Magna Surgical Center

7456 S. State Road, Suite 300
Bedford Park, IL 60638

Phone: 773-445-9696
Fax: 888-531-2827

Acknowledgement and Release from Liability

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment of cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment to the medical staff of this facility, I acknowledge that I am familiar with the principles and standards of the facility's accrediting organization and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, and I agree to abide by the Medical Staff Bylaws, Rules and Regulations and to the Bylaws, Policies and Procedures of the facility. I further agree to abide by such facility and medical staff rules and regulations as may be from time to time enacted and I pledge to provide for continuous care of my patients, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matter relating to the consideration of my application for appointment to the medical staff.

I will not participate in any form of fee splitting. Moreover, I pledge myself to shun unwarranted publicity, dishonest money-seeking, and commercialism; to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any procedures for which I am not qualified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges, and I am familiar with the laws of this state governing the practice of medical and pledge to abide by these laws.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the facility its medical staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the facility, its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the facility and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability and all individuals and organizations who provide information to the facility or its medical staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this facility, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the facility and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the facility and its staff for so doing.

I understand and agreed that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

_____ Date _____

Signature of Applicant

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APPLICANT AGREEMENT

In making application for appointment to the Medical Staff of the Magna Surgical Center (the "Center") I:

1. I have received a copy of the operation policy and related policies of the Magna Surgical Center, I agree to abide by the Bylaws, Rules and Regulations of the Medical Staff and the Magna Surgical Center, as they may be from time to time amended.

2. Pledge to provide for continuous quality care for my patients;

3. Signify my willingness to appear for interviews in regard to the application;

4. Agree to execute and deliver to the Center or Center's representatives all documents reasonably requested by the Center or Center's representatives as prerequisites for Medical Staff membership or in connection with such membership, including, without limitation, an Authorization for Release of Information;

5. Represent and warrant that all information provided by me is true, correct and complete in all material respects and is not misleading;

6. Agree to update and correct any information provided by me to the Center or Center's representatives in connection with this application if such information becomes, or I later discover that such information is or becomes, false or misleading in any material respect;

7. Pledge to comply with all laws, regulations and standards relating to my services at the Center's facilities, including without limitation: (a) all statutes and regulations regulating my profession or specialty, (b) the principles and standards of the Center's accrediting organization applicable to ambulatory care facilities, (c) the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty or profession, (d) all prohibitions or restrictions on fee-splitting and the corporate practice of my profession or specialty, (e) the Illinois Health Care Worker Self-Referral Act, 225 ILCS 47/1 et seq., (f) Section 1877 of the Social Security Act, 42 U>S>C> 1395nn (commonly known as "Stark II" and (g) all laws and regulations relating to fraud and abuse in connection with the Medicare or Medicaid programs, including, without limitation, Section 1128B of the Social Security Act, 42 U.S.C. 1320a-7b;

8. Pledge to comply with, and agree to be subject to the Bylaws, Rules and Regulations of the Medical Staff and Center and with the Center's policies and procedures manual, code(s) of conduct, ethics and disruptive behavior and all policies and procedures of the Center or its Medical Staff, all as amended from time to time;

9. Understand and agree that I, as an applicant for Medical Staff membership, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications;

10. Recognize that although certification by a board does not necessarily qualify me to perform certain procedures, I believe that I am qualified to perform all procedures for which I have requested privileges; and

11. Recognize that failure to adequately complete and update the application form and documents and other information submitted in connection with my application, the withholding of requested information or the providing of false or misleading information, shall, in and of itself, constitute a basis for denial, suspension or revocation of Medical Staff appointment.

12. Moreover, I hereby declare that I shall not engage in the practice of the division of fees under any guise whatsoever. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit others to collect fees for me, nor make joint fees with physicians referring patients to me for operation or consultation, nor permit any agent or associate of mine to do so. Further, I agree to comply with the principle that all physicians participating in the care of a patient, or the group practices with which they are affiliated, shall render separate bills and receipts.

As used herein, the term "Center's representative" includes, without limitation, the Center's Board, consulting committee(s), members, committees, Officers and staff members; the Center's Medical Staff; all Medical Staff members, departments and committees which have responsibility for collecting or evaluating my credentials or acting upon my application; and any authorized representative of any of the foregoing.

Signature _____ Date _____

MAGNA SURGICAL CENTER

INITIAL SUPPLEMENTAL INFORMATIONAL FORM

Applicant's Name: _____

Health Status Attestation

By applying for privileges as indicated on my delineation of privilege form, I attest that no health problems exist that could effect my ability to perform these privileges.

Signature _____ Date _____

Continuing Medical Education

I certify that I have previously met and are continuing to meet the State of Illinois Department of Financial and Professional Regulations CME requirements for renewal of licensure. I understand that I may be asked to produce documentation supporting this certification.

Signature _____ Date _____

Information for IDPH "Single Cycle Re-Credentialing" and Federal DEA Validation

Social Security No:_____

(This is required for the purpose of meeting IDPH single cycle re-credentialing requirements)

Providers Taxonomy Number _____

Identifying Information

Home Address: _____

_____

Home No.: _____

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CONSENT / RELEASE OF INSURANCE INFORMATION

Insurance Company Name & Address

_____

_____

_____

I authorize my professional liability insurance carrier and/or insurance broker listed above to release a copy of my certificate of insurance to the Magna Surgical Center.

Please provide a photocopy at this time, and add the Magna Surgical Center, / Medical Director, as a Certificate Holder so that they are notified of any future renewals, cancellations or non-renewal.

Policy Holder Signature _____

Policy Number _____

Date _____

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POLICY ACKNOWLEDGEMENT

MINIMUM CASE ACTIVITY REQUIREMENTS

I acknowledge that I have read the following policy:

It is the Magna Surgical Center policy that reappointment to the Medical Staff is dependent upon meeting the established minimum case activity level of three (3) cases per year or nine (9) cases during the three-year IDPH re-credentialing cycle or at the discretion of the Governing Board.

Signature _____

Date _____

MAGNA SURGICAL CENTER

Professional Reference Questionnaire

Professional Evaluation Concerning: _____

Reference Provided By:

Name (Print) M.D. /Other Degree	Signature Date
Medical Specialty	Present Professional Position
Hospital/Organization Name	Telephone Number
Streets Address	City State Zip

Please answer all questions based on your personal knowledge and direct observations. Your candor will be greatly appreciated, and your answers will be confidential, except as is necessary for accomplishing the credentialing process, or for any related due process procedures. If you need additional space to answer any question, you may use the back of the form or attach additional sheets.

I. RELATIONSHIP OR REFERENCE SOURCE TO APPLICANT

1. How long have you known the applicant?_____

2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine? _____

3a. In what setting(s) and with what frequency did you observe the applicant? (i.e., office, hospital residency program, etc.; daily, weekly, monthly, infrequently). _____

b. Was your observation done in connection with any official professional title or position? If so, please indicate title?_____

c. What was the applicant's title or position?_____

4. Are you now or about to become related to the applicant as family or through a professional partnership or financial association? Yes_____ No_____ If yes, please explain: _____

_____

II. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

1. Please rate the following:

	POOR	FAIR	GOOD	EXCELLENT	NO INFO
A. Medical knowledge					
B. Technical & clinical skills					
C. Clinical judgment					
D. Pattern of resource use (necessary for hospital admission, LOS, tests, etc.)					
E. Use of consultants when needed					
F. Availability					
G. Thoroughness in patient care					
H. Interpersonal skills					
I. Ability to understand English					
J. Ability to speak English					
K. Rapport with patient/family					
L. Ability to work with physicians and Other health professionals					

MAGNA SURGICAL CENTER

Professional Reference Questionnaire – Page 2

2. Have you ever observed or been informed of any physical/mental health/drug or alcohol dependencies or other problems which the applicant has that have or could potentially impair ability to exercise all or any of the privileges requested? Please include any problems which are currently under control by medication/therapy, but which could impair ability if the medication/therapy were stopped: Yes ____ No ____ Unknown ____ Please explain:_____

   _____

3. To the best of your knowledge, has the applicant's license, clinical privileges, practice patterns, hospital staff membership or any aspect thereof, or other professional status ever been denied, challenged, investigated, suspended, revoked, modified, placed on probation, made the subject of an individual focused review, or voluntarily surrendered, or do you have knowledge of any such actions that are pending? Yes _____ No _____ Unknown _____

4. Do you know of any malpractice actions instituted or in process against the applicant?
   Yes_____ No_____ If yes, please explain:_____

5. Would you be pleased to have this applicant as an associate with you in practice?
   Yes _____ No_____

III. MEDICAL STAFF PARTICIPATION

1. The applicant's participation in Medical Staff affairs, and fulfillment of medico-administrative duties (e.g., quality review program participation, medical records timeliness, clarity and completeness, committee attendance, ER coverage, etc.) is generally:

   Poor _____ Fair _____ Good _____ Excellent _____ Unknown _____

   AdditionalComments:_____

   _____

IV. QUESTIONNAIRE SUMMARY

1. My general recommendation concerning this applicant is:
   Recommend without reservation: _____
   Recommend with reservation: _____ (Please explain below)
   Not recommend: _____ (Please explain below)

   _____

   _____

2. Please add any additional comments relevant to the applicant's medical knowledge, competence, judgment, demonstrated skills and abilities. Are there any clinical areas, procedures or severity of illness levels, which you would be concerned about allowing the applicant to manage/perform if they were in practice with you? _____

   _____

Please date and sign where indicated on Page 1. Your prompt return of this recommendation is greatly appreciated.

Thank you for your time and cooperation.