Hillcrest Educational Centers, Inc.

APPLICATION FOR 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.
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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
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