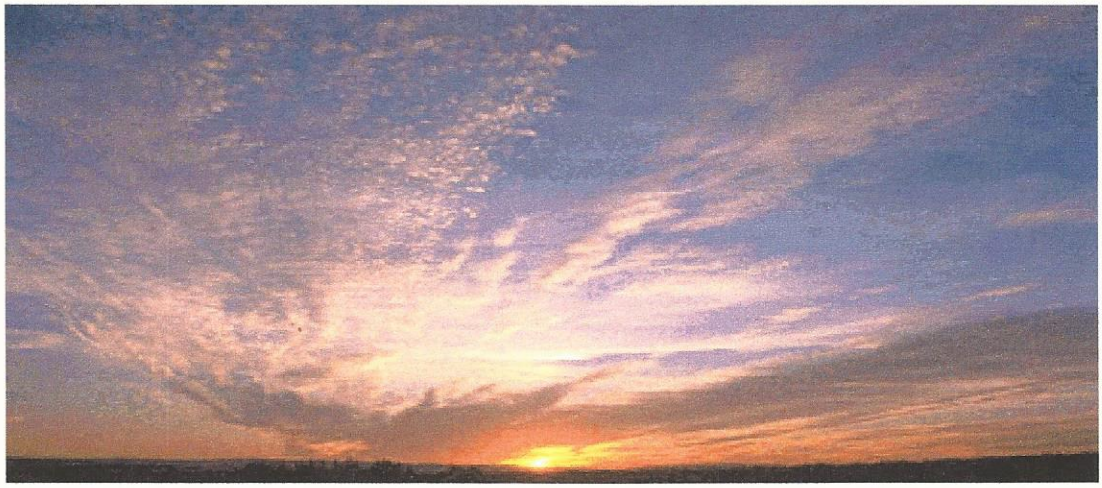

Application to join the Medical Staff of New Horizon Surgical Center

- Same-Day Ambulatory Surgery Center
- 23 Hour Stay Permitted
- State Licensed by NJ DOHSS
- Joint Commission Accredited
- Medicare Certified
- 2 Operating Rooms

680 Broadway, Suite 201
Paterson, NJ, 07514
Tel.: (973) 782-4202
Fax: (973) 782-4206
www.NewHorizonASC.com

GENERAL INSTRUCTIONS

- Complete the Application in full. Print or type all responses.
- Attach additional sheets if necessary to complete your response & reference the question being answered.
- Submit photocopies of all other Required Documentation as per attached sheet.

PERSONAL INFORMATION

Physician Name

Office Address

Office Telephone | Office Contact | Office Email

Home Address

Home Telephone | Cell Phone | Personal Email

Birthplace | Date of Birth | Citizenship

EDUCATION

	School Name & Location	Degree	Dates Attended
Medical School			
	Institution & Address		Dates Attended
Internships			
Residencies			
Fellowships			
Preceptorships			

CURRENT HOSPITAL & SURGERY CENTER PRIVILEGES

Institution	Dates	Staff Status: Active, Courtesy
	From -- To	
	From -- To	
	From -- To	
	From -- To	

BOARD CERTIFICATIONS

Board Name	Year Certified	Year Recertified

Active Candidate for Board of:

Name of Board | Date of Exam

LICENSING

New Jersey License No. _____ Date Issued _____

In what other States are you Licensed? _____

PROFESSIONAL LIABILITY INSURANCE

Carrier _____ $ Limits _____ Specialty & Special Procedures Included _____

Copy of Certificate of Insurance must be attached

STATEMENT OF HEALTH

Answer one (1) of the following:

1) I certify that I am in good health and have no physical or mental limitations. _____

2) I do have a chronic illness, physical disability or mental limitation to my health, which may include alcohol or drug abuse, but believe that this does not significantly impair my ability to render quality patient care. _____

If you answered #2 and there has been any significant change in your health status in the past two (2) years, a full statement of explanation must be attached. This statement must include the name and address of your personal PCP.

MEDICAL REFERENCES

List three (3) Peer References & their addresses/contact information:

1) _____

2) _____

3) _____

PROFESSIONAL STATUS

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET(S) OF PAPER.

Within the past six (6) years:

1) Has your license to practice medicine been voluntarily or involuntarily limited, suspended, revoked or restricted? ☐ Yes ☐ No

2) Has your license to prescribe narcotics been voluntarily or involuntarily refused, suspended or revoked? ☐ Yes ☐ No

3) Have you relinquished or reduced your privileges at any hospital or dropped any hospital from your practice? ☐ Yes ☐ No

4) Have you ever been denied requests for privileges at any hospital or surgery center? ☐ Yes ☐ No

5) Have you ever resigned or been asked to resign from a Medical Staff or a professional society? ☐ Yes ☐ No

6) Has any hospital or surgery center ever suspended, diminished, revoked, or failed to renew your privileges? ☐ Yes ☐ No

7) Have you ever been convicted of a crime (other than a motor vehicle citation)? ☐ Yes ☐ No

8) Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any medical organization? ☐ Yes ☐ No

9) Have you ever had professional liability insurance denied, cancelled, issued on special terms or renewal refused? ☐ Yes ☐ No

10) Do you have any malpractice claims pending? ☐ Yes ☐ No

Have you had any malpractice judgments or settlements made against you? ☐ Yes ☐ No

If "Yes" to either, please describe the date and nature of the alleged malpractice, name of insurance company defending you, settlement amount if settled, judgement amount or verdict if case went to trial, current status if case is not resolved.

STATEMENT OF APPLICANT

I fully understand that any significant misstatement in or omission from this application or any future application constitutes cause for denial of appointment to or dismissal from the Medical Staff. All information submitted by me in this application is true to the best of my knowledge and belief.

I have read the Bylaws and Rules and Regulations of the Medical Staff. In making application for appointment to the Medical Staff of *New Horizon Surgical Center*, I agree to abide by the Bylaws of the Medical Staff, as same may be amended from time to time, and by such Rules and Regulations as may be adopted in accordance with these Bylaws. I further agree to abide by all policies enunciated by the Medical Advisory Board of *New Horizon Surgical Center*.

I agree to carry at least minimum professional liability insurance in accordance with the Bylaws of the Medical Staff of *New Horizon Surgical Center*. I understand I am not permitted to exercise any clinical privileges until appropriate evidence of professional liability coverage has been submitted to the Medical Staff. I agree to notify *New Horizon Surgical Center* of any malpractice claim or suit that may be filed against me resulting from my practice either at *New Horizon Surgical Center* or elsewhere. Furthermore, should any malpractice insurance coverage be interrupted or terminated for any reason, I will notify the Medical Director immediately.

I hereby authorize *New Horizon Surgical Center*, 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 professional liability carriers, who may have information bearing upon my professional competence, character and ethical qualifications. I further consent to the inspection by *New Horizon Surgical Center*, the Medical Staff and their representatives of all 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, and I hereby consent to the release of such information.

I hereby release from liability all representatives of *New Horizon Surgical Center* and its Medical Staff for their acts performed without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to *New Horizon Surgical Center* or its Medical Staff, 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 believe that I am qualified to perform all *New Horizon Surgical Center* procedures for which I have applied for in this application.

I agree that I shall not rebate a portion of a fee or accept other inducements in exchange for a patient referral, that I shall not deceive a patient as to the identity of an operating surgeon or any other medical practitioner providing treatment or services and that I shall not delegate the responsibility for diagnosis or care of patients to another medical practitioner unless I believe such practitioner to be qualified to undertake this responsibility.

_____ _____

Signature of Applicant Date

NOT TO BE FILLED IN BY APPLICANT

The attached privileges are recommended to the Board of Directors for:

☐ **Approval as requested**

☐ **Approval with conditions as specified:**

_____

_____

☐ **Denial – Reason for denial:**

_____

_____

_____

Date **Signature – Administrator**

_____

Date **Signature – Medical Director**

_____

Date **Signature – Director of Nursing**