectations that practitioners have of each other as members/practitioners with privileges of the medical staff based on the ACGME/Joint Commission General Competencies framework. The expectations described below reflect current medical staff bylaws, policies and procedures and organizational policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our medical staff's culture and vision.

Medical staff leaders will work to improve individual and aggregate medical staff performance through providing appropriate measurement of these expectations that provides positive and constructive feedback so each practitioner has the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital.

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff (or national) standards of care as defined by comparative outcome data, medical literature and results of peer review activities.
2. Plan and provide appropriate patient management based on patient information, patient preferences, current indications, available scientific evidence and sound clinical judgment.
3. Assure that each patient is evaluated by a physician as defined in the bylaws, rules and regulations and document findings in the medical record at that time.
4. Demonstrate caring and respectful behaviors when interacting with patients and their families.
5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards.
6. Counsel and educate patients and their families.
7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.
8. If applicable, supervise residents, students and allied health professionals to assure patients receive the highest quality of care.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment.
2. Maintain ongoing medical education and board certification as appropriate for each specialty
3. Demonstrate appropriate technical skills and medical knowledge using medical simulation technology where appropriate and if available.

Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self improvement of patient care.
2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.
3. Use hospital information technology to manage information and access on-line medical information.
4. Facilitate the learning of students, trainees and other health care professionals.

Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams as evidenced by the following:

1. Communicate effectively with practitioners, other caregivers, patients and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies.
2. Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and direct practitioner-to-practitioner contact for urgent or emergent requests.
3. Maintain medical records consistent with the medical staff bylaws, rules, regulations and policies.
4. Work effectively with others as a member or leader of a health care team or other professional group.
5. Maintain patient satisfaction with practitioner care.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

1. Act in a professional, respectful manner at all times.
2. Respond promptly to requests for patient care needs.
3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers.
4. Participate in emergency call as defined in the bylaws, rules and regulations.
5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.
6. Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
7. Make positive contributions to the medical staff by participating actively in medical staff functions and by responding in a timely manner when input is requested.

Systems Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals and improve quality.
2. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care.
3. Ensure timely and continuous care of patients by clear identification of covering physicians and by availability through appropriate and timely electronic communication systems.
4. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.
5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.
6. Advocate for quality patient care and assist patients in dealing with system complexities.

I acknowledge that I have been given, and have read the Expectations for Practitioners Granted Privileges at University Hospitals and Health System.

_____	_____	_____
Signature	Printed Name	Date