



APPLICATION FOR ALLIED HEALTH PROFESSIONAL - CATEGORY II

CHANGE OF PRACTICE AND/OR SPONSOR OR ADDITIONAL SPONSOR

All information must be printed legibly. Please attach copies of the following documents to this application if this information has been updated for your new group:

- Copy of your original state(s) license(s) and current registration;
- Copy of current DEA certificate (must have a valid date and refer to current address);
- Copy of the face sheet of your current professional liability insurance policy, indicating by name, provider(s) covered coverage amounts, effective date, expiration date, and policy number.

I. PERSONAL IDENTIFICATION DATA

Name in Full _____

Scope of Practice (please check one):

- | | | |
|---|---|--|
| <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Professional Counselor | <input type="checkbox"/> Nurse Midwife |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> OR Technician | <input type="checkbox"/> Dental Assistant |
| <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> RN First Assistant |
| <input type="checkbox"/> Psychologist (masters level) | <input type="checkbox"/> Rounding Nurse (RN) | <input type="checkbox"/> Surgical Nurse (RN) |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Audiologist | <input type="checkbox"/> Medical Assistant |
| <input type="checkbox"/> Vascular Ultrasound Technician | | |

(New) Group _____

New/Additional Sponsor: _____

Date starting practice _____ Office Manager/Contact person _____

Office Address _____

Office Telephone _____ Office Fax _____

Second Office Address, if applicable _____

Office Telephone _____ Office Fax _____

Home Address _____

Home Telephone _____

Cell Phone number _____ Beeper number _____

Email address _____

II. PRIVILEGES REQUESTED:

- I hereby request the scope of practice permitted by the Policy and Procedure for my category of AHP Category II which is checked on page 1.

 - I also request the privilege(s) **listed below** in addition to the scope of practice permitted by my category of AHP Category II: *[Please attach documentation of training, experience and current competence to perform the privilege(s) requested.]*
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III. AREAS OF PRACTICE - check facilities where you will be practicing (must match the facilities that your sponsoring physician has privileges at:

- Presbyterian Hospital
- Presbyterian Orthopaedic Hospital
- SouthPark Surgery Center
- Presbyterian Hospital Matthews
- Presbyterian Hospital Huntersville

IV. HEALTH STATUS

Do you presently have a physical or mental condition, including substance dependency, which could affect your ability to perform professional duties? _____ Yes _____ No (If you have answered yes, please give a full explanation of the details on a separate sheet and attach.

V. APPLICANT'S CONSENT TO CONDITIONS FOR PERMISSION TO PRACTICE

A. Applicant's and Sponsoring Physician's Responsibility (as applicable)

- (1) I, the undersigned physician, apply for permission for the undersigned applicant to practice as requested above, in the capacity of Allied Health Practitioner (Category II). I, the undersigned applicant, apply to engage in the scope of practice at the hospital as a Category I or Category II Allied Health Practitioner. I/we are willing to make ourselves available for interviews in regard to this application and intend to be legally bound by the terms of this Consent and Release.
- (2) I/we understand that it is our responsibility to produce information that the hospital deems necessary to perform a proper evaluation of the application. I/we agree to provide the hospital with updated information regarding all questions on this application form as new or changed information becomes available. I/we also agree to provide the hospital with additional information that the hospital or one of its authorized representatives may request. Failure to produce any requested information in a timely fashion will prevent this application from being processed further.

B. Terms and Conditions of Practice

- (1) By applying for permission to practice at The Presbyterian Hospitals, I/we accept the terms and conditions set forth below and intend to be legally bound thereby:
 - (a) permission to practice at this hospital is not a right of every licensed professional who makes application for the same;
 - (b) this request for permission to practice will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, policies, rules and regulations;
 - (c) all medical staff recommendations relative to this application are subject to the ultimate action of the hospital Board, whose decision shall be final;
 - (d) if permitted to practice, such practice shall be provisional for the time period determined by the Board;
 - (e) I/we have the responsibility to keep the information in this application current by informing the

hospital, through the President of the Hospital or his/her designee, of any changes, including but not limited to any change in my/our professional liability insurance coverage, the filing of a lawsuit against me/us, and any change in my medical staff status or practice at any other hospital; and

- (f) continued permission to practice remains dependent on my/our continued demonstration of professional competence and cooperation, my/our general support of the hospital, and acceptable performance of all related responsibilities, as well as the other factors deemed relevant by the hospital.

C. Undertakings

- (1) I/we have had an opportunity to read a copy of such hospital policies and directives as are applicable to Category I and II Allied Health Professionals including the Rules and Regulations of the Medical Staff. I/we specifically agree to abide by the bylaws, policies, and rules and regulations that are in force during the time I/we are granted permission to practice at the hospital.
- (2) If permitted to practice at this hospital, I/we specifically agree to:
 - (a) refrain from fee splitting or other inducements relating to patient referral;
 - (b) refrain from deceiving patients as to the identity of any practitioner providing treatment or services;
 - (c) abide by generally recognized ethical principles applicable to my/our profession;
 - (d) provide continuous care and supervision as needed to all patients in the hospital for whom I/we have responsibility; and
 - (e) accept such duties and responsibilities as shall be assigned to me/us by the hospital Board and medical staff.

D. Affirmation

I/we represent that information provided in or attached to this application is accurate. I/we 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 permission to practice at the hospital.

DATE: _____

Signature of Applicant

Printed or Typed Name of Applicant

*** I hereby request the privileges outlined in the Policy and Procedure packet for this AHP II Applicant and agree to monitor and supervise this AHP Applicant performing these duties in the Hospital setting.**

DATE: _____

Signature of Sponsoring Physician (for Category II AHP's)

Printed or typed name of Sponsoring Physician