

HOSPITAL ADDENDUM

TO THE TEXAS DEPARTMENT OF INSURANCE (TDI) STANDARDIZED CREDENTIALING APPLICATION

(Attach **Government issued** photo)

SECTION ONE - PERSONAL INFORMATION

Last Name:	First Name:	
Mobile/Cellular Phone Number:	Pager Number:	Answering Service Number:

SECTION TWO - EDUCATION INFORMATION

Did you complete all your internship/residency/fellowship training programs? Yes No
If no, please explain. If additional space is needed, please supply the information as an attachment.

SECTION THREE – PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

Current Type of Policy: Occurrence Claims-Made

1. Has your insurance carrier ever refused to renew your policy, placed limitations on your scope of coverage, excluded any specific area of practice from your coverage or terminated your coverage? Yes No
2. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty? Yes No

If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.

3. Have you EVER had any malpractice claims brought against you? Yes No
If you have answered yes, please complete and submit Attachment G of the TDI Application for each claim.

SECTION FOUR – HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

1. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your medical practice changed at any hospital or other healthcare institution? Yes No
2. Do you or a member of your immediate family maintain ownership (direct or indirect), or receive compensation from any company or entity providing healthcare services (e.g. clinical labs, hospitals, or diagnostic testing centers) where you could benefit financially from patient referrals (excluding syndications and/or retirement plans)? Yes No
3. Have you ever withdrawn an application for medical staff membership or clinical privileges or failed to seek reappointment or renewal of medical staff membership or privileges? Yes No
4. Have your clinical privileges or Medical Staff membership at any hospital or other healthcare institution ever been voluntarily or involuntarily limited, reduced, excluded, surrendered or relinquished, or have proceedings toward any of those ends been instituted or recommended by any hospital or other healthcare entity, medical staff or committee or governing board? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

SECTION FIVE – ADDITIONAL INFORMATION

1. Has your license to practice ever been involuntarily or voluntarily relinquished or have you ever been subject to any disciplinary actions, by a state licensing board? Yes No
2. Have any investigations or disciplinary action ever been initiated or are there now pending challenges against you by any state licensure board? Yes No
3. Have you ever been required to obtain additional education or training, proctoring, supervision, or consultation as a result of peer review of quality assurance/improvement or utilization review activities by any type of health care entity? Yes No
4. Have you ever been investigated, declared an ineligible person or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other private, federal or state government health care plan or program or are there any such actions pending? Yes No
5. Have you ever been convicted of, pled guilty to, pled nolo contendere to, or formally charged with a felony or misdemeanor (including DUI) other than minor traffic violations? Yes No
6. Have you ever been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever been subject to civil money penalties under the Medicare or Medicaid program? Yes No
7. Have your Federal DEA and/or DPS Controlled Substance Certificate(s) registrations or authorization(s) in any state ever been limited, or involuntarily relinquished or are any such challenges currently pending? Yes No
If so, which registration number and state? _____
8. If not board certified, have you ever taken the exam given by any specialty board, but failed to pass? Yes No
9. Has your membership in any medical/professional society or association been voluntarily or involuntarily challenged, denied, limited, suspended, revoked or relinquished, or are there any actions currently pending that would affect your membership in any medical/professional society? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

SECTION SIX – HEALTH STATUS

1. Tuberculin (PPD) Test Results: Date of Last PPD Test (MM/DD/YYYY): _____
Results of Tuberculin (PPD) Test? Positive Negative If positive, was x-ray taken: Yes No
2. Have you been diagnosed with or in the past received treatment for a physical, mental, chemical dependency or emotional condition which could impair your current ability to provide patient care or fulfill the essential functions of medical staff membership or participation in any healthcare institution? Yes No
3. Are you currently under a monitoring or rehabilitation contract/agreement for any health condition including substance abuse or mental illness, or disruptive behavior that could impair your current ability to provide patient care or fulfill the essential functions of medical staff membership or participation in any healthcare entity? Yes No

If the answer to any of the above questions is yes, please provide detailed information.

SECTION SEVEN – CONTINUING MEDICAL EDUCATION

1. Have you met the minimum continuing medical education requirements for renewal of your license in the past two years? Yes No **Please complete Statement of Continuing Medical Education Attestation attachment.**

APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this application and addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing.

APPLICANT'S SIGNATURE _____ DATE _____

APPLICANT'S PRINTED NAME _____