

 **Initial Credentialing Application:**

 **Dentist / Pediatric Dentist**

Dear Dentist / Pediatric Dentist,

Thank you for your interest in providing services at our facility. Tennessee Surgery Center (TSC) is an Ambulatory Surgery Center that is certified by the Center for Medicare/Medicaid Services (CMS) as well as the Accreditation Association for Ambulatory Healthcare Facilities (AAAHC) as a premier provider of outpatient surgical care in middle Tennessee. The following application is required by state regulations and facility bylaws. In addition to this application, you will need to submit the following documentation before your application is considered complete:

\_\_\_\_\_Copy of current photo ID (Driver’s License is acceptable)

\_\_\_\_\_Copy of current Dental License (Tennessee issued Professional License)

\_\_\_\_\_Copy of current Liability Certificate (Professional Liability Insurance)

\_\_\_\_\_Copy of Loss History Report related to your Professional Liability Insurance

\_\_\_\_\_Copy of current BLS/CPR, ACLS &/or PALS certification (If applicable)

\_\_\_\_\_Copy of Dental School Diploma

\_\_\_\_\_Academic Certificates

\_\_\_\_\_Copy of Residency Completion Certificate

\_\_\_\_\_Copy of DEA License (If applicable)

\_\_\_\_\_Current Curriculum Vitae

\_\_\_\_\_List of facilities where you currently hold active privileges (if applicable)

\_\_\_\_\_$150 application fee

The credentialing process will begin upon receipt of your complete Initial Credentialing Application as well as the initial application fee of $150. Temporary Privileges can be granted within 2 weeks, whereas your full appointment could take up to 6 weeks. Once full privileges are granted, they are active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact scooke@ssctn.com or call (615) 525.8998. We look forward to receiving your completed application and to working with you at Tennessee Surgery Center.

 Sincerely,

 **Sandra Cooke, BSN, RN**

 **Administrator**

Tennessee Surgery Center

410 42nd Avenue N Suite 300

Nashville, TN 37209

 P: (615) 321.6161

F: (615) 645.9870

**Section I: Demographic Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial Gender

\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Preferred Contact Method: E-mail Phone Fax

Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/ Cell Phone Number Email Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Practice Name Office Manager/Contact

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Practice Address City State Zip

(\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Practice Telephone Practice Fax

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person Emergency Contact Phone Emergency Contact Relation To You

 **Section II: Professional License/Certification Information**

 (Attach copies of all licenses and certifications)

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

DEA/Controlled Substance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

BLS Certification Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACLS Certification Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PALS Certification Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty Board(s) by which you are certified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Certified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Certification Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever taken & failed a professional certification examination? Yes No

If yes, please provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Section III: Professional Liability Information** (Attach proof of Liability Certificate & Loss History Report)   |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Liability Carrier Name Policy Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Effective Date Expiration Date Per Occurrence Amount ($) Aggregate Amount ($)

 **Section IV: Education, Training, & Employment Information**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental School Dates attended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatric Residency (Graduate Program) Dates attended

*Please list your employment history for the previous five years, including your current employer*

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there has been any lapse in employment (+6 months) during the past five years, please explain:

 **Section V: Health Status**

 (If you answer “yes” to the following questions, please explain on separate)

1. Do you presently have any physical or mental condition, illness or injury (including use of or dependency on any

chemical substance or alcohol) that in any way impairs or limits your ability to practice or perform procedures for the privileges you are requesting at Tennessee Surgery Center with reasonable skill and safety (with or without accommodation)?

 YES NO

1. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?

  YES NO

1. Are you currently engaged in illegal use of controlled dangerous substances?

 YES NO

1. Have you received treatment or been advised to receive treatment for alcohol or substance dependency?

 YES NO

1. Are you currently taking any medications that may affect either your clinical judgment or motor skills?

YES NO

 **Section VI: Professional Information**

 (If you answer “yes” to the following questions, please explain on separate)

1. Has your license, DEA, or certification to practice in this state or any other state ever been suspended, revoked, voluntarily relinquished, or put on probation status; or, are any of these actions pending with

respect to your license, DEA, registration or certification?

 YES NO

1. Have your hospital or surgical facility privileges ever been revoked, suspended, limited reduced, non- renewed; or, have disciplinary proceedings ever been instituted against you by a hospital or surgical

facility; or, are any of these actions now pending with respect to your hospital or surgical facility privileges?

 YES NO

Have any complaints or adverse action reports been filed against you with a local, state, or national professional society or licensure board?

 YES NO

1. Are you now or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation; or have you ever received any notice of any claim or complaint against you?

 YES NO

1. Has your professional liability insurance ever been cancelled, non-renewed or have you ever been denied professional liability insurance?

YES NO

1. Have you ever been sanctioned or disciplined by Medicare/Medicaid?

 YES NO

1. Have you ever been prosecuted for, convicted of or charged with a felony or misdemeanor (other than

 minor traffic violations)?

YES NO

**Section**

 **VII: Professional Reference Information**

Please list the name, address, email address, phone number, and title or relationship of two (2) professional peer references and one (1) personal reference who have observed you during your practice of procedures who can attest to your current clinical abilities, ethical character, and health status.

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Peer Reference #1 Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone E-mail

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peer Reference #2 Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone E-mail

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Reference Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

(\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone E-mail

 **Section VIII: Conditions of Application**

I attest that the information contained in this profile and all enclosed/attached documents, which I agree to provide to support this profile, are complete and accurate. I agree to notify TSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Dentist / Pediatric Dentist Applicant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Dentist / Pediatric Dentist Applicant

**Privilege Delineation Form For:**

 **General Dentistry**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Official Use Only**  |
| **Accept**  | **Denied**  |
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**Please check the requested privileges below:**

\_\_\_\_\_\_\_ Extraction of teeth, simple and surgical

\_\_\_\_\_\_\_ Treatment of infections of dental origin or arising from the oral cavity or associated structures

\_\_\_\_\_\_\_ General restorative dentistry, operative dentistry, and fixed/ removable partial dentures

\_\_\_\_\_\_\_ Treatment of caries and replacement of teeth

\_\_\_\_\_\_\_ Basic gingival curettage, splinting, occlusal adjustment, scaling, and root planning

\_\_\_\_\_\_\_ Basic, non-surgical, pulp capping, pulpotomy, root filling (root canal)

\_\_\_\_\_\_\_ Reimplantation and stabilization of avulsed teeth

\_\_\_\_\_\_\_ \*Dental Implants

 *\*Subject to review and approval of the Governing Body based upon documentation of*

 *Previous experience and/or course certification*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Governing Board Signature Date Approved? (YES or NO)

**Privilege Delineation Form For:**

**Pediatric Dentistry**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Official Use Only**  |
| **Accept**  | **Denied**  |
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**Please check the requested privileges below:**

\_\_\_\_\_\_\_ Fulfillment of general dentistry (reference General Dentistry Privilege Delineation Form)

\_\_\_\_\_\_\_ Dental treatment of handicapped children and adults

\_\_\_\_\_\_\_ Dental trauma, excluding the treatment or manipulation of fractures to the maxillofacial region

\_\_\_\_\_\_\_ Dental treatment of medically compromised children, including evaluation and treatment of Hematology/Oncology patients, including treatment and prevention of microstomia, therapy to increase oro-motor function and dental preventive care

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| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |
| Applicant’s Signature      | Date  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Governing Board Signature  | Date  | Approved? (YES or NO)  |

#  Informed Consents

I recognize that it is my responsibility as the attending Dentist/ Pediatric Dentist, to explain the procedures, alternative treatment(s), possible complications, and expected outcome(s) to all my patients being admitted to Tennessee Surgery Center.

A photocopy of this shall serve as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

#  Release of Information

By making an application to the Tennessee Surgery Center as a Health Professional, I hereby authorize the Corporate Compliance Officer, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts.

A photocopy of this shall serve as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

#  Right of Confidentiality

As a member of the Medical Staff of the Tennessee Surgery Center, I recognize the patient’s right to confidentiality and agree to abide by the Patient’s Bill of Rights as posted within the Tennessee Surgery Center. Additionally, I agree that information relating to a patient’s physical, mental, and/or emotional status will not be released except as set forth within the policies and procedures of the Tennessee Surgery Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

#  Total Release of Liability

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Health Professional of the Tennessee Surgery Center (TSC), understand that TSC’s first priority is to meet the needs of the patient. In meeting this goal, I understand that Tennessee Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Tennessee Surgery Center from any liability during my stay as a Health Professional at Tennessee Surgery Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Full Name (Printed)

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  Signature    | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  Witness Signature  | Date  |

#  Acknowledgement of Notification

Notice to Physicians/Dentists: **“Medicare payment to ambulatory surgery centers is based on each patient’s principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient’s attending**

**Physician/Dentist by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal and State Laws.”**

I hereby acknowledge receipt of the above notice provided to me by Tennessee Surgery Center acting in accordance with 42 CFR Part 405, #405.472.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

#  Dictation Authorization

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Health Professional, authorize the Tennessee Surgery Center to automatically sign my dictation by typing “electronic signature on file” at the end of my reports. I will review copies of my transcribed reports and will provide corrected, dated and initialed copies whenever errors are found. The Tennessee Surgery Center will file the corrected report on the record together with original marked “Addended.” If I wish to personally review any dictation, I will dictate “to be personally reviewed prior to signing” at the end of my dictation and the Tennessee Surgery Center will flag the transcribed report for my signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Signature    | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Witness Signature  | Date |
|  |  |
|  |  |

#  Temporary Staff Privileges for:

#  Pediatric Dentist

Compliance Officer:

Please find my attached, completed, application for staff privileges as a Dentist/ Pediatric Dentist. I subsequently request temporary privileges for dental/surgical procedures delineated in my application so that I may perform procedures at Tennessee Surgery Center for a period of ninety (90) days or until such time as my application has been approved by the governing board.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

*(Official Use Only Below Line)*

Approved: \_\_\_\_\_\_\_\_ Denied:\_\_\_\_\_\_\_\_ Effective:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Credentialing Director Date

#  Full Approval of Appointment for:

#  Dentist / Pediatric Dentist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (Printed)

*(This Page Official Use Only)*

**Approved By Credentialing Staff:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Compliance Officer Signature     **Approved By Governing Body:**    | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| President, Tennessee Surgery Center  | Date  |

 **TENNESSEE SURGERY CENTER**

#  HEALTH SCREENING

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEALTH HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have you ever had the following: (yes or no)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Heart disease  | \_\_\_\_\_\_\_\_  |   | Liver disease  | \_\_\_\_\_\_\_\_  |
|  Lung disease  | \_\_\_\_\_\_\_\_  |   | Mental illness  | \_\_\_\_\_\_\_\_  |
|  Diabetes  | \_\_\_\_\_\_\_\_  |   | Depression  | \_\_\_\_\_\_\_\_  |
|  Epilepsy  | \_\_\_\_\_\_\_\_  |   | Musculoskeletal  | \_\_\_\_\_\_\_\_  |
|  Seizures  | \_\_\_\_\_\_\_\_  |   | disease or injury  | \_\_\_\_\_\_\_\_  |
|  Cancer  | \_\_\_\_\_\_\_\_  |   | Stomach or bowel  | \_\_\_\_\_\_\_\_  |
|  Tuberculosis  | \_\_\_\_\_\_\_\_  |   | Renal disease  | \_\_\_\_\_\_\_\_  |
|  Hypertension  | \_\_\_\_\_\_\_\_  |   | Fever/night sweats  | \_\_\_\_\_\_\_\_  |
|  |  |  |  |  |

 What are your current immunizations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any major hospitalizations and any previous surgeries including year. Exclude

childbirth.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAM:

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ Temp: \_\_\_\_\_ Sat: \_\_\_\_\_

Any recent illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent exposure to communicable diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent unexplained weight loss? \_\_\_\_\_\_ lbs \_\_\_\_\_\_\_\_\_\_over \_\_\_\_\_\_\_\_\_\_ months

Hepatitis B Series: Yes \_\_\_\_\_ No \_\_\_\_\_\_ Hep Titer results: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

T.B. skin test date: \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Influenza vaccine: Yes \_\_\_\_\_ No \_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ Comments:

Examiners Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

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Suite 300

Nashville, TN 37209

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Fax: (615) 645.9870

Bring Your Whole Self to Work

Tennessee Surgery Center is passionate about creating an inclusive workplace. A place where employees are engaged, knowing they are included and valued. An inclusive workplace that promotes and values diversity. Ambulatory Surgery Centers that are diverse in age, gender identity, race, sexual orientation, physical or mental ability, ethnicity, and perspective are proven to be better patient caregivers.

More importantly, creating an environment where everyone, from any background, can do their best work is the right thing to do. Thank you for not only bringing your whole self to work, but respecting others who do the same.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_