LINCOLN COMMUNITY HEALTH CENTER

1301 Fayetteville Street; P.O. Box 52119
Durham, NC 27717-2119
Fax # (919) 956-4511

Vision Statement - Lincoln Community Health Center will be a viable provider of high-quality, culturally-competent, efficient, customer-centered primary care services while using state of the art technology.

APPLICATION FOR APPOINTMENT/REAPPOINTMENT
AN EQUAL OPPORTUNITY EMPLOYER

In compliance with Federal and State equal employment laws, qualified applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital status, or disability.

Name: _____ **SS#** _____

Office Address: _____
(Street) (City) (State) (Zip)

Office Telephone#: _____ **Office Fax#:** _____

Home Address: _____
(Street) (City) (State) (Zip)

Home Telephone#: _____ **Email Address:** _____

Place of Birth: _____ **Date of Birth:** _____

LICENSES AND REGISTRATIONS

Please provide a copy of your original North Carolina license and current North Carolina certificate of registration

Type: ☐ MD ☐ DDS ☐ Other: _____

NORTH CAROLINA License Number: _____ Expiration Date: _____

Other State: _____ Number: _____ Expiration Date: _____

Individual Medicare #: _____ Individual Medicaid #: _____

NPI #: _____

DRUG ENFORCEMENT ADMINISTRATION

Please provide a copy of your current North Caroline DEA registration Certificate

Number: _____ **Expiration Date:** _____

BOARD CERTIFICATIONS

Name of Board: _____ Expiration Date: _____

Name of Board: _____ Expiration Date: _____

EMPLOYMENT HISTORY

Please account for **all** times spans FOLLOWING training. Please list all present and prior affiliations (institutional practice affiliations, military service, solo, partnership or group practices, or academic appointments). Please list in chronological order. Please note that all time gaps in excess of three months must have an explanation (including name [s] and address [es] to obtain verification). Attach additional sheets if necessary.

Employer Name: _____ Department: _____

Preceptor, Supervisor or Associate (Name) _____

Date of Employment: From _____ To _____

Address: _____

Telephone #: _____ Fax #: _____

Employer Name: _____ Department: _____

Preceptor, Supervisor or Associate (Name) _____

Date of Employment: From _____ To _____

Address: _____

Telephone #: _____ Fax #: _____

Employer Name: _____ Department: _____

Preceptor, Supervisor or Associate (Name) _____

Date of Employment: From _____ To _____

Address: _____

Telephone #: _____ Fax #: _____

HOSPITAL AFFILIATION (S)

Please account for **all** hospital, ambulatory care, out-patient surgical, etc. facilities where privileges are or have been granted (including moonlighting during training). Please list all present and prior affiliations.

Affiliation Name: _____ Department: _____

Date of Appointment: From _____ To _____

Address: _____

Telephone #: _____ Fax #: _____

Affiliation Name: _____ Department: _____

Date of Appointment: From _____ To _____

Address: _____

Telephone #: _____ Fax #: _____

CONTROLLED SUBSTANCES REPORTING SYSTEM	YES	NO
Registered with Controlled Substances Reporting System (If not, please complete form attached to this application)		

If you answer "YES", Please provide detailed information on a separate sheet.		
HEALTH STATUS	**YES**	**NO**
During the past five (5) years, have you been hospitalized, institutionalized or involved in an outpatient treatment program (other than for childbirth)?		
Do you have any physical/mental condition which may limit your ability to participate fully in the care of your patients, with or without reasonable accommodation, within the scope of the privileges requested?		
Do you have any continuing physical/mental health problems requiring ongoing treatment?		
Do you now have or have you ever had an impairment problem (alcohol or chemical dependency or psychiatric problem) requiring intervention? If you respond in the affirmative, please provide the following: Information regarding your recovery, including on-going therapy, support groups, mandatory or voluntary surveillance programs, as well as the name(s) addresses of the individual(s) involved in your medical and support care.		

If you answer "YES", Please provide detailed information on a separate sheet.		
PROFESSIONAL SANCTIONS IN THE PAST TWO YEARS	**YES**	**NO**
Has your license to practice medicine, dentistry, or any other profession in any jurisdiction been, or is it in the process of being denied, revoked, suspended, reduced, not renewed or voluntarily relinquished?		
Have you been refused membership on a hospital staff or a health care facility for clinical or character related reasons?		
Have your membership and/or clinical privileges been reduced, suspended, not renewed, or voluntarily relinquished at any other hospital or health care facility?		
Has your request for any specific clinical privileges been denied or granted with stated limitation(s), or have you voluntarily relinquished your privileges at any hospital health care facility?		
Has your employment at any hospital or health care facility ever been suspended, diminished, revoked, not renewed or voluntarily relinquished?		
Has your narcotics registration (DEA) ever been suspended, revoked or voluntarily relinquished?		
Have you been denied membership or renewal thereof or been subject to disciplinary action in any medical or dental organization?		
Have you voluntarily resigned or withdrawn your membership in any medical or dental organization?		
Are you or have you ever been the subject of any pending professional misconduct proceeding as defined by the North Carolina Board of Medical/Dental Examiners?		
Has your participation in Medicare, Medicaid, or any other government program ever been denied, revoked, suspended, reduced, not renewed or voluntarily relinquished?		
Are you or have you ever been addicted to the use of narcotics, barbiturates, alcohol or other drugs?		
Except for minor traffic violations, have you been arrested/convicted of a crime?		
Have you ever been found guilty of professional misconduct by any Board or Agency?		

If you answer "YES", Please provide detailed information on a separate sheet.		
LIABILITY INSURANCE ACTIONS IN THE PAST TWO YEARS	**YES**	**NO**
Are there any malpractice actions pending against you in this or any other state?		
Have any judgments in a malpractice action been entered against you in this or any other state?		
Have you entered into a settlement of any malpractice action brought against you in this or any other state?		
Has your professional liability insurance ever been denied or canceled?		

MANAGED CARE ORGANIZATION AFFILIATIONS

Please indicate all managed care organizations with which you are currently a provider:

_____ _____ _____

_____ _____ _____

CONTINUING EDUCATION ACTIVITES & PROFESSIONAL RECOGNITION

a. **Attach evidence of continuing medical education credits for the past two (2) years.**

b. Document professional recognition (offices held, honors) received in the past two (2) years.

PEER RECOMMENDATIONS

List three (3) practitioners who can personally attest to your current clinical abilities (do not include family).
NOTE: These must be "peers", i.e. dentist should list other dentists.

Name _____ Email Address: _____

Address _____

Phone#: _____ Fax#: _____

Name _____ Email Address: _____

Address _____

Phone#: _____ Fax#: _____

Name _____ Email Address: _____

Address _____

Phone#: _____ Fax#: _____

REQUEST FOR APPOINTMENT/REAPPOINTMENT

Your signature below signifies that you agree to the following conditions pertaining to this application.

- I have the burden of producing adequate information as requested by Lincoln Community Health Center, for proper evaluation of my professional training, experience, competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

- All the information contained in this application is complete and accurate. I understand that any misstatements or omissions from this application, whether intentional or not, whether discovered prior to or after appointment/reappointment and/or privileges have been granted, may result in the denial or termination of membership and/or privileges.

- I pledge that I am free from chemical dependency and physically and mentally able to practice medicine. I agree to report to Lincoln Community Health Center any changes in physical and mental health status, including impairment due to chemical dependency that would affect my ability to practice medicine.

- I agree to report to Lincoln Community Health Center any changes in staff membership status at other hospitals or health care facilities during the next two years.

- I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff of Lincoln Community Health Center. I am familiar with the principles and standards of the Joint Commission, as well as the principles, standards and ethics of national, state and local associations that apply to and govern my specialty and/or profession.

- I agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment /reappointment to the medical staff.

- I agree to abide by such hospital, medical staff and Lincoln Community Health Center Bylaws, Rules and Regulations as may from time to time be enacted/amended.

- I pledge to provide continuous care for my patients and to refrain from delegating the responsibility or care of my patients to any practitioner not qualified to take that responsibility.

- I agree that I will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services and to abide by generally recognized ethical principles applicable to my profession and specialty.

- I agree to notify Lincoln Community Health Center within 30 days if I receive notification of an adverse Action Report or Medical Malpractice Payment Report filed on me with the National Practitioner Data Bank.

_____ _____

Signature Print Name

_____

Date

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize Lincoln Community Health Center, its medical staff, or their representatives, to consult with the following and any other persons or entities who may have information relative to my professional practice.

- Administrations and members of medical staffs of other hospitals, health care facilities or professional associations with which I have been associated.

- Past and present malpractice carriers.

- All records and documents, including medical records, at other hospitals or health care facilities that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges.

- Any State Departments of Education of Health, the National Practitioner Data Bank and other interested persons on request, provided the release of information is done in good faith and without malice, and in conformance with federal and state laws.

A photocopy of the waiver shall be as effective as the original when so presented. This waiver shall remain in full force and effect for a period of two (2) years from the date shown.

Signature	Print Name
Date	Department

BACKGROUND CHECKS RELEASE FORM

Have you ever been convicted of any offenses other than a moving traffic violation? (You must include any and all felonies or misdemeanors.) An example of a common misdemeanor is a "worthless check".

☐ No

☐ Yes

If yes, please explain nature of crime, date, and place. State whether the crime was a felony or misdemeanor. State whether the crime was a federal or state offense.

_____

_____

_____

List any pending court or trial dates.

_____

_____

All applicants to the medical staff at Lincoln Community Health Center must agree to an extensive screening process, which may include, criminal history, driving record, National Practitioner Data Bank (NPDB) Query, Excluded Parties List System (EPLS) Query, and Office of Inspector General (OIG) Exclusion List.

It is very important that applicants complete this form fully and accurately; therefore, consider your answers carefully.

I certify that I accurately and truthfully answered the above questions related to my background.

Signature: _____

Print Full Name: _____

Date: _____