Sunset Community Health Center, Inc.

Administration
2060 W. 24th Street • Yuma, Arizona 85364

Date of Application: _____

APPLICATION FOR EMPLOYMENT AND CREDENTIALING

Personal Data

Full Name _____ SS#_____
Last First Mi

Have you Used Other Names? ☐ No ☐ Yes _____
If yes, please list

Home Address _____
City State Zip

Phone: Home _____ Mobile _____ Business _____

Date of Birth _____/_____/_____ Place of Birth _____ Citizenship _____

Email Address _____

Are you related (by birth or marriage) to anyone currently serving on the Sunset Board of Directors, or to anyone currently employed by Sunset? ☐ Yes ☐ No Please specify to whom: _____

Have you ever applied here before? ☐ Yes ☐ No If so, when? _____

Have you ever been employed by Sunset Community Health Center? ☐ Yes ☐ No Please provide dates and position:

_____

In the past, have you ever been convicted of a crime? ☐ Yes ☐ No

EMPLOYMENT HISTORY

Please attach a CV and complete this application

Starting with present or most recent employer, list all previous employers. Include self-employment, summer and/or part-time jobs. If more space is required, please continue on a separate page following this application.

Last Employer: _____ Job Title: _____

Street address: _____ Phone number: _____

City: _____ State: _____ Zip Code: _____

Supervisor's name: _____ Phone number: _____

Dates worked: From:_____ To: _____

Reason for leaving:_____

May we contact your present employer? ☐ Yes ☐ No

EMPLOYMENT HISTORY - Continued

Employer: _____ Job Title: _____

Street address: _____ Phone number: _____

City: _____ State: _____ Zip Code: _____

Supervisor's name: _____ Phone number: _____

Dates worked: From:_____ To: _____

Reason for leaving:_____

Employer: _____ Job Title: _____

Street address: _____ Phone number: _____

City: _____ State: _____ Zip Code: _____

Supervisor's name: _____ Phone number: _____

Dates worked: From:_____ To: _____

Reason for leaving:_____

Employer: _____ Job Title: _____

Street address: _____ Phone number: _____

City: _____ State: _____ Zip Code: _____

Supervisor's name: _____ Phone number: _____

Dates worked: From:_____ To: _____

Reason for leaving:_____

Please list additional work history, if necessary, on page 3

ADDITIONAL WORK HISTORY

EDUCATION AND TRAINING

MEDICAL/PROFESSIONAL EDUCATION:

Institution_____ Full Address_____

_____

City/State Country Zip

Type of Degree _____ Attended From (Mo./Yr.)_____ To (Mo./Yr.)_____

Did you complete this program: ☐ Yes ☐ No

INTERNSHIP (If applicable):

Institution_____ Full Address _____

_____

City/State Country Zip

Attended From (Mo./Yr.)_____ To (Mo./Yr.)_____ Did you complete this program? ☐ Yes ☐ No

RESIDENCY

Institution_____ Full Address _____

_____

City/State Country Zip

Attended From (Mo./Yr.)_____ To (Mo./Yr.)_____ Did you complete this program? ☐ Yes ☐ No

Specialty:_____

FELLOWSHIP (If applicable):

Institution_____ Full Address_____

_____

City/State Country Zip

Attended From (Mo./Yr.)_____ To (Mo./Yr.)_____ Did you complete this program: ☐ Yes ☐ No

Specialty:_____

OTHER GRADUATE TRAINING (Teaching Appointments, Postgraduate Education)

Institution Type of Training (Be Specific) Date

_____

Name/Address From/To

_____

Name/Address From/To

_____

Name/Address From/To

BOARD CERTIFICATION

Board Certified? ☐ Yes ☐ No If yes, date certified _____ recertification date _____

Board Eligible? ☐ Yes ☐ No Date of application _____

Certified by American Board of _____
Name and Address

Certified by: _____
Name and Address

LICENSURE

List all state professional licenses/certifications, past and present. If necessary, attach a separate sheet.

State	License Number	Current Status	Date Issued	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FEDERAL DRUG ENFORCEMENT ADMINISTRATION

Please submit copy of original certificate with application.

DEA Number _____ Expiration Date: _____

Date Issued:_____ (If you are moving from out-of-state, you must change your address of record to Arizona

PRACTICITIONER NUMBERS

NPI number _____ UPIN number _____

PROFESSIONAL LIABILITY COVERAGE HISTORY– Must demonstrate last 5 years if applicable

Carrier: _____ Address: _____

Policy Number: _____ Dates Covered: From _____ To _____

Policy Limits: Aggregate _____ Occurrence _____ Tail Coverage _____

Carrier: _____ Address: _____

Policy Number: _____ Dates Covered: From _____ To _____

Policy Limits: Aggregate _____ Occurrence _____ Tail Coverage _____

REFERENCES

Give names of at least three persons, not related to you, who have extensive experience in observing and working with you and who can provide adequate references pertaining to your professional competence, mental stability, background, moral integrity, character; and ethics.

1. _____

Name | Title | Relationship to Candidate

_____

Phone number | Fax number | Email Address

2. _____

Name | Title | Relationship to Candidate

_____

Phone number | Fax number | Email Address

3. _____

Name | Title | Relationship to Candidate

_____

Phone number | Fax number | Email Address

LANGUAGE SKILLS

Language Skills (indicate fluency level)

❒ English ❒ Speak ❒ Read ❒ Write
❒ Spanish ❒ Speak ❒ Read ❒ Write
❒ Other: ❒ Speak ❒ Read ❒ Write Language:_____
❒ Sign Language

MILITARY RECORD

Branch of Service:

_____

Present Military Affiliation: ❒ None ❒ Reserve (active) ❒ Reserve (inactive)

Special Notice to Disabled Veterans, Vietnam Era Veterans, and Individuals with Physical or Mental Disabilities

Government contractors are subject to 38 USC 2012 for the Viet Era Veterans Readjustment Act of 1974 which requires that they take affirmative action to employ and advance in employment qualified disabled veterans of the Vietnam Era, and section 503 of the Rehabilitation Act of 1973, as amended, which requires government contractors to take affirmative action to employ and advance in employment qualified handicapped individuals.

If you are a disabled veteran, or have a physical or mental handicap you are invited to volunteer this information, which will be treated as confidential. Failure to provide this information will not jeopardize your consideration. If you wish to be identified, please sign below.

❒ DISABLED ❒ DISABLED VETERAN ❒ VIETNAM VETERAN

Name: _____

❒ Please check box confirming that you understand typing your name is considered the same as your handwritten signature.

CREDENTIALING RELEASE STATEMENT

TO: ANY PRECEPTOR, COLLEAGUE, HOSPITAL, MEDICAL COLLEGE OR UN IVERSITY, MEDI CAL/ DENTAL ASSOCIATION OR PROFESSIONAL SOCIETY, INSURANCE CARIUER OR ANY OTHER PERSON HAVING KNOWLEDGE OR IN FORMATION ABOUT MY PERSONAL REPUTATION AN D PROFESS I ONAL ABILITY.

Attest to the accuracy of this information

I, the undersigned, have made application to the Medical or Dental Staff of Sunset Community Health Center, Inc., or have applied as an Affiliate Health Practitioner, and I hereby authorize and direct the release of any and all information pertaining to my personal reputation or professional ability or competence. In so doing, I hereby fully release and discharge the above individual or institution making a response to this inquiry from any and all liability or whatsoever kind of nature for releasing information or records pertaining to my personal reputation or professional ability or competence.

The authorization to seek the above such information in the course of evaluation of my application for medical staff privileges, and subsequent reappointments, is granted to any authorized agent of Sunset Community Health Center, Inc.

The release date is effective from the date shown below through any date of subsequent reappointments. A photocopy of FAX of this authorization shall have the same effect as the original.

_____

PRINT NAME:

_____

SIGNATURE: DATE:

Sunset Community Health Center, Inc.

Administration
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NOTICE OF INTENT TO VERIFY BACKGROUND INFORMATION

In connection with my application for employment with Sunset, I understand that a consumer report may be requested that may include information as to my character, along with reasons for termination of past employment from previous employers. Further, I understand that you may be requesting information concerning my motor vehicle operation history and criminal history from various state, private and insurance sources along with other public records available.

Applicant Name:_____

Applicant Signature:_____

Date: _____

☐ Please check box confirming that you understand typing your name is considered the same as your handwritten signature.

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Mission Statement

To deliver comprehensive and preventive primary care in a culturally sensitive, compassionate and professional manner, ultimately improving the health of our patients and responding to the health and education needs of our communities.

An Equal Opportunity Employer

We do not discriminate on the bases of race, color, religion, national origin, age over 40 and older disability, genetic information or any other status protected by law or regulation. It is our intention that all qualified applicants be given equal opportunity and that the selection decisions are based on job-related factors.

Drug-Free Workplace

You are required to submit and successfully pass a drug screening examination for employment with Sunset Community Health Center.

Applicant's Statement

I hereby certify that the answers and other information on this application are true and correct and that I understand any misrepresentation or omission of facts on my part will be justification for separation from the company's service, if employed.

I understand that my employment may be contingent upon any other pertinent information bearing upon my employment, and that my continued employment depends upon the will of the company or myself.

I understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause.

I understand that any offer of employment is contingent upon the results of:

1. Reference checks
2. A background investigation
3. A post-offer, pre-employment physical examination (including a drug/alcohol test)
4. Proof of eligibility to work in the United States.

As part of Sunset Community Health Center's Employment Policy & Procedure, I authorize Sunset Community Health Center to receive the results of my post-offer pre-employment physical examination. I acknowledge and consent to the results being reviewed by members of the Sunset Community's staff and Sunset Community's Medical Director or his/her designee.

I authorize the investigation of all statements contained in this application for employment, as may be necessary in arriving at an employment decision.

I understand that neither, this document, or any offer of employment from Sunset Health Center constitutes an employment contract, unless a specific document to that effect is executed by Sunset Health Center and myself in writing.

In the event of employment, I understand that false or misleading information given in this application, or any other documents submitted with my application or interview(s) may result in immediate discharge.

I understand that I am required to abide by all rules and regulation of Sunset Community Health Center.

In signing this statement I am granting Sunset Community Health Center my permission to investigate any representations I have made on this application and to contact the individuals I have listed as references.

Applicant agrees to indemnify, defend at his or her own cost, and hold Sunset Community Health Center, Inc., and its directors, officers, employees, agents, and contractors harmless from and against any and all claims, demands, obligations, liabilities, costs, and expenses (including reasonable attorneys' fees and costs) arising out of, or in any way related to, Applicant's application, drug screening or physical(s), and background check(s); Sunset's review, consideration of, or decision on, Applicant's application, and any inquiries or requests made incident thereto; and any other act or omission of Applicant.

Signature/Name:_____ **Date**: _____

☐ Please check box confirming that you understand typing your name is considered the same as your handwritten signature.

HEALTH STATUS AND STATEMENT OF HEALTH

Do you presently have, or have you **ever** had, any physical or mental condition that affects or is reasonably likely to affect your ability to perform professional or medical duties appropriately? Yes ☐ No ☐

Have you **ever** had a problem or been under treatment for chemical dependency or alcoholism? Yes ☐ No ☐

Are you currently taking any medications that may affect either your clinical judgment or motor skills? Yes ☐ No ☐

Applicant **must** check one of the following:

1. ☐ I certify that I am in good health and have no physical or mental limitations.
2. ☐ I do have or have had a chronic illness, physical disability and/or medical limitations to my health, which may include alcohol or drug use, but believe that this does not significantly impair my ability to render high quality medical care. *

* If you answered #2 above, a **Full Statement of Explanation must be attached**. This must include the name and address of your physician. Your physician will only be contacted with your permission.

_____ _____ _____

Signature Print Name Date

PROFESSIONAL INFORMATION

1. Has your professional/medical license to practice in any state **ever** been voluntarily or involuntarily surrendered, denied, restricted, limited, suspended, revoked, or otherwise acted against, or are there any such actions pending? Yes* ☐ No ☐
2. Have you **ever** been notified to appear before any licensing agency (State Board of Examiners, Drug Enforcement Administration, State Medical Board, etc.) for a hearing or complaint of any nature? Yes* ☐ No ☐
3. Has your DEA Registration **ever** been voluntarily or involuntarily surrendered, denied, restricted, limited, suspended, or otherwise acted against, and are any of these actions pending with respect to your DEA registration? Yes* ☐ No ☐
4. Have your clinical privileges (including admitting, consulting, and assisting) or your staff membership at any health care facility **ever** been voluntarily or involuntarily suspended, lifted, revoked, denied, not renewed, or otherwise acted against? Yes* ☐ No ☐
5. Have disciplinary proceedings **ever** been instituted against you, and are any of these actions now pending with respect to your clinical privileges? Yes* ☐ No ☐
6. Have you **ever** been denied membership, or renewal thereof, or had your membership revoked or otherwise acted against, or been subject to disciplinary action, in any medical or professional organization or by any licensing agency of any state, district, territorial possession, or country? Yes* ☐ No ☐
7. Have you **ever** voluntarily relinquished hospital privileges, DEA registration, academic appointments or any other professional status while an investigation was conducted? Yes* ☐ No ☐

PROFESSIONAL INFORMATION - Continued

8. Has your participation in any private, federal or state health insurance program (PPO, HMO, Medicare or Medicaid, etc.) **ever** been voluntarily or involuntarily suspended, sanctioned, or otherwise restricted? Yes* ☐ No ☐

9. Have you **ever** been sanctioned or convicted with respect to Medicare/Medicaid or any other medical reimbursement for inappropriate fees or quality of care issues? Yes* ☐ No ☐

10. Have you **ever** been convicted of a felony or misdemeanor (other than a minor traffic offense) and are any such actions pending? Yes* ☐ No ☐

11. Have you **ever** discontinued practice for any reason (other than a routine vacation, maternity leave, illness, formal education/training) for three months or more? Yes* ☐ No ☐

12. To your knowledge, have you **ever** been reported to the National Practitioner Data Bank? Yes* ☐ No ☐

***If you responded "yes" to any of the above questions, please provide full details on a separate page and attach to application.**

PROFESSIONAL LIABILITY

1. Are there currently any professional liability cases pending against you? Yes* ☐ No ☐

2. Have any judgments or settlements ever been made against you in a professional liability case? Yes* ☐ No ☐

3. Has any liability insurance carrier canceled, refused coverage, or increased your rates because of unusual risk? Yes* ☐ No ☐

* If you responded "yes" to any question, please provide the following information on a separate sheet and attach it to this application.

- Date suit or claim was initiated
- Brief description of action/complaint
- Names of parties/plaintiff involved
- Current status/outcome
- Where suit or claim occurred
- Name, address, phone & fax of your insurance carrier
- Name, address, phone & fax of your attorney
- Any other pertinent information

Required Documentation

To process your Application for Medical Staff Appointment, we will need copies the following documents:

- All documentation pertaining to Medical Education
  - Copy of Medical Doctor degree (or DO)
  - Copy of Residency Certificate
  - Foreign Medical Graduate certificate (if applicable)
- Board Certification
- DEA registration
- All State Medical Licenses (active and inactive)
- Copy of the documentation from NPPES issuing your NPI number
- BLS, ACLS, PALS certification(s)
- Small photo of yourself (should be head/shoulders passport type photo will be used to include with Peer Recommendations)
- Copy of your current/last Malpractice Coverage policy face sheet
- Any other documentation related to education or training as applicable

SUNSET COMMUNITY HEALTH CENTER
PROVIDER PRIVILEGING APPLICATION

Practitioner Name: _____ **Title:** _____

Specialty: _____ **Application Date:** _____

Please check the boxes next to the appropriate areas of clinical privileges you are requesting.

PRENATAL CARE

Request		Approved
☐	Routine, Prenatal Care	☐
☐	Ultrasound, First trimester	☐
☐	Ultrasound, Second trimester	☐
☐	Ultrasound, Third Trimester	☐

GENERAL ADULT CARE

☐	General care	☐
☐	Cryosurgery	☐

GENERAL OB/GYN CARE

☐	Bartholin abscess w/ward catheter placement	☐
☐	Bartholin abscess marsupialization	☐
☐	Breast cyst needle aspiration	☐
☐	Cervical biopsy	☐
☐	Cervical LEEP	☐
☐	Cervical polypectomy	☐
☐	Colposcopy with/without biopsy	☐
☐	Cryosurgery	☐
☐	Endo-cervical curettage	☐
☐	Endometrial biopsy	☐
☐	IUD, insertion/removal	☐
☐	Implanon, insertion/ removal	☐
☐	Norplant, removal	☐
☐	NST Interpretation	☐
☐	Urodynamics	☐
☐	Vulvar lesion removal	☐

PEDIATRIC CARE

Request		Approved
☐	General care, routine	☐

SURGICAL PROCEDURES

☐	Anoscopy	☐
☐	Calluses/Corns debridment	☐
☐	Digital Block anesthesia	☐
☐	Excision of superficial benign tumors	☐
☐	Excision of sebaceous cyst	☐
☐	Fingernail/toenail care, nail removal	☐
☐	Incision and drainage of abscess	☐
☐	Skin Biopsy:	☐
☐	Excisional biopsy, extremities	☐
☐	Excisional biopsy, face	☐

LACERATION REPAIRS

☐	Simple	☐
☐	Complex, layered	☐
☐	Facial	☐

ORTHOPEDICS

☐	Joint aspiration/injections	☐
☐	Shoulder	☐
☐	Elbow	☐
☐	Hip	☐
☐	Knee	☐
☐	Digits	☐
☐	Trigger point injections	☐

OTHER REQUESTED PROCEDURES

Request		Approved
☐	_____	☐
☐	_____	☐
☐	_____	☐
☐	_____	☐

Practitioner Name: _____ **Title:** _____

Specialty: _____ **Application Date:**_____

I have reviewed the above list and have checked the procedures to which I am limiting my practice. I have been trained accordingly and request permission to do these procedures. I understand that I may be required to prove training and competence in specific procedures checked. I agree that to add additional procedures, I must demonstrate adequate training and competency before performing them on Sunset Community Health Center. patients.

_____ _____

Provider Signature Date

To be completed by Medical Staff Services Department

- ☐ Credentials have been verified and meet requirements.
- ☐ Health status has been evaluated and meets requirements.
- ☐ Continuing medical education has been verified and meets requirements.
- ☐ Performance evaluations have been completed and meet requirements.

The above named provider has been recommended privileges for the procedures checked for the patients of Sunset Community Health Center

_____ _____

Chief Medical Officer Date

Privileges will be: ☐ Supervised ☐ Unsupervised

Privileges Effective: _____ through _____

Approved By:

_____ _____

CEO Date Board of Directors Chairperson Date

(Staff Credentialing and Privileging Procedure GS-02 P&P ADM 44 Revision Date: May 2014)

Sunset Community Health Center, Inc.

REQUEST FOR CLINICAL PRIVILEGES – DENTAL

Applicant Name: _____ **Date:** _____

Specialty: _____

Location: _____

Privileges

I am qualified and request the following privileges (check level in which you are primarily engaged):

	Required Degree	Required Certification
☐ **General Practice Dentist**	**DDS/DMD**	**Arizona License**
Procedures: Emergency Dental Care Preventive Dental Care Restorative Dental Care Basic Periodontal Care Pediatric Dental Care Basic Oral Surgery and Exodontia Endodontic Dental Care Dentures		
☐ **Pediatric Dentist**	**DDS/DMD**	**Arizona License**
Procedures: Simple/Complex Restorative Dental Care-Children Pediatric Oral Surgery/Exodontia		**Board eligible/qualified**

I have received post-graduate training in the following special procedures (please attach documentation of training)

☐ Interosseous Implant Insertion ☐ Laser Surgery ☐ Other (specify):

	Required Degree	Required Certification
☐ **Dental Hygienist**	**AAS/BS**	**Arizona Licensure**
Procedures: Basic Preventive Dental Care Dental Prophylaxis Periodontal Scaling		

I possess the following certifications for expanded care from the Arizona Board of Dental Health Care:

☐ Certificate in Local Anesthesia Administration

☐ Affiliated Practice Dental Hygienist

Applicant Attestation:_____

I hereby certify that the documentation and information contained or attached to this application is true and complete to the best of my knowledge. I realize that misstatement or omission may result in denial of this application. I affirm that, if granted the requested privileges, I will provide services in accordance with the established standards, protocols, policies and procedures of Sunset Community Health Center. I also affirm that I will practice only within the scope of privileges granted, and will do so in keeping with the established professional ethics guidelines of my professional discipline.

_____ _____

Applicant Signature **Date**

_____ _____

Dental Director's Signature Indicating Approval **Date**