

Please complete this form, sign it, and e-mail to medicalstaffoffice-pamc@providence.org, or fax to (907) 212-4865			
<i>Degree types eligible to request application: MD, DO, DDS, DMD, DPM, CNM, ANP, PA, PhD, PsyD, Surgical Asst, Dental Asst, Pathology Asst, Perfusionist</i>			
Facility or Facilities you wish to apply for privileges: <input type="checkbox"/> PAMC (Anchorage) <input type="checkbox"/> PSMC (Seward) <input type="checkbox"/> PVMC (Valdez) <input type="checkbox"/> PKIMC (Kodiak Island) <input type="checkbox"/> St. Elias			
Applicant's Name:	Degree	Contact Phone#	Employment Type: <input type="checkbox"/> Employed by Prov <input type="checkbox"/> Contracted by Prov <input type="checkbox"/> Independent <input type="checkbox"/> Fellowship Program
E-Mail:	SSN:	Date of Birth:	Primary Specialty:
Group you will be employed by OR affiliated with in Alaska:		If Locums, who will you be covering for? (<i>Office AND physician name</i>)	
Who will you share call with? (Call coverage is required to be on staff):		If AHP, who will be your supervising Physician?	
Applicant Mailing Address: _____ City _____ State _____ Zip Code _____			
Anticipated Start Date:		If a Locums, please provide anticipated End Date:	
Medical/Professional School Graduation Year:	Internship Program Graduation Year:	Residency Program Graduation Year:	Fellowship Program Graduation Year:
Have you completed a 3 year Residency Program? <input type="checkbox"/> Yes <input type="checkbox"/> No, if NO, you will not qualify to be on staff at PAMC. <input type="checkbox"/> N/A for AHP			
Are you currently on staff at another Providence, Swedish, or Kadlec location? <input type="checkbox"/> Yes <input type="checkbox"/> No --- If so, at which facility?			
Do you grant permission for PAMC to request your demographic profile from the above Providence affiliated facility, to assist you in completing your online application? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had Medical Staff or Allied Health Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this medical center, or health plan for reasons related to clinical competence or professional conduct? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had your medical license revoked, restricted or suspended by any state licensing agency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you board certified in your primary specialty by a board recognized by the ABMS, AOA, or applicable AHP certifying agency? <input type="checkbox"/> Yes <input type="checkbox"/> No,			
If NO, are you board admissible and will board certified within 5 years of training completion? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been excluded from Medicare, Medicaid or any healthcare program as identified on the Government Services Agency "Excluded Parties Listing System" or the Health and Human Services Officer of the Inspector General "Excluded Individual Search"? <input type="checkbox"/> Yes <input type="checkbox"/> No			

CLINICAL PRIVILEGES CHECKLISTS AVAILABLE ✓ PLEASE CHECK THE BOXES OF THE PRIVILEGES YOU WOULD LIKE TO REQUEST.

<ul style="list-style-type: none"> ❖ PRIVILEGES THAT CROSS SPECIALTY LINES: <ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Aortic Stent Grafting <input type="checkbox"/> e-ICU Telemedicine <input type="checkbox"/> Gastrointestinal Endoscopy <input type="checkbox"/> Flexible Fiberoptic Bronchoscopy <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Palliative Care <input type="checkbox"/> Peripheral & Carotid Angioplasty <input type="checkbox"/> Robotics Assisted Surgery <input type="checkbox"/> Sacral Nerve Stimulation (Urology & OB/GYN) <input type="checkbox"/> Sacral Nerve Stimulation for Bowel Control (Colorectal Surgeons) <input type="checkbox"/> Sedation – Moderate & Deep <input type="checkbox"/> Transcatheter Aortic Valve Replace. ❖ ANESTHESIA <ul style="list-style-type: none"> <input type="checkbox"/> Anesthesia (exclusive) <input type="checkbox"/> Chronic Pain Management <input type="checkbox"/> Physical Medicine & Rehabilitation <input type="checkbox"/> EMERGENCY MEDICINE (exclusive) 	<ul style="list-style-type: none"> ❖ FAMILY MEDICINE <ul style="list-style-type: none"> <input type="checkbox"/> Family Medicine <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Family Medicine Center (<i>ONLY for Family Practice Residency Instructors</i>) ❖ MEDICINE <ul style="list-style-type: none"> <input type="checkbox"/> Internal Medicine – General <input type="checkbox"/> Allergy Immunology <input type="checkbox"/> Cardiology <input type="checkbox"/> Critical Care Medicine <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology, Diabetes & Metabolism <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Genetics <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Preventive Medicine/ Occupational <input type="checkbox"/> Pulmonary Medicine <input type="checkbox"/> Radiation Oncology (exclusive) <input type="checkbox"/> Rheumatology <input type="checkbox"/> Sleep Medicine ❖ OB/GYN <ul style="list-style-type: none"> <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Fetal-Maternal Medicine <input type="checkbox"/> Gynecologic Oncology 	<ul style="list-style-type: none"> <input type="checkbox"/> ORTHOPEDIC SURGERY <input type="checkbox"/> PATHOLOGY ❖ PEDIATRICS <ul style="list-style-type: none"> <input type="checkbox"/> Pediatrics – General <input type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Allergy Immunology <input type="checkbox"/> Cardiology <input type="checkbox"/> Critical Care <input type="checkbox"/> Developmental – Behavioral <input type="checkbox"/> Endocrinology, Diabetes & Metabolism <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Medical Genetics <input type="checkbox"/> Neonatology <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology <input type="checkbox"/> PSYCHIATRY <input type="checkbox"/> RADIOLOGY (exclusive) <ul style="list-style-type: none"> <input type="checkbox"/> Eagle River Clinic Privileges 	<ul style="list-style-type: none"> ❖ SURGERY <ul style="list-style-type: none"> <input type="checkbox"/> Bariatric Surgery <input type="checkbox"/> Cardio-Thoracic Surgery <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology <input type="checkbox"/> Vascular Surgery <input type="checkbox"/> Dentistry: <ul style="list-style-type: none"> <input type="checkbox"/> General Dentistry <input type="checkbox"/> Oral-Maxillo Surgery <input type="checkbox"/> Pediatric Dentistry ❖ ALLIED HEALTH PROFESSIONALS <ul style="list-style-type: none"> <input type="checkbox"/> Advanced Nurse Practitioner <ul style="list-style-type: none"> <input type="checkbox"/> Hematology/Oncology <input type="checkbox"/> Psychiatric ED <input type="checkbox"/> Cardio Perfusionist <input type="checkbox"/> Certified Nurse Midwife <input type="checkbox"/> Pathology Assistant <input type="checkbox"/> Physician Assistant <ul style="list-style-type: none"> <input type="checkbox"/> PA Family Medicine Center (<i>employed only</i>) <input type="checkbox"/> Psychologist <input type="checkbox"/> Rehab Psychologist <input type="checkbox"/> Surgical Assistant <ul style="list-style-type: none"> <input type="checkbox"/> Dental Assistant
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I represent that the information provided on this pre-application is accurate, complete and fairly represents my training and current expertise. I understand and agree that any misrepresentation, misstatement, or omission from this application request whether intentional or not may constitute cause to not be provided an application as requested. I understand that in the event of discovery of such an event, or if I do not meet the minimum criteria of PAMC, I will not be provided an application and I will not be entitled to any hearing or appeal rights that are contained in the Hospital or Medical Staff Bylaws, Policies or other regulations. I understand that with the information I have provided above, basic steps to understand my training and background may be checked to further determine my eligibility for medical staff membership and privileges at PAMC, prior to my submitting a full application. If I currently have privileges at a facility that PAMC holds a credentials information sharing agreement with, I authorize such facility to release information covered in the credentials sharing agreement to PAMC. I formally request an application for membership and privileges and certify that I am currently competent to perform the privileges selected above based on my training, recent experience and within the scope of my professional licensure. I will agree that I will provide all necessary documentation, as required, in support of the application for membership and privileges I receive. I also know of no health condition or inability to perform that, without reasonable accommodation that would impair my ability to competently perform the privileges I may be granted.

Signature: _____

Date: _____