Bartlett Regional Hospital

Human Resources Department
Phone: 907-796-8418 Fax: 907-796-8673 Website: http://www.bartletthospital.org/
Physical Location: Medical Arts Building Mailing address: 3260 Hospital Drive, Juneau, Alaska 99801

ALLIED HEALTH PROFESSIONAL APPLICATION FOR NON-CLINICAL PRIVILEGES

Instructions to Applicant: Applications must be completed in its entirety, typed or printed in ink and signed. Incomplete applications will be returned. Resumes may be attached but not submitted in lieu of the application. Do not say "See Resume." Licenses and certifications must be submitted with application. Two professional references must be submitted with application. PPD Tuberculosis screening form must be submitted with application. All information submitted is subject to verification.

Instructions to Sponsoring Agency: Proof of verification of a criminal background check must be provided to the BRH Human Resources. The sponsoring agency must submit an initial six month evaluation to the BRH Human Resources Department, with biennials evaluations thereafter. Sponsoring Agency is responsible for the applicant. Sponsoring Agency must sign the application.

Today's Date:_____

Available Privileges:	**Requested Privileges:**
Mental Health Consults, Case Management, Surgical Assist, Dialysis Treatment, Speech Therapists, Dental Assists, and Sleep Studies.	

PERSONAL INFORMATION

_____
Legal Name (Last) (First) (Middle Initial) Other names you have used

_____
Mailing Address City State Zip

(___)_____(___)_____(___)_____
Day time phone Evening Phone Cell Email address

SPONSORING AGENCY

_____
Sponsoring Agency Contact Person Name

_____
Mailing Address City State Zip

(___)_____(___)_____
Contact Phone Alternate Phone Email address

BACKGROUND INFORMATION

☐ **Yes**	☐ **No**	Has your license to practice your professional in any jurisdiction ever been limited, suspended, revoked, denied, subjected to probationary conditions or have proceeding toward any those ends ever instituted? If yes, give details on a separate sheet of paper.
☐ **Yes**	☐ **No**	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any origination or professional society, local, state, or nation, or have proceedings toward any other ends ever instituted? If yes, give details on a separate sheet of paper.
☐ **Yes**	☐ **No**	Have you ever been discharged or asked to resign from any position? If yes, please describe in full:
☐ **Yes**	☐ **No**	Have you ever been or are currently on the Center Medicare/Medicaid Service Office of Inspector General List of Sanctioned or Excluded Providers?
☐ **Yes**	☐ **No**	Have you ever been convicted of a felony? If yes, please describe in full and include the date and disposition on a separate sheet of paper.
☐ **Yes**	☐ **No**	Have you been convicted of a misdemeanor? If yes, please describe in full and include the date and disposition on a separate sheet of paper.
☐ **Yes**	☐ **No**	Do you have any relatives working for the Bartlett Regional Hospital or Board of Directors? If yes, please list:
☐ **Yes**	☐ **No**	Do you have or have you recently had any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice with or without reasonable accommodations regarding the privileges requested? If yes, please describe in the detail the reasonable accommodations requested.
☐ **Yes**	☐ **No**	Do have you presently have a physical, mental condition, or substance abuse problem that affects or is reasonably likely to affect your ability to perform professional duties appropriately? If yes, please describe the details on a separate sheet of paper.
☐ **Yes**	☐ **No**	Have you at anytime during the last five (5) years been hospitalized or received any other type of institutional care for a physical, mental health or substance abuse problem? If yes, please describe the details on a separate sheet of paper.

Post Secondary Education: Please attach transcripts or diploma to application				
Name of college/institution	Course of study	Did you graduate?		Degree and date
		☐ **Yes**	☐ **No**	
		☐ **Yes**	☐ **No**	

Licenses and/or Certifications: Please attach copy to application.			
Type of License/Certificate	Organization	Date Issued	Expiration Date

EMPLOYMENT HISTORY

Employer name and address:						
Job title and responsibilities:						
From:		To:		Hours per week:		Number supervised:
Supervisor Name and Title:				Phone:	( )	
Reasons for leaving:						
Starting Salary:	$	Final Salary:	$	May we contact this employer? ☐ Yes ☐ No		

Employer name and address:						
Job title and responsibilities:						
From:		To:		Hours per week:		Number supervised:
Supervisor Name and Title:				Phone:	( )	
Reasons for leaving:						
Starting Salary:	$	Final Salary:	$	May we contact this employer? ☐ Yes ☐ No		

Employer name and address:						
Job title and responsibilities:						
From:		To:		Hours per week:		Number supervised:
Supervisor Name and Title:				Phone:	( )	
Reasons for leaving:						
Starting Salary:	$	Final Salary:	$	May we contact this employer? ☐ Yes ☐ No		

Employer name and address:						
Job title and responsibilities:						
From:		To:		Hours per week:		Number supervised:
Supervisor Name and Title:				Phone:	( )	
Reasons for leaving:						
Starting Salary:	$	Final Salary:	$	May we contact this employer? ☐ Yes ☐ No		

Authorization to Provide Information and Release of Liability

Under penalties of perjury, I declare that my answers to the questions on this application and any necessary examinations and supplements are true and give BRH the right to investigate all information given and to secure additional appropriate information if necessary. I understand that an investigation report may be made from the information obtained through personal interviews with others. I understand that this inquiry may include information as to my personal characteristics, employment verification, credential verification, personal identity verifications, reference checks, and criminal records.

I understand that any misrepresentation herein may cause my application to be rejected, and may be grounds for immediate revocation of privileges. I understand that this application, exam documents, and attachments become a part of BRH records and will not be returned. I certify that to the best of my knowledge all the statements are true, correct, and complete and made in good faith.

Applicant Signature:_____ Date:_____

Applicant Printed Name:_____

Sponsoring Agency Responsibility

The Sponsoring Agency agrees to be responsible for identified criteria for the allied health professional named in this application. Criteria include Physician Sponsorship and Performance Management. The sponsoring physician must maintain privileges at Bartlett Regional Hospital through the Medical Credentialing Committee for applicant to maintain AHP privileges. The sponsoring agency is responsible for performance management and must submit an initial six month evaluation to the BRH Human Resources Department, with a minimum of biennials evaluations thereafter. The sponsoring agency is responsible for notifying BRH Human Resources of any performance management corrections or discipline of the allied health professional as a result from potential incidents that may occur at Bartlett Regional Hospital.

Sponsoring Agency Signature:_____ Date:_____

Sponsor Printed Name:_____

HR ALLIED HEALTH PROFESSIONAL PRIVILEGES REQUEST

Today's Date:_____

Applicant Name:_____

Briefly summarize the specific duties and responsibilities, including surgery, which the Allied Health Professional (AHP) will perform in the hospital. **The sponsoring Physician needs to indicate "Yes" or "No" and initial.**

Requested Privileges	YES	NO

To be signed by the Sponsoring Physician: "It is my understanding that the Allied Health Professional (AHP) will perform only those privileges as granted".

_____ _____

Sponsoring Physician Signature Date Applicant Signature Date

_____

Printed Physician Name

Recommendation Letter for Allied Health Professional Privileges

Relationship of Reference to Applicant:		
Do you personally know the applicant?	☐ Yes ☐ No	If yes, how long?
Relationship/Affiliation to the applicant?	What is your specialty?	
When did you last practice with/refer to, etc., this practitioner?	Are you Board Certified? ☐ Yes ☐ No If yes, what board	

(Rate and check appropriate answers)

Rate the Applicant in the Categories Below:	Exceptional	Very Good	Good	Poor	Unknown
Patient Care					
Rate the applicant's aptitude in relationships with patients *(compassionate, appropriate, effective)*, health promotion, illness prevention, disease treatment, and end-of-life care.					
Medical / Clinical Knowledge					
Rate the applicant's knowledge of established and evolving biomedical, clinical, and social sciences, and his/her application of that knowledge to patient care, as well as in educating others.					
Practice-Based Learning and Improvement					
Rate the applicant's use of scientific evidence and methods to investigate, evaluate, and improve patient care practices.					
Interpersonal and Communication Skills					
Rate the applicant's ability to establish and maintain professional relationships with patients, families, and other health care teams.					
Professionalism					
Rate the applicant's commitment to continuous professional development					
Rate the applicant's commitment to ethical practice					
Rate the applicant's understanding and sensitivity to diversity *(race, gender, culture, religion, ethnicity, sexual preference, language, mental capacity, physical disability)*					
Rate the applicant's responsible attitude toward patients and his/her profession					
Systems-Based Practice					
Rate the applicant's understanding of the contexts and systems in which health care is provided, and his/her application of that knowledge to improve and optimize health care					
Health Status					

To your knowledge, does the applicant have any health issue that may affect his/her ability to practice medicine in a safe and competent manner, any physical limitations, substance abuse, etc.? ☐ No ☐ Yes (if Yes, explain: _____)

To Your Knowledge Has the Applicant:	Yes	No	Pending	Unknown
Ever been a defendant in a malpractice situation?				
Ever been under investigation by any governmental or other legal body?				
Ever been a defendant in a criminal act?				
Ever been accused of using illegal drugs or abusing alcohol?				
Ever shown signs of mental or physical health problems?				
Ever been investigated or was any disciplinary action taken, such as imposition of consultation requirements, suspension or termination?				
Ever had any actions instituted, in process, or pending?				

**If you answered yes to any question above, please provide details on the back of this form.

To Your Knowledge:	Yes	If no – please explain
Do you attest that this practitioner is able to safely and competently exercise the clinical privileges requested, and perform the duties and responsibilities of appointment to the medical staff?		

My general recommendation concerning this applicant is: ☐ Recommended ☐ Not Recommended
☐ Recommended with reservations: Please describe on back of this form

Printed Name Signature Date