



Dear prospective candidate:

Thank you for expressing an interest in our vacancy.

We will need additional information from you as well as applications completed and returned before we can continue with our interview process.

Please complete and return the following:

- Updated CV
- Texas Standardized Credentialing Application
- 3 Professional Reference Letters
- 3 References we can contact directly
- Employment Application
- Application for Privileges
- Copy of current Texas license
- Copy of current DEA license
- Copy of current DPS license
- Copy of current CPR certificate
- Copy of certificates from undergraduate, graduate, doctorate institutions
- Attestation authorizing MLK Jr. Family Clinic and affiliates to verify all credentials, background and claims.
- Lists of Medicare, Medicaid, UPIN, TPI and other provider billing numbers.

For additional information, feel free to view the following websites:

www.mlkfamilyclinic.org

www.tachc.org

If you have any further questions, please contact Darla Gray, Chief Operations Officer, at dgray.mlk@tachc.org or at 214-426-3645, ext. 121.

Thank you.



General Staff Application

Position applying for _____ Date _____

APPLICANT NAME _____
Last First Middle Maiden

BUSINESS ADDRESS _____ Telephone ____/____/____
Street City State Zip

RESIDENCE ADDRESS _____ Telephone ____/____/____
Street City State Zip

SOCIAL SECURITY NUMBER ____/____/____ DOB ____/____/____
(To be used for identification purposes only)

EDUCATION

UNDERGRADUATE /Technical EDUCATION

School/College or University Address City/ State Zip
Dates of Enrollment ____/____/____ to ____/____/____ Degree _____ Date of Graduation ____/____/____

GRADUATE EDUCATION _____
Graduate School Address City State/Zip
Dates of Enrollment _____ Degree _____ Date of Graduation _____

PROFESSIONAL EDUCATION _____
Institution Address City State/Zip
Dates of Enrollment _____ Degree _____ Date of Graduation _____

LICENSURE _____
State Date Issued Number Expiration Date

State Date Issued Number Expiration Date

State Date Issued Number Expiration Date

PROFESSIONAL SPECIALIZATION CERTIFICATION

Are you certified by a professional board or association? Yes No If yes, please answer the following:

Name of Board or Association _____

Type of Certification _____ Issued ____/____/____ Expiration Date ____/____/____

(Please attach a copy to application)



General Staff Application

MILITARY SERVICE

Have you served in the Military? Yes No If yes, please answer the following:

_____	_____
Branch	Rank
_____	_____
Dates	Type of Discharge

CONTINUING EDUCATION

Please attach a list of the continuing education programs that you have attended or presented for the period since last license renewal.

CPR Basic Life Support Advanced Life Support Instructor

OTHER CERTIFICATION

_____	_____
Type of certification	Date of Certification

1. Are you currently taking controlled substances by prescription or otherwise? Yes No

"**Currently**" means recently enough so that the use of the substance may have an ongoing impact on one's functioning, or within the past two years.

"**Controlled Substances**" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the licensed prescriber's direction, as well as those used illegally.

"**Ability to provide health care services**" is to be construed to include the following:

- a. The cognitive capacity to make appropriate assessments and judgments and learn and keep abreast of health care services developments; and
- b. The ability to communicate those judgments and health care information to patients and other health care providers with or without the use of aides or devices, such as voice amplifiers; and
- c. The physical capability to perform health care services tasks such as checking vital signs and assigned portions of the physical examination procedures and tasks that may fall within your scope of practice, with or without the use of aides or devices, such as corrective lenses or hearing aids.

If you answered, "yes" to question 9, please answer a and b below.

- a. Does your use of controlled substances in any way impair or limit your ability to provide health care services with reasonable skill and safety? Yes No
- b. Are you currently participating in a professionally supervised program that monitors you in order to assure that you are not illegally utilizing the controlled substances? Yes No

2. Do you have a medical condition that would require special accommodations for you to provide health care services with reasonable skill and safety? Yes No

"**Medical condition**" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV/AIDS, tuberculosis, drug addiction and alcoholism.

If you answered "yes" to question 10, please answer a and b below.

- a. Are any limitations that may be related to your medical condition ameliorated by current ongoing treatment or participation in a monitoring program? Yes No
- b. Are any limitations that may be related to your medical condition overcome by the manner in which you have chosen to provide health care services? Yes No

3. Have you ever been convicted of a crime (not including traffic violations)? Yes No

4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? Yes No

If you answered "Yes" to any of the above, please attach explanation and related documents.

_____	_____
Applicant Signature	Date



General Staff Application

Employment/Privileges History

Please list (most recent first) all places where you have practiced, had staff privileges or been employed. Also, please explain any periods of time not accounted for since graduation from professional educational program. Use additional page(s) if necessary. **All time periods must be accounted for, including periods of unemployment and vacations between employment.**

1. Place _____
 Contact _____ Phone Number ____/____/____

 Address City County State Zip
 Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

 Reason for Leaving _____

2. Place _____
 Contact _____ Phone Number ____/____/____

 Address City County State Zip
 Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

 Reason for Leaving _____

3. Place _____
 Contact _____ Phone Number ____/____/____

 Address City County State Zip
 Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

 Reason for Leaving _____

4. Place _____
 Contact _____ Phone Number ____/____/____

 Address City County State Zip
 Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

 Reason for Leaving _____

5. Place _____
 Contact _____ Phone Number ____/____/____

 Address City County State Zip
 Position/Title/Status _____ Dates: ____/____/____ to ____/____/____

 Reason for Leaving _____



General Staff Application

Professional and References

Please list the names, full mailing addresses, and phone numbers of three professional references.

Professional References (persons not related to you and with first-hand knowledge of your professional work).

1. Name _____ Title _____
 Employer _____

 Address _____ City _____ State _____ Zip _____
 Phone Number _____

2. Name _____ Title _____
 Employer _____

 Address _____ City _____ State _____ Zip _____
 Phone Number _____

3. Name _____ Title _____
 Employer _____

 Address _____ City _____ State _____ Zip _____
 Phone Number _____



General Staff Application

(THIS PAGE TO BE COMPLETED BY LICENSED AND/OR CERTIFIED STAFF ONLY)

APPLICANT NAME _____ TITLE _____

SPECIALTY/TITLE _____

CONTROLLED SUBSTANCE REGISTRATION

DEA # _____

DPS # _____

EXP. DATE _____

EXP. DATE _____

Advanced Practice Nurse

Physician Assistant

Prescriptive authority? Yes No

PROFESSIONAL MEMBERSHIP(S) _____

(PROFESSIONAL ASSOCIATION, SOCIETY OR ACADEMY)

TRAINING

Entity/Hospital _____ Type of Program _____ Dates _____

Address _____ City _____ State/ZIP _____

Entity/Hospital _____ Type of Program _____ Dates _____

Address _____ City _____ State/Zip _____

Entity/Hospital _____ Type of Program _____ Dates _____

Address _____

TEACHING

Institution _____ Department _____ Dates _____

APPOINTMENTS

Rank _____ Dates of Affiliation _____

Institution _____ Department _____

Rank _____ Dates of Affiliation _____

Institution _____ Department _____

PRIVATE PRACTICE

Address _____ City _____ State/ _____ ZIP _____ Type _____ Dates of Practice _____

Address _____ City _____ State/ _____ ZIP _____ Type _____ Dates of Practice _____



Licensed/Certified Clinical Applicant: _____

HOSPITAL/ENTITY

AFFILIATION

(LIST ALL PAST AND PRESENT)

Address	City	State	ZIP	Type	Dates of Affiliation

OTHER POSITION (S)

NAME	Address	City/State	ZIP

NOTE: STATE HOSPITAL/ENTITY AFFILIATIONS ON PRACTICE/EMPLOYMENT HISTORY

USE ATTACHED EMPLOYMENT/PRIVILEGES HISTORY PAGE TO LIST ADDITIONAL ENTRIES

- Has your license to practice in any jurisdiction ever been limited, suspended, revoked or probated? Yes No
- Have your privileges at any entity ever been suspended, reduced, revoked or not renewed? Yes No
- Have you ever been denied membership or been subject to discipline by any health care entity? Yes No
- Name of current professional liability insurance carrier _____

Address _____ City _____ State _____ ZIP _____
 Policy # _____ Expiration Date: _____

5. List previous professional liability insurance carriers:

Name	Address	City,	State, Zip	Dates Covered

6. Have you ever had any liability claims filed against you? Yes No
For any liability claims, provide full information on each claim and disposition or status. Use separate page(s)

7. Have you ever been restricted or sanctioned by Medicare or Medicaid? Yes No
If you answered "Yes" to any of the above, please attach explanation and related documents.

Applicant Signature _____

_____ Date



General Staff Application

AUTHORIZATION AND CONSENT

I fully understand that any misstatements in or omissions from this application constitute cause for denial or termination of privileges and employment. All information submitted by me in this application is true to the best of my knowledge.

In making this application, I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of the Center, to make decisions as appropriate to the patient's needs, to maintain my practice knowledge and skills current through continuing education opportunities, to abide by the bylaws, rules and regulations of the Professional Staff, and to participate in and cooperate fully with the Compliance/Performance Improvement Program and all programs to improve quality and reduce risks. I agree to participate in the review of records and documents relating to patient care and services, and to subject my performance to the review by the Center and its representatives for the purpose of improving the quality of care and services and reducing risks, and I hold the Center and its representatives free of all liability for such actions.

I hereby release from liability the Center and all its representatives for their acts performed in connection with obtaining and evaluating my application, credentials and qualifications. I hereby release from any liability any and all individuals and organizations that provide information to the Center or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and privileges and I hereby consent to the release of such information.

I hereby authorize the Center CPI Committee or subcommittee as a professional review committee through the Compliance/Performance Improvement Program to communicate with other entities and individuals concerning knowledge of my professional competence, character and ethics, and agree to hold the Center and its representatives free of liability. I hereby consent to the inspection by the Center or its representatives of all documents, including medical records at other entities, school transcripts, and county records, that may be material to an evaluation of my qualifications and competence for the clinical privileges and functions requested, as well as my moral and ethical qualifications for employment. I agree to hold the Center and its representatives free of liability.

I hereby accept that I will abide by the requirements for coverage by the Federal Tort Claims Act, will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims. I understand that if I am made an offer for privileges or functions and employment, an evaluation of my physical and mental fitness may be requested consistent with the requirements for liability coverage by the Federal Tort Claims Act.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

I understand that my employment with the Center, if any, may be terminated at any time without cause.

Signature of Applicant

Date

Print Name

SWORN TO AND SUBSCRIBED BEFORE ME ON THE _____ DAY OF _____, 20____.

SEAL OF NOTARY PUBLIC, STATE OF TEXAS

The Center is an equal opportunity employer and its decisions are made without regard to race, color, ethnicity, religion, sex, age, sexual orientation, disability, citizenship, national origin or veteran status.



**REQUEST FOR PRIVILEGES FOR
LICENSED OR CERTIFIED HEALTH PROFESSIONALS**

Position Title: _____

I hereby request the attached privileges/scope of practice/competencies for which I am trained and experienced to perform, as listed on the attached forms. I understand that it is my responsibility to demonstrate my competence to perform the listed privileges. I understand that the privileges requested may differ from those finally approved. I further understand that the completion of this form at this time does not preclude me from requesting additional privileges in the future.

Signature of Applicant

Date

Print Name

Attachment (List of privileges, scope of practice or competencies)

NOTE:

The requested privileges must be reasonably comprehensive (i.e., not just specialty designation), must be based on documented education, training and/or experience, and must be specific to the job description you are applying for at the Center. Provide information on any special training you may have had that qualifies you for additional services or functions.

Please attach a delineation of privileges, scope of practice, competencies or detailed job description. If you are requesting privileges or functions in addition to those listed on the job description, please indicate accordingly on the attachment.



APPLICATION FOR CLINICAL PRIVILEGES

General

Granting, reviewing, and changing of clinical privileges for the staff of the Center will be in accordance with the Center policy. Assignments of such clinical privileges are based upon education, clinical training, experience, demonstrated current competence, documented results of patient care, and other quality review and monitoring deemed appropriate. The principle of “documented competency” will prevail. Primary care medicine is a dynamic and comprehensive field. Adult medicine, pediatric care, perinatal care, surgical care, critical care, and mental health care are integral components of Center continuity of care. As a result, privileges in these areas are identified to pertain to primary care, specialties of pediatrics, internal medicine, family practice, general practice, and obstetrics/gynecology.

The privileges for the Center will be granted in the following three classes:

Level One (General)

This class includes privileges for uncomplicated, basic procedures and clinical application of cognitive skills. Physicians applying for privileges in this class will be graduates of approved medical/osteopathic schools who are properly licensed and demonstrate skills in appropriate general medicine practice.

**Level Two
(Residency/Board Certification)**

Privileges in this class include Level One privileges as well as privileges for those procedures and cognitive skills involving more serious medical problems which are normally taught in residency programs. This will include procedures and clinical application of cognitive skills appropriate to the care in perinatal, surgical, psychiatric, and critical care units. Physicians requesting privileges in this class will have to meet criteria in Level One and have either completed training in a residency program and/or will be Board Certified, or will have documentation experience, demonstrated abilities and current competence in primary care medicine.

**Level Three
(Advanced Procedures)**

Privileges in this category include privileges in Level I and II. Additional privileges may be granted to physicians who have acquired added experience and/or training, and who have special skills and knowledge in specified areas of medicine. As appropriate, the Medical Director will review these additional privileges.

It should be noted that, even though a physician is assigned to one of the three classes, he or she might also elect to apply for individual privileges that may be considered to be a higher level.



*PRIVILEGED AND CONFIDENTIAL
Proceedings and Records of the
Professional Review Committee*

Privilege Request Form

Print Name: _____

Hire Date: _____

Primary Location: _____

Board Certified: _____ Date: _____

Subspecialty: _____ Date: _____

Board Eligible: _____

Projected Certification Date: _____

**** Write the number of the level and clinical site that applies for each privilege ****

Privilege Level: (General) (Residency/Board Certification) (Advanced Procedures)

Clinical Site Legend: _____ _____ _____

_____ _____ _____

Procedures	Requested	Level	Site	Medical Director Approval	Special Conditions/ Comments
General Privileges					
Management of Routine Adolescent Care					
Management of Routine Adult Care					
Management of Routine Geriatric Care					
Supervision of Residents and Students					
Abscess I & D					
Biopsy, skin					
Cardiopulmonary resuscitation (BLS)					
Excision, benign lesion, skin					



Foreign body removal, eye					
Foreign body removal, ear					
Ingrown toenail excision					
Lacerations, infected					
Paronychia, I & D					
Suturing of simple laceration					
Privileges in Anesthesia Care					
Use of local anesthetics for wound repair					
Use of topical anesthetics					
Privileges in Emergency Care					
Debridement, skin subcutaneous, tissue					
Dressing/Debridement, burn					
Foreign body removal, nose					
Incision and removal of foreign body					
Laceration, simple					
Privileges in Internal Medicine					
Independent Care: Basic Life Support					
Basic Diagnosis & Management					
Full care of uncomplicated cases					
EKG interpretation					
Needle aspiration of subcutaneous lesion					
PFT (pulmonary function test) interpretation					
Superficial nerve block					
Privileges in Gynecological Care					
I & D Bartholin cyst					
Cervical biopsy					
Colposcopy/Cervical Cryotherapy					
Culdocentesis					
Endometrial biopsy					
IUD insertion and removal					
Laninaria Placement					



Curettage, 1 st trimester spontaneous abortion					
Privileges in Obstetric Care					
Routine prenatal care					
Spontaneous delivery in vertex presentation					
Uncomplicated episiotomy and repair					
Repair of minor vaginal lacerations					
OB ultrasounds on I & D for fetal position, placental localization, FHT's, etc.					
Abnormal labor					
Chronic hypertension - Mild					
Diabetes - gestational					
Fetal distress					
History of genital herpes					
Pre-eclampsia - mild					
Premature rupture of membranes					
Post-partum hemorrhage					
Thrombophlebitis of heparin					
Other medical illness during pregnancy-stable/mild					
Any other high-risk OB patients – stable/mild					
Privileges in Orthopedic Care					
Initial evaluation of orthopedic problems					
Treatment of acute back and neck pain					
Treatment of contusions, simple lacerations, sprains					
Treatment of bursitis, tendonitis, tennis elbow, etc.					
Casting procedures for closed fractures requiring no reduction					
Joint aspirations					
Procedures involving destruction of nail beds					
Treatment of Planters Warts					
Treatment of corns, calluses and bunions					
Treatment of Pes Planus					
Foot Care					



Treatment of closed dislocations						
Privileges in Pediatric Care						
Management of routine pediatric care including full-term newborns						
Special Procedures for Three Privileges	Level Requested	Level	Site	Medical Director Approved	Special Condition/ Comments	

I hereby request the privileges identified above. Furthermore, I am physically and mentally capable to perform the above requested privileges.

Applicant's Signature Date

* * *

The following recommendation is made to the Center Governing Board that has authority to grant or deny privileges.

As Executive Director and Medical Director we recommend that:

Privileges for _____ at the Center are:

_____ Approved _____ Approved with Modifications _____ Denied

Modifications:

Denial based on:

Executive Director Date

Medical Director Date

REQUEST FOR VERIFICATION OF FITNESS

PRIVILEGED AND CONFIDENTIAL
*Professional Review Committee
Records and Proceeding*



To: _____
Name of physician

I hereby authorize and consent to the release of information concerning me from the above identified physician and I hereby release from liability the above addressee for complying with this request.

Applicant Signature: _____ Date: _____

Applicant Name (type or print): _____

Position applied for: _____
(Attach copy of Position Description and Requested Privileges)

To Physician:

The above individual has applied for a staff position or to contract for services for the Center. It is a requirement of the Federal Tort Claims Act liability coverage for the Center and for licensed or certified staff that each licensed or certified individual be determined fit to provide services at the Center. This information is requested at the direction of the Center Compliance/Performance Improvement Committee as a professional review committee and will become a part of the Confidential File for the above applicant. Your assistance is greatly appreciated.

Please provide the following information:

I certify that the above individual is/has been under my care as a patient. It is my professional opinion as his or her physician that the individual is:

- Fit to provide services in the Center without limitation.
- Fit to provide services in the Center under the following conditions: _____

Not fit to provide services in the Center

Signature of Physician _____ Print Name _____ Date _____

Address _____ City _____ State, Zip _____ Phone Number _____

Please complete and return this form to the Center to the attention of:

Joyce Tapley, Center Credentialing Coordinator, Phone: 214-426-2686 ext 112

MLK Family Clinic, PO Box 150128, Dallas, TX 75315-0128 or Fax: 214-426-6813

PRIVILEGED AND CONFIDENTIAL

***PRIVILEGED AND CONFIDENTIAL
Professional Review Committee
Records and Proceeding***



To _____
Name of Hospital or Institution

Phone Number _____

Re: Request to Verify Intern/Residency/Fellowship and Reference

Applicant: _____ Physician Dentist Podiatrist
(Indicate name used while in program)

Program: Intern Residency Fellowship

Dates of Program: ____/____/____ to ____/____/____

I hereby authorize and consent to the release of information concerning me to the Center Compliance/Performance Improvement Committee as a professional review committee and I hereby release from liability the above addressee for complying with this request.

Applicant Signature _____ Date _____

* * *

The above applicant has authorized you to provide information concerning his/her educational training program for the Center's use in considering his/her application for employment and privileges at the Center. This information is requested at the direction of the Center Compliance/Performance Improvement Committee as a professional review committee and will become a part of the applicant's Confidential File. Please complete this form and the attached evaluation form and forward both to me.

Center Credentialing Coordinator

Phone Number

Address City Zip

Phone



Re: Request to Verify Employment and Reference

PRIVILEGED AND CONFIDENTIAL
Professional Review Committee
Records and Proceedings

To: _____
Name of Hospital or Institution

Phone Number _____

Applicant (print or type) : _____ Title:

Dates of Employment: ____/____/____ to ____/____/____

Position: _____

I hereby authorize and consent to the release of information concerning me to the Center Compliance/Performance Improvement Committee as a professional review committee and I hereby release from liability the above addressee for complying with this request.

Applicant Signature

Date

* * *

The above applicant has authorized you to provide information concerning his/her employment for the Center's use in considering his/her application for employment at the Center. This information is requested at the direction of the Center Compliance/Performance Improvement Committee as a professional review committee and will become a part of the applicant's Confidential File. Please complete this form and forward it to me.

Center Credentialing Coordinator

Phone Number



Re: Applicant (print or type) _____

The following information must be provided by a person who supervised the applicant or has firsthand knowledge of the applicant's performance during the time he or she served on staff. The evaluation should be based on demonstrated performance compared to that reasonably expected of a person at his/her level of training, experience and background.

	Poor	Fair	Good	Superior	No Knowledge
Basic knowledge					
Judgment					
Sense of responsibility					
Ethical conduct					
Competence and Skill					
Cooperativeness					
Ability to Work with Others					
Committee Work					
Carrying out assignments/functions					
Record Keeping					
Organization of work					
Relationships with Patients					
Relationships with Peers					
Communication Skills					

To your knowledge, has this applicant:

- Been guilty of fraud or dishonesty? Yes No
- Been guilty of unprofessional conduct? Yes No
- Had action taken on his/her professional license or certification? Yes No
- Been disciplined or had practice limited by any employer, supervisor of staff? Yes No
- Been convicted of a crime, indicted, imprisoned or placed on probation? Yes No
- Had a professional liability claim filed against him/her? Yes No

If Yes to any of the above, please explain on a separate sheet.

Based on your knowledge of this applicant, do you recommend him or her for a staff position?

- Recommend highly without reservation
- Recommend as qualified and competent
- Recommend with some reservations
- Do not recommend

I verify that the above information is Correct Not Correct. If not correct, please explain.

This individual is eligible for reemployment Yes No

Signature of Person Verifying Information

Date

Print or type name

Title



REQUEST FOR PROFESSIONAL REFERENCE

*PRIVILEGED AND CONFIDENTIAL
Professional Review Committee
Records and Proceeding*

To: _____

I hereby authorize and consent to the release of information concerning me from the above identified individual and I hereby release from liability the above individual for complying with this request.

Applicant Signature _____ Date _____

Applicant Name (type or print) _____

Position applying for _____

The above applicant has authorized you to provide information concerning your knowledge of his/her professional credentials and competence for the Center's use in considering the applicant for a staff position at the Center. This information is requested at the direction of the Center Compliance/Performance Improvement Committee as a professional review committee and will become a part of the applicant's Confidential File. Please complete this form and return it to my attention.

Center Credentialing Coordinator

Is the applicant related to you? Yes No

Do you have any business relationship with the applicant? Yes No

How long have you known the applicant? _____ years

Did you supervise the applicant at any time? Yes No

Were you a coworker of the applicant at any time? Yes No

Do you consider the applicant to be of good moral character? Yes No

