Hillcrest Educational Centers, Inc.

APPLICATION FOR REAPPOINTMENT OF CLINICAL RESPONSIBILITIES

Name:_____ Date:_____

Staff Category:_____ Department:_____

Part I. Please answer all questions.

Have you met the CME requirements for licensure under Massachusetts State Law?
Yes____No____ Please submit documentation (certificates, receipts) for our file.

Do you have any mental or physical conditions that might prevent you from fulfilling your professional responsibilities as a member of the privileged staff?
Yes____No____

Have you earned Board Certification or Recertification in the past two years?
Yes____No____N/A____ Please submit photocopy of confirming letter.

Have you affiliated with any new or additional health care institutions in the past two years?
Yes____No____

Institution_____ Status_____
Institution_____ Status_____

In the past three years has a Malpractice judgment or a new claim been made against you?
Yes____No____ If yes, please complete attachment "A" and describe the status of any claims remaining open.

In the past two years, has any of the following been limited, denied, revoked, suspended, reduced, not renewed, voluntarily relinquished or involuntary relinquished, or has a process been initiated that would do the same?

	Yes	No
• License to proactive your profession in any jurisdiction	___	___
• Specialty Board Certification	___	___
• Drug Enforcement agency certificate	___	___
• Staff membership status or clinical responsibilities at a hospital or health care facility	___	___
• Membership/fellowship in any professional society, local, state or national	___	___

Have you been convicted of any criminal actions other than minor motor vehicle violations?
Yes____No____

Have you ever been convicted of a drug or alcohol related offense? Yes___No___

If the answer to any of the above questions is "yes", please give full details.
_____
_____
_____
_____

Part II. Please complete all questions.

Affiliations

List all present hospital and professional staff memberships and/or appointments. Specify clinical responsibilities granted. Do not include Hillcrest Education Centers, Inc.

_____	_____	_____
Name of Institution	Dates of Association	Position

_____

Address City State Zip

_____

Department Director/Head

Please check all clinical responsibilities granted:

___Admission to hospital
___Discharge from hospital
___Medical history & physical exam
___Prescribing medication
___Prescribing psychopharmacological agents
___Prescribing unusual use of medications and experimental use of medication
___Milieu Treatment orders (passes, observations, etc.)
___Diagnostic assessment
___Individual psychotherapy
___Group psychotherapy leader
___Family Therapy
___Alcohol/substance abuse counseling
___Psychodrama
___Psychological testing
___Consultation
___Treatment of adolescents
___Treatment of children
___Research
___IV Insertion

Explain in detail the suspension, reduction, revocation or non-renewal of appointment of clinical responsibilities at any hospital or professional agency, either voluntary or involuntary.

Please use back of form, if needed to provide additional information.

If you are affiliated with more than one hospital/professional agency, please copy this page and complete for each affiliation. Attach to application.

Part III. Please complete all questions.

Request for Clinical Responsibilities

Please check all clinical responsibilities requested.

___Admission to hospital
___Discharge from hospital
___Medical history & physical exam
___Prescribing medication
___Prescribing psychopharmacological agents
___Prescribing unusual use of medications and experimental use of medication
___Milieu Treatment orders (passes, observations, etc.)
___Diagnostic assessment
___Individual psychotherapy
___Group psychotherapy leader
___Family Therapy
___Alcohol/substance abuse counseling
___Psychodrama
___Psychological testing
___Consultation
___Treatment of adolescents
___Treatment of children
___Research
___IV Insertion

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CONDITIONS OF REAPPOINTMENT

By applying for reappointment to the medical/clinical staff of Hillcrest Educational Centers I hereby:

- Authorize the agency to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, qualifications, ability to work cooperatively with others, and other qualifications;
- Consent to the inspection by the agency and their representatives of all documents that may be material to an evaluation of my qualifications and competence;
- Consent to the release of such information;
- Release from liability all representative of HEC and its staff for their acts performed and statements made, in good faith and without malice, in connection with evaluating this application and my credentials and qualifications;
- Release from liability any and all individuals and organizations who provide information to the agency, in good faith and without malice, concerning my professional competence, background, experience, ethics, character, utilization, practice patterns, health status and other qualifications for staff appointment and clinical responsibilities.
- Acknowledge that I have received, or been given access to, and read the related manuals and policies relevant to the reappointment process and general to clinical practice at the agency, and agree to be bound by the terms thereof in all matters relating to staff membership and clinical responsibilities and to the consideration of my application for reappointment to the staff and for clinical responsibilities.
- Acknowledge that the provisions of policies relating to confidentiality and release from liability are express conditions to my application for, and acceptance of, reappointment to the staff and the continuation of such appointment and to my exercise of clinical responsibilities;
- Pledge to maintain an ethical practice, to provide for continuous care for my patients, and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility.
- Agree to inform the Director of Human Resources of any change made or proposed in the status of my professional license or permit to practice, state or federally controlled substances registrations, professional liability insurance coverage, and membership/employment/faculty status or clinical responsibilities in other institutions/facilities/organizations, and on the status of current or initiation of new malpractice claims and health status.
- Acknowledge that I, as an applicant for reappointment and responsibilities, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical responsibilities and for resolving any doubts about such qualifications; and

- Acknowledge that any material misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the agency.

All information submitted by me in this application is true and complete to my best knowledge and belief. A photocopy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Print Name Signature

_____
Date

Hillcrest Educational Centers, Inc will treat this application and any information secured in connection therewith in confidence and will employ all reasonable safeguards to prevent the unauthorized disclosure of any such information.

Print Name (HR) Signature

_____
Date