San Francisco's Volunteers in Medicine Clinic
4877 Mission Street, San Francisco, CA 94112
415-405-0207, 405-0223 (fax)
info@clinicbythebay.org
www.clinicbythebay.org

Dear Prospective Medical Provider Volunteer,

Please find enclosed the credentialing application materials for physicians, nurse practitioners and physician assistants to provide services at Clinic by the Bay. This is required in addition to the Volunteer Application that all volunteers complete. The credentialing application includes:

1. Practitioner Application Personal Data form
2. Appointment of Credentialing Agent, who will be myself as Medical Director, to allow me to collect information from the National Practitioner Data Bank, the Medical Board of California, Board of Registered Nurses, etc.
3. Practitioner Credentialing Form
4. Primary Care Privileges
5. A copy of your Curriculum Vitae
6. Two phone reference checks done by myself
7. Copies of driver's license/passport, practitioner license and if available, your DEA certificate
8. A statement regarding communicable disease status

Thank you for interest in volunteering with Clinic by the Bay and all of your efforts in bringing this vision to life. We look forward to working with you.

Regards,

David Goldschmid, MD
Medical Director

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Practitioner Application – Personal Data Form

1. **Name** _____
2. **Other Name(s) Previously Used**
   _____
3. **Social Security Number** _____
4. **UPN #** _____
5. **Medicaid #** _____
6. **Medicare #** _____
7. **License #** _____
8. **NPI (National Provider Identifier)** _____
9. **Tax ID#** _____ **Name affiliated with Tax ID** _____
10. **Place of Birth** _____ **Date of Birth** _____
11. **Gender** _____ **Citizenship**
    _____
12. **If not a US Citizen: Visa #** _____ **Status** _____ **Expiration Date**
    _____
13. **Name of Spouse/Significant Other** _____
14. **Local Residence Address**
    _____

    City _____ **State** _____ **Zip** _____

    Recent Primary/Group Name
    _____

    Complete Address
    _____

    City _____ **State** _____ **Zip** _____

    Office Phone _____ **Fax** _____ **Email** _____
15. **Any Practice Restrictions (license or other) ___yes ___no (if yes provide details)** _____
16. **Have you ever been named in a malpractice suit ___yes ___no (if yes provide details)**
17. **Language Spoken Other Than English**
    _____

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Appointment of Credentialing Agent- Clinic by the Bay

I hereby consent to the disclosure, copying and transmission of information and documents related to my credentials, qualifications, conduct and performance by my credentialing agent (listed below). This exchange will be for the purpose of any credentialing/re-credentialing applications or Mid-Cycle credentialing evaluations regarding my professional training, experience, character, conduct, judgment, ethics, ability to work with others, health issues, sanctions, against, or loss of licensure, or other items needed to complete my credentialing.

In this regard, care will be taken to safeguard the privacy of patients, confidentiality of patients, confidentiality of patient records, and to protect credentialing information from being further disclosed. I am informed and acknowledge that Federal and State laws provide immunity protections to certain individual and entities for their acts and/or communication in connections with evaluating the qualifications of health care providers. I hereby release all persons and entities from any liability that might incur for their acts and/or communications in connection with the evaluation of my qualifications for employment or credentialing, to the extent the law protects those acts and/or communications.

I understand and agree that, as an applicant, I have the burden o f producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubt about such qualifications or the ability to practice in a safe and effective manner.

I hereby authorize David Goldschmid, MD, Medical Director of Clinic by the Bay to act as my agent in all matters related to credentialing/re-credentialing until I revoke this authorization in writing or until such time I no longer participate as a volunteer at Clinic by the Bay.

Print Name_____

Practitioner Signature_____

Date _____

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CLINIC-BY-THE-BAY PRACTITIONER QUESTIONNAIRE

. **If your answer to any of the following questions is YES, please provide full details on a separate sheet.**

A. Has your license to practice medicine in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or have you ever been issued a citation or letter of reprimand by the licensing agency? **□YES □ NO**

B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? **□YES □ NO**

C. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? **□YES □NO**

D. Have you ever voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? **□YES □NO**

E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? **□YES □NO**

F. Have you ever voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? **□YES □NO**

G. Has your membership or status in any state or local professional society or other comparable medical organization ever been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced? □YES □ NO

H.	Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs ever been sanctioned, denied, suspended, voluntarily or involuntarily, , limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?	□YES □NO
I.	Has a letter of concern or reprimand ever been issued to you?	□YES □ NO
J.	Have you ever been denied professional liability insurance or has your policy ever been canceled?	□YES □ NO
K.	(1) Have you ever been named in a complaint based on allegations of professional negligence or professional misconduct or have you ever received notice of an intent to commence litigation of that type? .	□YES □NO
	(2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition (or is it still pending)?	□YES □ NO
L.	Does your professional liability (malpractice) coverage (if you still are covered elsewhere) exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges?	□YES □NO
M.	Has your specialty board certification or eligibility ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings or investigations toward any of those ends ever been commenced?	□YES □ NO
N.	Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?	□YES □ NO
O.	Have you ever been convicted of a criminal offense other than a minor traffic violation?	□YES □ NO
P.	Are you now or have you ever been addicted to a controlled substance or alcohol?	□YES □ NO
Q.	Do you have any mental or physical condition that may significantly affect your ability to practice medicine? If so, do you believe that, with reasonable accommodation, you will be able to provide primary care at Clinic by the Bay?	□YES □ NO

Print Name: _____

Signature: _____ Date: _____

Standard Authorization, Attestation and Release for Health Plans, Health Insurers and Health Care Organizations

(Not for Use for Employment Purposes)

Confidential Volunteer Physician Questionnaire

1) Are you now, or have you ever been involved, directly, or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ___ No ___ Yes

If yes, please complete the claims detail addendum attached.

2) Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? ___ No ___ Yes

If yes, have these been reported to your present carrier?

By signing this form I represent the above statements and facts are true and that no material facts have been suppressed or misstated.

Signature: _____

Print Name: _____

Date: _____

CLAIMS DETAIL ADDENDUM

Applicant's Name: (please print)

_____

Total Number of claims, suits, or inquiries: _____

Please print or type the answers to each of the following questions in detail. If more than one claim exists, please photocopy this sheet for each claim.

FULL DISCLOSURE OF THE INFORMATION REQUESTED BELOW IS NECESSARY.

Patient / Plaintiff's Name: _____
Insurance Carrier Involved: _____
Date of Occurrence: _____ Date Reported: _____ Date Closed (if applicable): _____

What is the status of the claim? (Please check only one)

☐ Pending Settled out of court Found for Plaintiff at Trial

☐ Dropped Dismissed Found for Defendant at Trial

If damages were paid, either by settlement or court award, what was the dollar amount?
Paid on your behalf: _____ Paid by all parties: _____

What is/was your status? (Please check only one) ☐ Primary Defendant ☐ Codefendant other

A) Provide a brief description of the incident / claim / suit (attach additional page(s) if needed).

_____
_____
_____
_____

B) What were you alleged to have done incorrectly or failed to have done correctly?

_____
_____
_____
_____

C) Provide any other details you feel are pertinent to the claim.

_____
_____
_____
_____

D) Identify any other parties who are / were named in the claim or suit.

_____
_____
_____
_____

Applicant's Signature _____ Date: _____

Communicable Disease Statement for Direct Patient Care Volunteers

CONFIDENTIAL

☐ **I am informed and believe, to the best of my knowledge, that I do not have any contagious disease or other health condition posing a risk of transmission to patients, staff or other volunteers.**

OR:

☐ **My Hepatitis B, and TB status is as follows (PPD or CXR within last year):**

_____

_____

Volunteer name: _____
Role(s): _____
Date: _____