RENEWAL APPLICATION: ACTIVE MEDICAL/DENTAL STAFF

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

To process your renewal application for medical staff privileges with the Kentucky OCSHCN, please return the following:

☐ Renewal Application for Medical / Dental Staff (form OCSHCN-60i) Please sign and date (see back)
☐ Signed Authorization, Attestation, and Release (form OCSHCN-60e)
☐ Copy of current malpractice insurance endorsement
☐ Copy of current Kentucky State license
☐ Copy of current DEA license (if applicable)
☐ Up-to-date Curriculum Vitae or Resume

For APRN**, in addition to above**, please include:
☐ Copy of the Collaborative Practice Agreement with a physician and yourself
☐ Copy of your current credentialing from ANCC or the AANP

For PA, **in addition to above**, please include:
☐ Copy of the Initial & any Supplemental Application for Physician to Supervise PA
☐ Current credentialing from the NCCPA

PERSONAL INFORMATION:

Name (Last) _____ (First) _____ (MI) _____

Professional degree _____ DOB _____ Primary Specialty _____

KY State License Number _____ KY Medicaid Number _____

Email_____

Practice Name _____

Office Address _____

Office Phone _____ Office Fax _____

Office Contact Name_____Office Contact Email_____

CLINICAL PRIVILEGES REQUESTED: _____

PEER REFERENCES:
Please provide two names of physicians who have worked closely with you and can comment on your professional skills

Name & Institution _____

Street Address _____

City, state, zip code &
Country_____

Peer Reference Email_____

Office Contact Name_____Office Contact Email_____

Name & Institution _____

Street Address_____

City, state zip code & Country _____

Peer Reference Email_____

RENEWAL APPLICATION: ACTIVE MEDICAL/DENTAL STAFF

Office Contact Name_____Office Contact Email_____

Office for Children with Special Health Care Needs

DISCLOSURE:

Please answer the following questions for the period since your initial / last renewal application (3 years). For any "Yes" response, give full details on a separate sheet and attach to your application.

1. Has your license to practice medicine/dentistry in any jurisdiction been denied, suspended, limited, revoked or surrendered? Yes ☐ No ☐

2. Has your DEA license been denied, suspended, limited, revoked or surrendered? Yes ☐ No☐

3. Have you been convicted of a felony? Yes ☐ No ☐

4. Have your privileges at any hospital or institution been denied, suspended, limited, revoked or not renewed (for other than administrative reasons)? Yes ☐ No ☐

5. Have you resigned from a hospital staff or institution while under investigation regarding a breach of professional activity? Yes ☐ No ☐

6. Have you been denied membership or a renewal thereof or been subject to disciplinary proceedings in any medical organization? Yes ☐ No ☐

7. Are you now abusing, or have you ever been treated for abuse of chemical substances? Yes ☐ No ☐

8. Do you carry Medical Liability Insurance in an amount and kind that will insure protection of Commission patients under your care? Yes ☐ No ☐

9. Any claims within past 5 years? Yes ☐ No ☐ Any pending? Yes ☐ No ☐

10. Have you ever had malpractice or liability insurance coverage suspended or denied? Yes ☐ No ☐

NOTE: If there is any other significant information not asked on this page, which should be known by the committees evaluating your eligibility for staff membership, please provide as an attachment to this application.

I certify that all information provided by me in my application is current, true, accurate and complete to the best of my knowledge and belief and furnished in good faith. In making application for re-appointment to the KY OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients.

_____ _____

Signature Print name

_____

Date