Johnstown Free Medical Clinic

Credentialing Application Form
Physicians, Dentists and Allied Health Professionals

NAME: _____/_____/_____
Last First Middle

I certify that I have successfully completed the credentialing and privileging process at Memorial Medical Center and I understand that if I am not in good standing with Memorial Medical Center that I must complete the full credentialing and privileging process with JFMC. ____*(initial)*

INSTRUCTIONS:

- Complete the application in blue or black ink. Incomplete applications will be returned and will delay processing.
- Please include copies of .
  - ☐ Current Pennsylvania State Professional License
  - ☐ Current DEA Registration if Applicable
  - ☐ Current Professional Liability Face Sheet if applicable
  - ☐ Photo ID (copy of driver's license acceptable)
  - ☐ Curriculum Vitae or Resume

PERSONAL INFORMATION

Type of Practitioner: ☐ MD ☐ DO ☐ DPM ☐ DDS ☐ DMD ☐ CRNP ☐ RN ☐ Other: _____

Personal Address: _____/_____/_____/_____
Street Address City State Zip

Person Contacts: _____ _____ _____
Home Phone Cell Phone Email Address

Business Name: _____

Business Address: _____/_____/_____/_____
Street Address City State Zip

SOCIAL SECURITY NUMBER: _____-_____-_____ DATE OF BIRTH: ____/____/_____ **(Required for NPDB)**
MM DD YYYY

PROFESSIONAL/MEDICAL/DENTAL SCHOOL EDUCATION

_____/_____/_____/_____/_____

PROFESSIONAL/MEDICAL/DENTAL SCHOOL NAME City State Zip Country

_____/_____ _____/_____ Degree Awarded: _____

MM YYYY MM YYYY

Start Date Completion Date

❒ Internship ***OR*** ❒ Other Training ***(please check appropriate box)***

Institution Name: _____ Specialty: _____

_____/_____/_____ Date of Entry:____/_____

City State Country (if other than US) MM YYYY

Program Completed: Yes: _____ _____/_____ No: _____ If no, please explain: _____

MM YYYY

Completion Date

Residency

Institution Name: _____ Specialty: _____

_____/_____/_____ Date of Entry:_____/_____

City State Country (if other than US) MM YYYY

Program Completed: Yes: _____ _____/_____ No: _____ If no, please explain: _____

MM YYYY

Completion Date

Fellowship

Institution Name: _____ Specialty: _____

_____/_____/_____ Date of Entry:____/_____

City State Country (if other than US) MM YYYY

Program Completed: Yes: _____ _____/_____ No: _____ If no, please explain: _____

MM YYYY

Completion Date

LICENSURE

State License Number: _____ Issue Date:_____/_____ Expiration Date: _____/_____

MM YYYY MM YYYY

DEA Number: _____ Issue Date: _____/_____ Expiration Date: _____/_____

MM YYYY MM YYYY

BOARD CERTIFICATION (S)

Specialty: _____ Board Certified? ❒ Yes ❒ No

Additional Certifications: (check appropriate box)

BLS: ❒ ACLS: ❒ CPR: ❒ Other : ❒ Please list: : _____

If you have additional board certification(s), please make a copy of this page, fill out, and attach to this application.

AFFILIATION

If applicable

_____/_____

PRIMARY Hospital Name Department

_____/_____/_____/_____

Street Address City State Zip Code

Specialty: _____ Status: _____ _____/_____ to _____/_____

MM YYYY MM YYYY

Start Date Reappointment Date

_____

PROFESSIONAL LIABILITY INSURANCE

If applicable

CURRENT Insurance Carrier:_____/_____/_____

City State

Policy #: _____ Effective Date: _____/_____/_____ Expiration Date: _____/_____/_____

MM DD YYYY MM DD YYYY

_____

PRACTITIONER'S ATTESTATION and RELEASE

By my signature I hereby;

1. attest that the information in this application is complete, accurate, truthful and correct in all respects;
2. understand that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the credentialing process;
3. authorize JFMC representatives and the organization to consult with others who have been associated with me and/or who have information bearing on my competence and qualifications;
4. consent to JFMC's representatives inspection of all records and documents that may be used to evaluate my professional qualifications and competence to carry out the practice privileges I request, my physical and mental health status, and my professional and ethical qualifications;
5. release from any liability and promise not to sue JFMC and its representatives for their

compilation and verification of my professional credentials;

6. agree to provide and update the information requested on my initial application and subsequent reapplications and privilege request forms.

_____

Applicant Signature *(Required)*

_____ _____

Print Name *(Required)* **Date *(Required)***

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@pa.gov

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

THIS APPLICATION IS FOR USE ONLY BY A PRIMARY SUPERVISING PHYSICIAN LICENSED BY THE PENNSYLVANIA STATE BOARD OF MEDICINE.

PLEASE PRINT OR TYPE ALL INFORMATION. If the written agreement is identical for all supervisors, submit one application for each physician assistant. Attach the fee and written agreement.

FEE. Submit the $35.00 fee. Make check or money order payable to the "Commonwealth of Pennsylvania." **FEES ARE NOT REFUNDABLE. The fee cannot be transferred to another application. Note**: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. Your cancelled check is your receipt of payment.

PLEASE NOTE: If this application is not completed **within six months**, updates of certain sections and/or supporting documents will be required. If the application has not been completed within one year from the date it was received, applicants will be required to submit a new application (**another application processing fee**) and supporting documents, as necessary.

PLEASE NOTE: Upon receipt of a **complete** application, the Board will issue a letter authorizing the physician assistant to temporarily commence practice in accordance with the pending written agreement submitted with this application. The temporary authorization to practice is valid for **120 days ONLY** while the written agreement is being evaluated for final Board approval.

PLEASE ALLOW AT LEAST 120 DAYS FOR PROCESSING OF THE WRITTEN AGREEMENT FINAL APPROVAL.

PLEASE NOTE: A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD ISSUING A TEMPORARY AUTHORITY TO PRACTICE

PRIMARY SUPERVISING PHYSICIAN NAME:	Last	First		Middle	
PRIMARY SUPERVISING PHYSICIAN LICENSE NUMBER:		**PRACTICE TELEPHONE NUMBER:**			
PRACTICE ADDRESS:	Street				
City	State	ZIP			
SUBSTITUTE SUPERVISOR NAME:	Last	First		Middle	
SUBSTITUTE SUPERVISOR'S LICENSE NUMBER:					
PHYSICIAN ASSISTANT NAME:	Last	First		Middle	
PHYSICIAN ASSISTANT LICENSE NUMBER:					

PENNSYLVANIA STATE BOARD OF MEDICINE

PRIMARY SUPERVISING PHYSICIAN MUST COMPLETE THIS SECTION:

LIST YOUR SPECIALTIES:			
DO YOU HOLD HOSPITAL STAFF PRIVILEGES?	Yes	No	
IF YES, LIST HOSPITAL(S):			

VERIFICATION

- I will direct and exercise supervision over the named physician assistant in accordance with the rules and regulations of the State Board of Medicine.
- I verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine.
- I recognize that I am obligated to comply with all provisions of the Act and Regulations including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant.
- I recognize that I retain full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the physician assistant's patients.
- I verify that the statements in this application and written agreement are true and correct to the best of my knowledge, information and belief.
- I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my registration.
- **I will provide all substitute supervising physicians with a copy of the approved supervising written agreement**.
- The physician assistant identified in this application will only work with the primary supervising physician and his/her substitute physician assistant supervisor(s).
- The physician assistant will only provide medical services to the patients under the care of the primary and substitute supervisor(s) **and WILL NOT practice if the supervising physician or an authorized substitute supervisor is not available**.

PRIMARY SUPERVISING PHYSICIAN (Printed Name):		
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:		Date
PHYSICIAN ASSISTANT (Printed Name):		
PHYSICIAN ASSISTANT SIGNATURE:		Date

PLEASE NOTE: The primary supervisor's responsibilities include:

- **Providing a copy of the final, Board approved written agreement to all substitute supervisors.**
- **Maintaining a current list of all locations where the physician assistant will perform duties.**
- **Maintaining a current list of all substitute supervisors under which the physician assistant will work.**
- **Notifying the Board of changes to the primary practice location utilizing a written agreement change form.**
- **Ensuring that the physician assistant will not practice without supervision by either the primary supervisor or an authorized substitute supervisor.**

PENNSYLVANIA STATE BOARD OF MEDICINE

WRITTEN AGREEMENT

NAME - PRIMARY SUPERVISING PHYSICIAN:	Last	First	Middle
NAME – SUBSTITUTE SUPERVISING PHYSICIAN:	Last	First	Middle
NAME – PHYSICIAN ASSISTANT:	Last	First	Middle

INSTRUCTIONS: Please provide the following information (typed) for question 1 on 8.5" x 11" sheets of paper and attach to this form. The information on this agreement must be agreed to by all supervisors (primary and substitute).

1.	Describe the functions/tasks to be delegated to the physician assistant.
2.	On-site supervision and direction will be provided to the physician assistant _____ (daily, every other day, once per week, etc.).
3.	If the physician assistant will practice in a hospital, provide the name and address of each hospital below. If more than three hospitals, please provide this information on a separate sheet of paper.

Name of Hospital	Address
Name of Hospital	Address
Name of Hospital	Address

4.	Will the physician assistant prescribe and dispense drugs/therapeutic devices?	Yes	No

If yes, please identify which categories of controlled substances may be prescribed and dispensed?

☐ None ☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

List below any specific drugs that the physician assistant **WILL NOT** be permitted to prescribe/dispense.

PENNSYLVANIA STATE BOARD OF MEDICINE

PATIENT RECORD REVIEW PLAN

NAME - PRIMARY SUPERVISING PHYSICIAN:	Last	First	Middle
NAME – PHYSICIAN ASSISTANT:	Last	First	Middle

VERIFICATION

The supervising physician must countersign 100% of the patient records completed by the physician assistant within a reasonable time, which shall not exceed ten days during each of the following cases:

- The first 12 months of the physician assistant's practice post graduation and after obtaining licensure.
- The first 12 months of the physician assistant's practice in a new specialty.
- The first 6 months of the physician assistant's practice in the same specialty under a new primary supervisor (unless, the new primary supervisor was registered as a substitute supervisor for at least six months under another written agreement).

I verify that I have read the above requirements and that I will countersign 100% of the patient records for the required time frame.

After you have countersigned 100% of the patient records for the required time frame(s) listed above, will you continue to countersign 100% of the patient records within the required 10 day period?	Yes	No

If NO, provide specific details below regarding how you will select patient records for review and with what frequency you will review patient records. This information should include specifics such as the percentage of patient charts, specific types or categories of patient cases, etc. Use additional 8 ½" x 11" paper, if necessary.

I affirm that the number of patient records reviewed shall be sufficient to assure adequate review of the physician assistant's practice. Deviation from 100% chart review will require Board approval **PRIOR TO IMPLEMENTING THE NEW REVIEW PLAN.**.

PRIMARY SUPERVISING PHYSICIAN	Last	First	Middle
PRIMARY SUPERVISING PHYSICIAN SIGNATURE:			Date