Abington Surgical Center
2701 Blair Mill Road, Suite 35
Willow Grove, PA 19090
215-443-8505

Thank you for your interest in becoming part of the medical staff of the Abington Surgical Center. To ensure prompt processing of your application, the following instructions are provided. Please do not hesitate to contact us with any questions.

Application must be legibly printed. If additional space is needed, please attach additional sheets. Please provide FAX numbers for education, affiliations and peer references.
The following MUST accompany your application: (if any of the items below are missing, your application will be returned).

1.) A completed, signed and dated application;
2.) A one-time application fee of $150.00; checks should be made payable to "*Abington Surgical Center*"
3.) Current Curriculum Vitae.
4.) Copy of current Medical License, DEA license, proof of malpractice coverage, copy of Board Certification, (if applicable), attached Authorization and Release form.
5.) Foreign Medical graduates must attach a copy of valid ECFMG or FMGEMS certification.

Application for Medical/Dental /Podiatric Staff Appointment

((Print or Type)

1. Name _____
Last First Middle
Date _____ Social Security # _____

UPIN# _____ National Provider Identification # _____

Date of Birth _____ Sex: _____ Birthplace _____

2. Office (mailing address) _____
City, State & Zip Code _____
Phone _____ FAX:_____ E-MAIL: _____

3. Home Address _____
City, State &Zip Code _____
Phone _____

4. Citizenship? ☐ U.S. ☐ Other, Specify _____

5. Premedical Education (college or university name and mailing address)
Name: _____
Street Address:_____
City, State, Zip Code:_____
Phone: _____ Fax: _____
Degree _____ Dates attended _____

6. Professional School (college or university name and mailing address)
Name: _____
Street Address:_____
City, State, Zip Code:_____
Phone: _____ Fax: _____
Degree _____ Dates attended _____

7. Other Education _____
_____
Degree _____ Dates attended _____

8. Internship, Residencies and Fellowships – List in chronologic order, indicating institution, mailing address and dates:

	Institution	**Street Address**	**Dates Attended**
INTERNSHIP:			
RESIDENCY:			
FELLOWSHIP:			

9. Applying for privileges in (state specialty) _____

10. **SPECIALTY BOARD** _____
Date Certified _____ Expiration Date _____

SPECIALTY BOARD _____
Date Certified _____ Expiration Date _____
ENCLOSE A COPY OR OTHER PROOF OF BOARD CERTIFICATION

11. **ENCLOSE A COMPLETE COPY OF *CURRENT* CURRICULUM VITAE.**

12. a. Date first licensed to practice in Pennsylvania _____
(ENCLOSE A COPY OF *CURRENT* LICENSE).

b. List other states in which you are licensed to practice _____

c. Has your professional license to practice in any jurisdiction ever been relinquished, denied, limited suspended or revoked? ☐ Yes ☐ No

d. Have any disciplinary actions or investigations ever been initiated or are any pending against you by any state licensure board? ☐ Yes ☐ No
IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER

13. a. Drug Enforcement Administration Number _____ Exp. Date: _____
ENCLOSE A COPY OF *CURRENT* DEA CERTIFICATE.

b. Has your DEA certificate in any jurisdiction ever been relinquished, denied, limited, suspended? ☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

14. a. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal, or state health insurance program (for example Medicare, Medicaid) ☐ Yes ☐ No

b. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ON SEPARATE SHEET OF PAPER

15. Please list membership in professional societies, colleges:
_____
_____

16. Has your membership in local, state or national professional societies ever been suspended or terminated?
☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

17. List chronologically all past and present hospital or other health care facilities (e.g. surgical center) affiliations, including staff rank, facility, mailing address, dates and phone number (except internships, residencies and fellowships).

Facility Name _____
Staff Rank _____
Mailing Address _____
Dates _____ **Phone** _____
Fax: _____

Facility Name _____
Staff Rank _____
Mailing Address _____
Dates _____ **Phone** _____
Fax: _____

Facility Name _____
Staff Rank _____
Mailing Address _____
Dates _____ **Phone** _____
Fax: _____

18. a. Have any of your appointments or privileges ever been relinquished, denied, limited, revoked, suspended or not renewed at any hospital or health care facility? ☐Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

b. Have you ever withdrawn your application for appointment, reappointment and/or clinical privileges or resigned from the staff before a potentially adverse decision by a hospital's or health care facility's governing board?
☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

c. Have you ever been the subject of disciplinary proceedings or investigations at any hospital or health care facility?
☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

19. Do you have any physical or mental condition which could affect your ability to exercise the clinical privileges requested or would require accommodation in order for you to exercise the privileges requested safely and competently? ☐ Yes ☐ No
IF YOU HAVE ANSWERED YES PLEASE SUBMIT A FULL EXPLANATION WITH THIS APPLICATION.

20. a. Present malpractice insurance carrier _____

b. List other insurance carriers since entering practice_____
_____

c. **PLEASE PROVIDE A COPY OF YOUR *CURRENT* INSURANCE CERTIFICATE.**

d. Are there currently any suits pending against you? ☐ Yes ☐ No

e. **PLEASE PROVIDE, ON A SEPARATE SHEET, A LIST OF ALL PENDING AND RESOLVED SUITS AGAINST YOU. PROVIDE A BRIEF DESCRIPTION OF THE NATURE OF THE SUIT, THE DATE OF OCCURRENCE AND THE OUTCOME.**

21. a. Has your professional liability insurance coverage ever been terminated by action of an insurance company?
☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

b. Have you ever been denied professional liability insurance coverage? ☐ Yes ☐ No

IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.

c. Has your present professional liability insurance carrier excluded any specific area of practice from your coverage?
☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

22. Have you ever been named as a defendant in any criminal proceedings? ☐ Yes ☐ No
IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.

23. Have you ever been the subject of a report filed with the National Practitioner Data Bank or any state licensure board? ☐ Yes ☐ No **IF YES, EXPLAIN ON A SEPARATE SHEET OF PAPER.**

24. List teaching appointments (give title, institution and dates) in chronologic order.

_____
_____
_____

25. List below the names, mailing addresses and phone numbers of three (3) persons (one of whom is your residency/fellowship director if in practice less than two years) who can provide relevant information regarding your clinical competency and ethical character from their experience in working with or observing you. If you have been in practice for two or more years after residency/fellowship, one reference must be your current department chief/chair or chief of staff. **Individuals who are members of your group practice may not be listed as references.** The Abington Surgical Center will contact these references on your behalf. Applications will not be deemed complete until all references have responded to us

Residency/Fellowship Director or Dept. Chair/ Chief of Staff: _____
Address: _____
_____
_____
Phone: _____ Fax: _____
E-mail: _____

Professional Reference: _____
Address: _____
_____
Phone: _____Fax: _____
E-mail :_____ _____

Professional Reference: _____
Address: _____
_____
Phone: _____Fax: _____
E-mail: _____

I attest that the aforementioned is true and accurate to the best of my knowledge.

_____ _____
Signature Date

Please return the completed application along with requested documents to:
Philomena Glowka, Director
Abington Surgical Center
2701 Blair Mill Road, Suite 35
Willow Grove, PA 19090
267-9601406
Fax: 2i5-957-0565
e-mail: pglowka@abingtonsurgery.org

AUTHORIZATION AND RELEASE

I am applying for appointment or reappointment to the Medical, Dental and Podiatric Staff ("Staff") of the Abington Surgical Center., together with the clinical privileges identified in the attached Request for Clinical privileges form. I understand that it is my responsibility to produce adequate information so the Center can perform a proper evaluation of my application. I agree to provide the Center with additional information that the Center or one of its authorized representatives may request and understand that the failure to produce any requested information will prevent my application from being processed. I am willing to make myself available for interviews in regard to this application and intend to be legally bound by the terms of this Authorization and Release.

I acknowledge that I have received and have read the Bylaws and Rules and Regulations of the Staff. I agree to abide by such Bylaws and Rules and Regulations as well as such policies and procedures of the Center, as in effect from time-to-time.

I agree to: (a) refrain from fee-splitting or other inducements relating to patient referral; (b) refrain from delegating responsibility for diagnosis or care of patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (c) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (d) seek consultation whenever necessary or required; (e) abide by generally recognized ethical principles applicable to my profession; (f) provide continuous care and supervision as needed to all patients for whom I have responsibility; (g) accept committee assignments and participate in the activities of the Staff; and (h) establish my fees commensurate with the services rendered.

By applying for appointment to the Staff and for clinical privileges, I accept, and intend to be legally bound by the following conditions during the processing and consideration of my application, regardless of whether I am granted appointment or reappointment to the Staff and for the duration of my appointment or reappointment, and regardless of the privileges granted.

I authorize the Center, its officers, employees, members of the staff and other representatives, including consultants to the Center, including its attorneys ("Representatives"), to consult with the members of the medical staff and representatives of any hospital, health care facility, or institution with which I have been associated and with others who may have information relating to my professional ability and qualifications, including information regarding any matter that might directly or indirectly, affect the patient care or the efficient operation of an institution or organization, including without limitation my credentials, clinical competence, judgment, character, ethics, behavior or any other matter, and to inspect all records and documents that may contain such information. I grant immunity to and release any and all hospitals, health care facilities, individuals, institutions, organizations and the authorized representatives who supply oral or written information, records or documents to the Center in response to an inquiry emanating from the Center or any of its Representatives.

To the fullest extent permitted by law, I extend absolute immunity and release the Center and its Representatives and any other party from any and all liability arising from any acts, communications, reports, recommendations or disclosures, including otherwise privileged or confidential information involving me, performed, made or received by the Center and its Representatives, to, by, or from, any third party anywhere, at any time, concerning activities relating to, but not limited to : (1) application for appointment or clinical privileges, including temporary privileges, (2) periodic reappraisals undertaken for reappointment or for increase or decrease clinical privileges; (3) proceedings for suspension or revocation of clinical privileges or revocation of medical staff appointment; (4) summary suspensions; (5) hearing and appellate reviews; (6) medical care evaluations; (7) utilization reviews; (8) other hospital and medical staff, department, service or committee activities relating to the quality of patient care or to my professional conduct and concerning matters or inquiries relating to my professional qualifications, credentials, clinical competence, character, ethics, behavior or any other matter that might directly or indirectly have or have had an effect on my professional competence, patient care, or the orderly operations of this or any other hospital, health care facility, or institution.

I understand that my initial application is provisional for no less than one year and represent that there is nothing which would impair my ability to fulfill my duties and obligations to patients or as a member of the Staff.

I understand that a copy of this Authorization and Release may be furnished to each person, institution or agency from whom information is requested.

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement or omission, the Center may immediately terminate my privileges.

_____ _____ _____

(Date) (Signature of Witness) (Signature of Applicant)