APPLICATION FOR CREDENTIALING & PRIVILEGES

LICENSED & CERTIFIED HEALTHCARE PROFESSIONALS

Please FAX application to 843-459-7963 or scan and email to dcockrell@dreamcenterclinic.org

PERSONAL INFORMATION

Name _____

Home Address _____

_____

Home Phone: _____ Cell Phone: _____

E-mail Addess_____

Date of Birth _____

TYPE OF PRACTICE

___ Dental ___DC ___DPM ___ MD/DO (Specialty) _____

___ RN ___ LPN ___ PA ___ NP ___ Paramedic

PRACTICE CONACT _____

EMPLOYMENT INFORMATION

Employer/Practice_____

Practice Address _____

_____

Phone ( ) _____ Fax ( ) _____

LICENSURE & REGISTRATIONS

List all active professional licenses:

State	Type	Number	Date of Issue	Expiration Date
_____			_____	_____

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

LICENSURE & REGISTRATIONS

List all active professional licenses:

State	Type	Number	Date of Issue	Expiration Date
_____			_____	_____

Federal DEA number_____

National Physician Identification # _____

CERTIFICATIONS

Specialty_____

Board Name _____

Current Certification Date_____ Expiration Date_____

Hospital/Health System Affiliations

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

PROFESSIONAL MALPRACTICE INSURANCE

Present Carrier's Name_____

Address_____

Policy Number_____

Dates of Coverage From_____ To_____

Coverage Amounts_____

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

CLAIMS INFORMATION

1. Have you ever been denied professional liability insurance or has coverage ever been canceled?

   ☐ Yes ☐ No

If yes, please explain:

_____

_____

2. Are there currently pending or have there been any malpractice claims, judgments or settlements involving your professional practice in the last 3 years? ☐ Yes ☐ No

If Yes, please explain

_____

_____

REQUIRED COPIES & REFERENCES

Copies of documents required

- ☐ Identification (via government issued picture id-driver's license)
- ☐ License/Certification
- ☐ DEA Registration, as applicable
- ☐ Malpractice Insurance
- ☐ CPR Certification

_____ _____

Signature of Applicant Date

_____

Print Name and Title

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

Dream Center Clinic
Physical and Spiritual Health is Our Center Focus.

Authorization and Consent

In making this application:

- I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of DCC,
- to make decisions as appropriate to the patient's needs, to maintain practice knowledge and skills current through continuing education opportunities,
- to abide by the bylaws, rules and regulations, policies and procedures of the clinic,
- to participate in and cooperate fully with the Quality Assurance Program and all programs to improve quality and reduce risks.

I agree to participate

- in the review of records and documents relating to patient care and services, and
- to subject my performance to the review by the Clinic and its representatives for the purpose of improving the quality of care and services and reducing risk.

I hold the Clinic and its representatives free of all liability for such actions.

I hereby release from liability DCC and all its representatives for their acts performed while evaluating my application, credentials and qualifications.

I hereby release from any liability any and all individuals and organizations that provide information to DCC or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

As applicable, I hereby accept that I will abide by the requirements for medical malpractice coverage for the Federal Tort Claims Act. I will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. I fully understand that any misstatements or omissions in the application constitute cause for denial or termination of privileges and/or employment. All information submitted by me in the application is true to the best of my knowledge.

_____ _____

Signature of Applicant Date

_____

Print Name and Title

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

Request to Verify Medical/Dental Staff Membership and/or Privileges

TO: Date

RE: Verification Hospital/Institution Membership and/or Privileges

____

Applicant/Practitioner-Print Name and Title

AUTHORIZATION AND CONSENT
TO VERIFY MEDICAL/DENTAL STAFF MEMBERSHIP AND/OR PRIVILEGES

I hereby authorize and release from any liability any and all individuals and organizations that provide information to Dream Center Clinic or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

____

Signature of Applicant/Practitioner Date

- -

The above applicant/practitioner is authorizing you to provide information concerning his/her medical/dental membership and/or privileges for DCC use in considering his/her request for privileges and/or employment at the Clinic. This information is requested at the direction of the Clinic's Clinical Services Committee and will become a part of the practitioner's Confidential File. Please complete this portion of this form and forward to the below assigned Credentialing Coordinator.

____

Signature of DCC Credentialing Coordinator

Below to be completed by Hospital/Organization/CVO Agent:

Medical Staff Status: □ Active □ Other: _________________________

Dates of Medical Staff Membership ____/____/____ to ____/____/____

Privileges granted in the practice/scope of service of

____

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

The following primary source verification has been obtained per JCAHO standards and supporting documentation is attached:

a) Current licensure;
b) Documentation of relevant education, training, or experience.

_____

Signature of Hospital CVO Verifying Agent Date

DCC PROFESSIONAL MEDICAL QUESTIONNAIRE

_____

Applicant/Practitioner-Name

PPD (TB Skin Test) Status_____ Date of most recent PPD (TB Skin Test)_____

History of a positive PPD ___ Yes ___ No If yes, date of last CXR_____

Immunization Status: Please provide copy of Immunization history to include (HEP. B) Vaccines, titer results or declaration statement.

Allergies: _____

Are you allergic to Latex? ___ Yes ___ No, If Yes, reaction?_____

Do you have any medical history or conditions that could cause you difficulties while working at the Clinic? (i.e., Type I diabetes, heart disease, etc.) Yes___ No___
If so, please explain

_____

Emergency Contact:

Name_____Relationship_____

Address_____

_____

Phone Contact_____

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org

Dream Center Clinic
Physical and Spiritual Health is Our Center Focus.

Health Fitness Statement

I hereby attest that I am **fit to perform** the care, treatment and other services provided at DCC. Further, the substantiation of this fitness may be confirmed by the Clinic's medical director, the hospital where I may be privileged or any other individual designated by the organization.

I further attest that I meet ongoing **continuing education requirements** not only to maintain any licensure or certification, but also to maintain practice skills and knowledge in the specific scope/content of patient care services I provide to patient's at DCC.

I verify that the information above is truthful and honest to the best of my knowledge.

_____

Applicant/Practitioner Signature Date

_____

Applicant Name: Printed

Informed Refusal for Hepatitis B Vaccination
(Confidential)

I volunteer as a health care practitioner at DCC. I am aware and understand the effectiveness of Hepatitis B immunization, the risk of contracting Hepatitis B, and the importance of taking active prevention to reduce the risk.

However, I, of my own free will and volition, and despite the Clinic's urging, have elected not to be vaccinated against Hepatitis B. I have personal reasons for making the decision not to be vaccinated.

_____ _____

Employee/Volunteer Signature Date

_____

Printed Name

5505 North Rhett Avenue – North Charleston, SC 29406 – PH 843.225.1115 FX 843.225.1107
www.dreamcenterclinic.org