PROVIDENCE Health & Services Alaska

REQUEST FOR PRACTITIONER APPLICATION / PRE-APPLICATION

Rev. 03-18

Please complete this form, sign it, and e-mail to medicalstaffoffice-pamc@providence.org, or fax to (907) 212-4865

Degree types eligible to request application: MD, DO, DDS, DMD, DPM, CNM, ANP, PA, PhD, PsyD, CRNA, Surgical Asst, Dental Asst, Pathology Asst, Perfusionist

Facility or Facilities you wish to apply for privileges: ☐ PAMC (Anchorage) ☐ PSMC (Seward) ☐ PVMC (Valdez) ☐ PKIMC (Kodiak Island) ☐ St. Elias

Applicant's Name:	Degree	Contact Phone#	Employment Type: ◯ Employed by Prov ◯ Contracted by Prov ◯ Independent ◯ 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? *(Office AND physician name)*	
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? ◯ Yes ◯ No, if NO, you will not qualify to be on staff at PAMC. ◯ N/A for AHP

Are you currently on staff at another Providence, Swedish, or Kadlec location? ◯ Yes ◯ 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? ◯ Yes ◯ 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? ◯ Yes ◯ No

Have you ever had your medical license revoked, restricted or suspended by any state licensing agency? ◯ Yes ◯ No

Are you board certified in your primary specialty by a board recognized by the ABMS, AOA, or applicable AHP certifying agency? ◯ Yes ◯ No,

If NO, are you board admissible and will board certified within 5 years of training completion? ◯ Yes ◯ 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"? ◯ Yes ◯ No

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

❖ PRIVILEGES THAT CROSS SPECIALTY LINES:

- ☐ Acupuncture
- ☐ Aortic Stent Grafting
- ☐ e-ICU Telemedicine
- ☐ Gastrointestinal Endoscopy
- ☐ Flexible Fiberoptic Bronchoscopy
- ☐ Fluoroscopy
- ☐ Palliative Care
- ☐ Peripheral & Carotid Angioplasty
- ☐ Robotics Assisted Surgery
- ☐ Sacral Nerve Stimulation (Urology & OB/GYN)
- ☐ Sacral Nerve Stimulation for Bowel Control (Colorectal Surgeons)
- ☐ Sedation – Moderate & Deep
- ☐ Transcatheter Valve Replacement

❖ ANESTHESIA

- ☐ Anesthesia (exclusive)
- ☐ Chronic Pain Management
- ☐ Physical Medicine & Rehabilitation

☐ EMERGENCY MEDICINE (exclusive)

❖ FAMILY MEDICINE

- ☐ Family Medicine
- ☐ Cesarean Section
- ☐ Family Medicine Center *(ONLY for Family Practice Residency Instructors)*

❖ MEDICINE

- ☐ Internal Medicine – General
- ☐ Allergy Immunology
- ☐ Cardiology
- ☐ Critical Care Medicine
- ☐ Dermatology
- ☐ Endocrinology, Diabetes & Metabolism
- ☐ Gastroenterology
- ☐ Hematology/Oncology
- ☐ Infectious Disease
- ☐ Medical Genetics
- ☐ Nephrology
- ☐ Neurology
- ☐ Preventive Medicine/ Occupational
- ☐ Pulmonary Medicine
- ☐ Radiation Oncology (exclusive)
- ☐ Rheumatology
- ☐ Sleep Medicine

❖ OB/GYN

- ☐ Cesarean Section
- ☐ Obstetrics/Gynecology
- ☐ Maternal-Fetal Medicine
- ☐ Gynecologic Oncology

☐ ORTHOPEDIC SURGERY

☐ PATHOLOGY (exclusive)

❖ PEDIATRICS

- ☐ Pediatrics – General
- ☐ Adolescent Medicine
- ☐ Allergy Immunology
- ☐ Cardiology
- ☐ Critical Care
- ☐ Developmental – Behavioral
- ☐ Endocrinology, Diabetes & Metabolism
- ☐ Gastroenterology
- ☐ Hematology/Oncology
- ☐ Infectious Disease
- ☐ Medical Genetics
- ☐ Neonatology
- ☐ Nephrology
- ☐ Neurology
- ☐ Pulmonology
- ☐ Rheumatology

☐ PSYCHIATRY

☐ RADIOLOGY (exclusive)

- ☐ Eagle River Clinic Privileges

❖ SURGERY

- ☐ Bariatric Surgery
- ☐ Cardio-Thoracic Surgery
- ☐ General Surgery
- ☐ Neurosurgery
- ☐ Ophthalmology
- ☐ Otolaryngology
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Urology
- ☐ Vascular Surgery
- ☐ Dentistry:
  - ☐ General Dentistry
  - ☐ Oral-Maxillo Surgery
  - ☐ Pediatric Dentistry

❖ ALLIED HEALTH PROFESSIONALS

- ☐ Advanced Nurse Practitioner
  - ☐ Hematology/Oncology
  - ☐ Psychiatric ED
- ☐ Cardio Perfusionist
- ☐ Certified Nurse Midwife
- ☐ Certified Registered Nurse Anesthetist
- ☐ Pathology Assistant
- ☐ Physician Assistant
  - ☐ PA Family Medicine Center *(employed only)*
- ☐ Psychologist
- ☐ Rehab Psychologist
- ☐ Surgical Assistant
  - ☐ Dental Assistant

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: _____