Salina Family Healthcare Center
A Federally Qualified Community Health Center
651 E. Prescott, Salina, KS 67401
Medical Center ~ (785) 825-7251
Dental Center ~ (785) 826-9017
Pharmacy ~ (785) 452-3900

Credentialing Application Packet

Dear Resident Applicant,

Thank you for your interest in becoming part of the Salina Family Healthcare Center clinical team. Prior to beginning your service with Salina Family Healthcare Center you must complete our credentialing process and be privileged by our Board of Directors. The credentialing process involves evaluating a practitioner's eligibility and competency for clinical privileges. Our credentialing and privileging policy applies to physicians, mid-level providers, and other licensed or certified healthcare practitioners who provide clinical services in the Salina Family Healthcare Center. All qualified applicants will receive an application for medical staff membership and/or clinical privileges. We will make every effort to process your application in a timely and efficient manner.

Credentialing is a five-step process:
Step 1: Applicant receives the initial applicant packet.
Step 2: Applicant will return completed applications along with requested documents.
Step 3: Application will be reviewed and processed by our Director of Human Resources and Compliance to make sure all information is complete and accurate.
Step 4: The completed and verified applicant packet will be presented to the Board of Directors for approval.
Step 5: The Applicant will be notified of the Board of Directors' decision.

The credentialing process can take up to 90 to 120 days to verify, review, and obtain final approval. To expedite the process, your application should be completed without blanks or missing requested documents. If anything is missing, the process will be delayed and could mean forfeiture of your privileges.

If at any time you have questions please contact me at (785) 825-7251 or set up a meeting to come to Salina Family Healthcare Center and go over your application prior to submission. Our goal is to assist you to get on staff quickly while ensuring that we are compliant with Joint Commission and other relevant guidelines.

Sincerely,

Audrey Lee
Director of Human Resources and Compliance

CREDENTIALING APPLICATION

Please type or print responses legibly and in ink. Please complete the form in its entirety and attach all required documentation. Incomplete applications will be returned to you and may result in a delay in the credentialing process.

Please return this application and the supporting documents to:

Kayla Coleman
Business Support Specialist
Salina Family Healthcare Center
651 E. Prescott Rd.
Salina, KS 67401

or email: kcoleman@salinahealth.org

Supplementary documents that must be completed and submitted include the following:

— Application

— Delineation of Privileges

— Background Check Authorization

— Attestation Statement

— Copy of most recent flu, hepatitis B vaccination, tuberculosis PPD test & immunization record

— Copy of government-issued picture identification

— Curriculum vitae (CV)

— Three (3) Peer References (letters of recommendation)

— Copy of medical Post-Graduate board permit

— Other certificates (BLS, ACLS, ATLS, PALS, APLS, NRP, etc.)

— Current Drug Enforcement Administration (DEA) registration

— Copies of diplomas (undergraduate, post-graduate, medical school, residency, fellowship)

— National Provider Identification number (NPI)

— KS Medicaid Number

I. Demographic Information

Applicant Name: _____ SSN: _____

Address/City/State/Zip: _____

Phone: _____Email: _____

Date of Birth: _____ Place of Birth: _____

Gender: ☐ Male ☐ Female

Are you a United States Citizen? ☐ Yes ☐ No

If not a United States citizen, please check applicable box below:

☐ Work Permit (attach notarized copy) ☐ Visa: Visa Type and Number: _____

Do you speak any other language other the English? If so, which language(s)? _____

_____

Are you presently or planning to reside within commuting distance to the Health Center? ☐ Yes ☐ No

II. Professional/Licensure Information

Have you applied for Board Certification? ☐ Yes ☐ No Application date: _____

Have you applied for your Drug Enforcement Administration (DEA) license? ☐ Yes ☐ No

Please provide the following information:

	Yes	**No**
Have you ever practiced under another name? If yes, what name? _____		
Do you currently provide services in your discipline in the state of Kansas?		
Are you presently practicing in your specialty?		
Do you currently have active staff privileges at an accredited hospital?		

III. Insurance

Has an insurance carrier denied, cancelled, or refused to renew your professional liability insurance coverage? ☐ Yes ☐ No

(If yes, please attach a separate sheet with an explanation)

Have you ever had any professional liability claims brought against you? ☐ Yes ☐ No

(If yes, please complete "Professional Liability Claims History Form")

IV. Disciplinary Information

Please attach a separate sheet with an explanation for any "yes" answers.

	Yes	**No**
Has your professional license ever been revoked, restricted, or suspended?		
Have your clinical privileges ever been revoked, restricted, or suspended?		
Has your membership on any medical or clinical staff ever been revoked, restricted, or suspended?		
Has your DEA license ever been denied or suspended?		
Have you ever been excluded from participation with a Medicare or Medicaid program?		
Have you ever been requested to appear before a licensing agency (State Board of Examiner's, Drug Enforcement Agency) for any reason?		
Have you ever been sanctioned by a federal or state agency?		
Have you ever been convicted of a felony or misdemeanor other than a minor traffic offense?		
Have you ever discontinued your practice (other than for vacation, education/training, maternity leave, or leave due to illness) for three months or more?		

V. Health Fitness

Please attach a separate sheet with an explanation for any "yes" answers.

	Yes	**No**
Do you presently have any physical or mental condition, including alcohol or drug abuse, that may affect your ability to perform clinical or professional duties?		
Are you currently taking any medications that may affect your ability to perform clinical or professional duties?		

Do you have any communicable diseases?		

___ Please initial to certify that you are in good health and have no physical or mental conditions that may affect your ability to perform clinical or professional duties.

Most recent physical exam performed by: _____Date: _____

Results of examination:

_____

DELINEATION OF PRIVILEGES (To be completed by Applicant)

Name of Applicant: _____

Specialty: _____

Each request for privileges will be considered on an individual basis and will require approval and supportive documentation. The above named individual certifies that s/he is a Licensed Physician with an active license granted by the Kansas State Board of Healing Arts.

Privilege	**Privilege Requested**	**Privilege Approved**	**Proctoring Required**	**Privilege Denied**
Management of routine pediatric care	✓			
Management of routine adolescent care	✓			
Management of routine adult care	✓			
Management of routine gynecological care	✓			
Management of routine obstetric care	✓			
Management of routine geriatric care	✓			
Duties delegated by attending physician. Acting under attending physician's designated privileges	✓			
Supervision of, medical students and other healthcare trainees.	✓			
Procedures:				
Trigger point injections	✓			
Joint aspiration	✓			
Joint injection	✓			
Minor Surgery:				
Lesion removal	✓			
Punch biopsy	✓			
Shave biopsy	✓			
Incision and drainage	✓			
Wound debridement	✓			
Skin tag removal	✓			
Laceration repair	✓			
Toenail removal, partial and full	✓			
Toenail trimming	✓			
Callus shaving	✓			
Nasopharynoscopy	✓			
Management of simple fractures of the extremities, clavicles, ribs and nose.	✓			
Casting for closed fractures required no closed reduction	✓			
Burn care	✓			
Wound care	✓			
Veni-puncture	✓			
Capillary blood draw	✓			

IV catheter placement	✓			
Urinary catheter replacement	✓			
Vasectomy	✓			
Breast aspiration	✓			
Spirometry	✓			
Piercing	✓			
House calls/home visits	✓			
Obstetrics and Gynecology Privileges:				
Gyn Exam, including but not limited to pelvic exam, breast exam, rectal exam, pap smear and vaginal swab.	✓			
Physical examination and prescription of birth control methods	✓			
Antenatal examination of pregnant patients, including high risk patients	✓			
Postpartum examination	✓			
Hormone replacement therapy	✓			
Treatment of medical conditions of postpartum patients	✓			
Diagnosis and treatment of STD	✓			
Removal of sutures	✓			
Removal of minor vulvar lesions	✓			
Removal of cysts or I&D of cysts	✓			
I & D of vulvar abcess	✓			
Biopsy of vuvlar lesions	✓			
Biopsy of vaginal lesions	✓			
Biopsy of cervix	✓			
Biopsy of endocervix	✓			
Colposcopy	✓			
Endometrial biopsy	✓			
Cryotherapy	✓			
Removal of Norplant implants	✓			
IUD insertion and removal	✓			
Obstetrical ultrasound	✓			

By signing below Applicant attests and acknowledges:

- That that they have received clinical training, adequate instruction, and experience for the above requested privileges.

- Any restriction on clinical privileges granted is waived in an emergency situation.

- Clinical privileges expire and must be renewed after two years on or before the anniversary of the original privileging date.

_____ _____

Applicant Signature Date

Submitted for approval by:

_____ _____

Director of Human Resources & Compliance Date

Temporary approval is granted until the next meeting of the SHEF Board of Directors by:

_____ _____

SHEF CEO/CMO Date

The Board of Directors of Salina Health Education Foundation (SHEF) dba. Salina Family Healthcare Center (SFHC) hereby approves credentials of the above named individual and grants them privileges and allows them to practice under the auspices of SHEF dba. SFHC within the scope of practice as defined by the Kansas Legislature as defined in the Kansas Healing Arts Act, K.S.A. 65-2801 et seq.
Approved on behalf of the Board of Directors by:

_____ _____

Board President (or designee) Date

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Background Check Authorization

The information contained in this application is correct to the best of my knowledge. I hereby authorize Salina Family Healthcare Center and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment, granting of privileges, and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to Salina Family Healthcare Center or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. I hereby release Salina Family Healthcare Center, the Social Security Administration, and its agents, officials, representative, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

If hired, privileged, or currently employed, I understand that this authorization will serve as ongoing authorization for a criminal background check to be obtained at any time in connection with my service to the organization.

_____ _____ _____

Print Name | Social Security Number | Date of Birth

_____

Previous Last Name or Other Names Used

_____ _____

Signature of Applicant | Date

_____ _____

Witness' Signature | Date

ATTESTATION STATEMENT

I, _____ (print full name), agree as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that the omission or falsification of information may be cause of ineligibility or termination from medical staff membership. I further agree that I have current professional liability coverage and I have disclosed the history of loss or limitation of privileges or disciplinary action.

_____ _____

Applicant Signature Date