

Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands

1 Lower Navy Hill Road Navy Hill, Saipan, MP 96950

**VERIFICATION OF HOSPITAL PRIVILEGES**

**PLEASE COMPLETE THE FOLLOWING FORM AND FORWARD TO YOUR PRIMARY HOSPITAL**

I hereby grant permission and consent to the release by any person, organization, or other entity to the Commonwealth Healthcare Corporation and/or its designee, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render clinical services in a cost-effective manner, character and moral and ethical qualifications and agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to the Commonwealth Healthcare Corporation and/or designee. I understand that participation as provider for the Corporation is dependent upon review of this application and completion of the credentialing process.

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| --- | --- |
| Provider Signature | State License Number |
| Print Name |
| Specialty | Name of Group (if any) |

INFORMATION BELOW MUST BE COMPLETED BY THE APPROPRIATE HOSPITAL STAFF

1. DATE(s) OF APPOINTMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. CLINICAL PRIVILEGES IN GOOD STANDING? YES NO
3. DOES THIS PRACTITIONER HAVE ADMITTING PRIVILEGES? YES NO
4. WERE (ARE) THERE ANY CONCERNS REGARDING:

A. CLINICAL/TECHNICAL SKILLS. YES NO

B. COMPETENCY TO PERFORM PRIVILEGES REQUESTED. YES NO

C. MENTAL/PHYSICAL HEALTH AS IT RELATES TO PRIVILEGE REQUESTED.

 YES NO

1. WERE THE APPLICANT’S PRIVILEGES EVER VOLUNTARILY OR INVOLUNTARILY REDUCED, SUSPENDED, TERMINATED OR RESTRICTED IN ANY WAY? YES NO
2. DID THE APPLICANT RESIGN IN LIEU OF DISCILPINARY ACTION? YES NO
3. TO YOUR KNOWLEDGE HOW DOES HE/SHE GET ALONG WITH:

NURSING STAFF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANCILLARY STAFF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL STAFF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE ELABORATE FURTHER ON UNFAVORABLE RESPONSES MADE IN ITEMS 2-6.

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IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT THIS PROVIDER? USE BACK OF PAGE, IF NECESSARY.

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| Signature of Chief Medical Staff or Designee | Print Name |
| Position |
| Hospital Name | Hospital Contact Number/Fax Number |
| Date |