APPLICATION FOR ACTIVE MEDICAL/DENTAL STAFF

PHYSICIAN ASSISTANT

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

To process your application for medical staff privileges with the Kentucky OCSHCN, please return the following:

☐ Application for Active Medical/Dental Staff (form OCSHCN-60d) Please sign and date (see back)
☐ Signed Authorization, Attestation, and Release (form OCSHCN-60e)
☐ Signed Anti-Harassment/Discrimination Acknowledgment (form OCSHCN-60f)
☐ Current credentialing from the National Commission on Certification of Physician Assistants (NCCPA)
☐ Copy of the Initial and any Supplemental Application for Physician to Supervise Physician Assistant.
☐ Copy of your current CAQH application
☐ Up-to-date Curriculum Vitae
☐ Copy of current malpractice insurance endorsement
☐ Copy of current Kentucky State license
☐ Copy of current DEA certificate (if applicable)

PERSONAL INFORMATION:

Name (Last) _____ (First) _____ (MI) _____

Professional Degree _____ DOB _____ KY State License Number _____

Email_____

Practice Name _____

Office Address _____

_____

Office Phone _____ Office Fax _____

Office Contact Name_____Office Contact Email_____

CLINICAL PRIVILEGES REQUESTED: _____

PEER REFERENCES: Please provide the names of two physicians/PAs that have worked closely with you and can comment on your abilities as a PA.

Name & Institution _____

Street Address _____

City, state, zip code &
Country_____

Peer Reference Email_____

Office Contact Name_____Office Contact Email_____

Name & Institution _____

Street
Address_____

City, state zip code & Country _____

Peer Reference Email_____

Office Contact Name_____Office Contact Email_____

APPLICATION FOR ACTIVE MEDICAL/DENTAL STAFF

PHYSICIAN ASSISTANT

Office for Children with Special Health Care Needs

Please answer the following questions. For any "Yes" response, give full details on a separate sheet and attach to your application.

1. Has your license to practice medicine/dentistry in any jurisdiction ever been denied, suspended, limited, revoked or surrendered? Yes ☐ No ☐

2. Has your DEA license ever been denied, suspended, limited, revoked or surrendered? Yes ☐ No ☐

3. Have you ever been convicted of a felony? Yes ☐ No ☐

4. Have your privileges at any hospital or institution ever been denied, suspended, limited, revoked or not renewed (for other than administrative reasons)? Yes ☐ No ☐

5. Have you ever resigned from a hospital staff or institution while under investigation regarding a breach of professional activity? Yes ☐ No ☐

6. Have you ever been denied membership or a renewal thereof or been subject to disciplinary proceedings in any medical organization? Yes ☐ No ☐

7. Are you now abusing, or have you ever been treated for abuse of chemical substances? Yes ☐ No ☐

8. Do you carry Medical Liability Insurance in an amount and kind that will insure protection of OCSHCN patients under your care? Yes ☐ No ☐

9. Any claims within past 5 years? Yes ☐ No ☐ Any pending? Yes ☐ No ☐

10. Have you ever had malpractice or liability insurance coverage suspended or denied? Yes ☐ No ☐

NOTE: If there is any other significant information not asked on this page, which should be known by the committees evaluating your eligibility for staff membership, please provide as an attachment to this application.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I certify that I have received a copy of the Medical Staff Policies. In making application for appointment to the KY OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients. I further acknowledge and understand that my application does not guarantee that the Kentucky Office for Children with Special Health Care Needs will grant me clinical privileges or contract with me as a provider of service.

_____ _____

Signature Date